This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.alliantplans.com. or by calling 1-800-811-4793.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$3500** person / **$7000** family. For non-participating providers **$20000** person / **$40000** family Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an **out–of–pocket limit** on my expenses?	Yes. For participating providers **$7150** person / **$14300** family. For non-participating providers **$40000** person / **$80000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See **www.alliantplans.com or call 1-800-811-4793** for a list of **preferred providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No.	You can see your **specialist** of choice without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Specialist visit	$60 co-pay/visit	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Other practitioner office visit	See Primary Care/Specialist Co-pay	See Primary Care/Specialist Co-pay	See your "Certificate of Coverage" for details
	Preventive care/screening/immunization	No Charge	60% co-insurance after deductible	See your "Certificate of Coverage" for details
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Imaging (CT/PET scans, MRIs)	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.alliantplans.com.	Generic Drugs	$10 co-pay/prescription	$10 co-pay/prescription	See your "Certificate of Coverage" for details
	Preferred brand drugs	$35 co-pay/prescription	$35 co-pay/prescription	See your "Certificate of Coverage" for details
	Non-preferred brand drugs	$70 co-pay/prescription	$70 co-pay/prescription	See your "Certificate of Coverage" for details
	Preferred Specialty drugs	25% co-insurance after deductible, $400 per Rx maximum	25% co-insurance after deductible	See your "Certificate of Coverage" for details
	Non-preferred Specialty drugs	N/A	N/A	N/A

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Physician/surgeon fees	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
If you need immediate medical attention	Emergency room services	$250 co-pay/visit	$250 co-pay/visit	See your "Certificate of Coverage" for details
	Emergency medical transportation	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Urgent care	$75 co-pay/visit	60% co-insurance after deductible	See your "Certificate of Coverage" for details
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Physician/surgeon fee	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health Outpatient Services	$30 co-pay / office visit	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Mental/Behavioral Health Inpatient Services	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Substance use disorder outpatient services	$30 co-pay / office visit	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Substance use disorder inpatient services	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
If you are pregnant	Prenatal and postnatal care	$30 co-pay/visit	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Delivery and all inpatient services	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-insurance after deductible	60% co-insurance after deductible	Limited to 120 visits per year
	Rehabilitation services	30% co-insurance after deductible	60% co-insurance after deductible	Limited to 40 visits per year
	Habilitation services	30% co-insurance after deductible	60% co-insurance after deductible	Limited to 40 visits per year
	Skilled nursing care	30% co-insurance after deductible	60% co-insurance after deductible	Limited to 60 days per year
	Durable medical equipment	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
	Hospice service	30% co-insurance after deductible	60% co-insurance after deductible	See your "Certificate of Coverage" for details
If your child needs dental or eye care	Eye exam	30 % Coinsurance after deductible	60 % Coinsurance after deductible	Limited to one exam per year
	Glasses	30 % Coinsurance after deductible	60 % Coinsurance after deductible	Limited to 1 item per year
	Dental check up	30 % Coinsurance after deductible	60 % Coinsurance after deductible	Limited to 2 procedures per year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care In-Network Chiropractic Services - limit 20 visits per year.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-811-4793. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can call 1-800-811-4793.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $3370**
- **Patient pays $4170**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$3500
Co-pays	$610
Co-insurance	$3002
Limits or exclusions	$60
Total	$7540

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $2722**
- **Patient pays $2678**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$1303
Co-pays	$1320
Co-insurance	$558
Limits or exclusions	$55
Total	$5400

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

જો તમે અથવા તમે કોઇને મદદ કરી રહ્ યા તેમ ાથી કોઇને [એસબીએમ ક ર્યક્રમન ં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ ચ વિન તમ રી ભ ષ મ ં પર્ મ કરી શક ર્ છે. દભ તિ કિર મ ટે,આ [અહીં ૬ ખલ કરો નાંબર] પર કોલ કરો (800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ ወይምእርስዎየ ሚገዙትግለሰብ፣ ስለAlliant Health Plansጥያቄ ካላችሁ፣ ያለ ምንምከፍያበቋንቋዎእርዳታና መረጃየ ማግኘት መብት አላችሁ። ከአስተርጓሚጋር ለመነ ጋገ ር፣ (800) 811-4793 ይደውሉ።

यदि आपके, या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधकिार है। दुभाषिए से बात करने के लिए, (800) 811-4793 पर कॉल करें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Alliant Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بتكلفة اية دون من بلغتك للتحدث مع مترجم اتصل ب (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر شما، یا به شما که کسی مورد در سوال ، میکنید کمک او Alliant Health Plans ، نمایید دریافت رایگان طور به را خود زبان به اطلاعات و کمک که دارید را این حق باشید داشته (800) 811-4793. نمایید حاصل تماس

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がござ いましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you.
Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).

Non Discrimination

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Alliant Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Alliant Health Plans tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Alliant Health Plans 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Alliant Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視 任何人。

Alliant Health Plans લાગુ પડતા સમવાયી નાગરક અધકાર કાયદા સાથે સુસંગત છે અને ત, રંગ, રાય મૂળ, મર, અશક્તતા અથવા લગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Alliant Health Plans respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Alliant Health Plans የፌዴራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Alliant Health Plans *लागू होने योग्य संघीय नाग□रक अ□धकार क़ानून का पालन करता है और जा□त, रंग, राष्ट्र□य मूल, आयु, □वकलांगता, या □लंग के आधार पर भेदभाव नह□ं करता है।*

Alliant Health Plans konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Alliant Health Plans соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

يلتزم ألصل الوطني أو السن أو الإعاقة أو الجنس. Alliant Health Plans *بقوانين الحقوق المدنية الفدرالية المعمول بها وال يميز على أساس العرق أو اللون أو*

Alliant Health Plans cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base naraça, cor, nacionalidade, idade, deficiência ou sexo.

افراد قابل نمی شود. Alliant Health Plans *از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت*

Alliant Health Plans erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Alliant Health Plansは適用される連邦公民権法を遵守し、人種、肌の色、出身国、 年齢、障害または性別 に基づく差別をいたしません