# 83761GA0040002012017

**Coverage for:** Individual or Individual + Family |**Plan Type:** PPO

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-811-4793 or visit www.alliantplans.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov or call 1-800-811-4793 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | **$1500** person / **$3000** family. For out of network 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 services covered before you meet your deductible? | Yes. Preventive care and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care without cost sharing and before you meet your deductible. See a list of covered preventive care at www.healthcare.gov/coverage/preventive-care-benefits. |
| Are there other deductibles for specific services? | No. | You don't have to meet for specific services, but see the chart starting on page 2 for other costs for services your plan covers. |
| What is the out-of-pocket limit for this plan? | Yes. For network providers **$7150** person / **$14300** family. For out of network 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 billing 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. |
| Will you pay less if you use a network provider? | Yes. See **www.alliantplans.com or call 1-800-811-4793** for a list of **preferred** providers. | If you use a network provider or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network provider 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 you need a referral to see a specialist? | No. | You can see your specialist of choice without permission from this plan. |

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copayment/visit | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Specialist visit | $50 copayment/visit | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Preventive care/screening/immunization | No Charge | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance after deductible | 40% coinsurance 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 (Tier 1) | $15 copayment/prescription | $15 copayment/prescription | See your "Certificate of Coverage" for details |
| | Preferred brand drugs (Tier 2) | $50 copayment/prescription | $50 copayment/prescription | See your "Certificate of Coverage" for details |
| | Non-preferred brand drugs (Tier 3) | $150 copayment/prescription | $150 copayment/prescription | See your "Certificate of Coverage" for details |
| | Specialty drugs (Tier 4) | 50% coinsurance after deductible | 50% coinsurance after deductible | See your "Certificate of Coverage" for details |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Physician/surgeon fees | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| **If you need immediate medical attention** | Emergency room care | $250 copayment/visit | $250 copayment/visit | See your "Certificate of Coverage" for details |
| | Emergency medical transportation | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Urgent care | $75 copayment/visit | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Physician/surgeon fees | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $20 copayment/office visit | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Inpatient services | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| If you are pregnant | Office visits | $20 copayment/visit | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Childbirth/delivery professional services | $20 copayment/visit | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Childbirth/delivery facility services | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance after deductible | 40% coinsurance after deductible | Limited to 120 visits per year |
| | Rehabilitation services | 0% coinsurance after deductible | 40% coinsurance after deductible | Limited to 40 visits per year |
| | Habilitation services | 0% coinsurance after deductible | 40% coinsurance after deductible | Limited to 40 visits per year |
| | Skilled nursing care | 0% coinsurance after deductible | 40% coinsurance after deductible | Limited to 60 days per year |
| | Durable medical equipment | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| | Hospice services | 0% coinsurance after deductible | 40% coinsurance after deductible | See your "Certificate of Coverage" for details |
| If your child needs dental or eye care | Children's eye exam | 0 % coinsurance after deductible | 40 % coinsurance after deductible | Limited to one exam per year |
| | Children's glasses | 0 % coinsurance after deductible | 40 % coinsurance after deductible | Limited to 1 item per year |
| | Children's dental check-up | 0 % coinsurance after deductible | 40 % coinsurance after deductible | Limited to 2 procedures per year |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any 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

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- 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 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.

**Does this plan provide Minimum Essential Coverage?** **Yes**

The Affordable Care Act requires most people to have health care coverage that qualifies as minimum essential coverage. **This plan or policy does provide minimum essential coverage.**

**Does this plan meet Minimum Value Standards?** **Yes**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| Total Example Cost | $12800 |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1500 |
| Copayments | $440 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $2000 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| Total Example Cost | $7400 |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1500 |
| Copayments | $1375 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | $2930 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| Total Example Cost | $1900 |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1500 |
| Copayments | $150 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1650 |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

## 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 i તેમ ાથી કોઇને [એસબીએમ ક ર્યક્રમન ં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ં પર્ મ કરી શક ર્ છે. દભ તિ કિર મ ટે,આ [અહીં ૂ ખવ 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 ሚገዘትግለሰብ፣ ስለ**Alliant Health Plans**ጥያቄ ካላችሁ፣ ያለ ምንምከፍያበቋንቋዎእርዳታና ሚጂየ ማግኘት መብት አላችሁ። ከአስተርጓሚጋር ለመ 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 अधिकार है। भिाषए से बात करने के लिए,* (800) 811-4793 *पर कॉि 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.

*بخصوص أسئلة تساعده شخص لدى أو لديك كان إن* Alliant Health Plans *، تكلفة اية دون من بلغتك الضرورية والمعلومات المساعدة على الحصول في الحق فلديك. ب اتصل مترجم مع للتحدث* (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 به یا کسی که او به کمک میکنید ، سوال در مورد* Alliant Health Plans *، داشته باشید حق را این خود زبان به را طور رایگان دریافت نمایید و کمک که دارید به اطلاعات نمایید حاصل تماس.* (800) 811-4793.

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 ધિધકાર 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 የፌደራል 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.

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

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

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 افراد قایل نمی شود.

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

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