Coverage Period: Beginning on or after January 1, 2019

SoloCare Bronze HDHP 40031-01

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?	**$6750** person / **$13500** 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?	No. You will have to meet the deductible before the plan pays for any services.	This plan may cover 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 a deductible 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 **$6750** person / **$13500** family. For out of network providers **$N/A** person / **$N/A** 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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after deductible	40% coinsurance after deductible	See your "Certificate of Coverage" for details
	Specialist visit	0% coinsurance after deductible	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)	0% coinsurance after deductible	0% coinsurance after deductible	See your "Certificate of Coverage" for details
	Preferred brand drugs (Tier 2)	0% coinsurance after deductible	0% coinsurance after deductible	See your "Certificate of Coverage" for details
	Non-preferred brand drugs (Tier 3)	0% coinsurance after deductible	0% coinsurance after deductible	See your "Certificate of Coverage" for details
	Specialty drugs (Tier 4)	0% coinsurance after deductible	0% 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	0% coinsurance after deductible	0% coinsurance after deductible	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	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 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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	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	0% coinsurance after deductible	40% coinsurance after deductible	See your "Certificate of Coverage" for details
	Childbirth/delivery professional services	0% coinsurance after deductible	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	See your "Evidence of Coverage" for details
	Children's dental check-up	0% coinsurance after deductible	40% coinsurance after deductible	See your "Evidence of Coverage" for details

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Alliant Health Plans at 1-800-811-4793, the Georgia Department of Insurance, 1-800-656-2298 or www.oci.ga.gov, 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.. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. The contact information for questions about your rights, this notice, or assistance: Alliant Health Plans at 1-800-811-4793, theGeorgia Department of Insurance, 1-800-656-2298 or www.oci.ga.gov, 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.. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have minimum essential coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the minimum value standard, you may be eligible for premium tax credits to help you pay for a plan through the Marketplace.

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 **$6750**
- Specialist coinsurance **0%**
- 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	$7000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7060

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

- The plan's overall deductible **$7000**
- Specialist coinsurance **0%**
- 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	$7000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$7055

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

- The plan's overall deductible **$6750**
- Specialist coinsurance **0%**
- 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	$1925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1925

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

Notice of 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 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alliant Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Customer Service at (800) 811-4793**.

If you believe that Alliant Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Sabrina LeBeau, Compliance Officer, 1503 N. Tibbs Rd. Dalton, GA 30720, Ph: (706) 237-8802 or (888) 533-6507 ext 125, Fax: (706) 229-6289, Email: Compliance@AlliantPlans.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Sabrina LeBeau is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

English

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-811-4793 (TTY: 711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-811-4793 (TTY: 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-811-4793 (TTY: 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-811-4793 (TTY: 711)번으로 전화해 주십시 h 오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-811-4793（TTY：711）。

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-811-4793 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-811-4793 (ATS : 711).

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-811-4793 (መስማት ለተሳናቸው: 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-811-4793 (TTY: 711) पर कॉल करें।

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-811-4793 (TTY: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-811-4793 (телетайп: 711).

العربية **(Arabic)**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-4793-811-800 (رقم هاتف الصم والبكم: (711 TTY).

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-811-4793 (TTY: 711).

فارسی **(Farsi)**
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-811-4793 (TTY: 711) تماس بگیرید.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-811-4793 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-811-4793（TTY:711）まで、お電話にてご連絡ください。