Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual or Individual + Family | **Plan TYPE: PSHCC**

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?	**$500** person / **$1,500** family. For non-participating providers **$1,500** person / **$4,500** 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 **$3,500** person / **$10,500** family. For non-participating providers **$9,000** person / **$27,000** 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**.

Questions: Call 1-800-811-4793 or visit us at www.alliantplans.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.healthcare.gov or call 1-800-811-4793 to request a copy.

- 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	$25 co-pay/visit	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Specialist visit	$50 co-pay/visit	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Other practitioner office visit	See Primary Care/Specialist Copay	See Primary Care/Specialist Copay	See your "Certificate of Coverage" for details
	Preventive care/screening/immunization	No Charge	40% co-insurance after deductible	See your "Certificate of Coverage" for details
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% 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	100%	See your "Certificate of Coverage" for details
	Preferred brand drugs	$25 co-pay/prescription	100%	See your "Certificate of Coverage" for details
	Non-preferred brand drugs	$50 co-pay/prescription	100%	See your "Certificate of Coverage" for details
	Preferred Specialty drugs	See Preferred/Non Preferred Brand Drugs	See Preferred/Non Preferred Brand Drugs	See your "Certificate of Coverage" for details
	Non-preferred Specialty drugs	See Preferred/Non Preferred Brand Drugs	See Preferred/Non Preferred Brand Drugs	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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Physician/surgeon fees	20% co-insurance after deductible	40% 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 if life threatening	See your "Certificate of Coverage" for details
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible if life threatening	See your "Certificate of Coverage" for details
	Urgent care	$75 co-pay	40% co-insurance after deductible	See your "Certificate of Coverage" for details
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Physician/surgeon fee	20% co-insurance after deductible	40% 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	$25 co-pay / office visit and subject to co-insurance after deductible on other outpatient services	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Mental/Behavioral Health Inpatient Services	20% co-insurance after deductible	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Substance use disorder outpatient services	$25 co-pay / office visit and subject to co-insurance after deductible on other outpatient services	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	See your "Certificate of Coverage" for details
If you are pregnant	Prenatal and postnatal care	20% co-insurance after deductible	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Delivery and all inpatient services	20% co-insurance after deductible	40% 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	20% co-insurance after deductible	40% co-insurance after deductible	Limit to 120 visits per Calendar Year
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	In Patient - Limited to 30 days per year Outpatient - Speech, Physical and Occupational - 30 visit limit combined
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Limit 20 visits combined with other therapy
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	Limited to 30 days per year
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	See your "Certificate of Coverage" for details
	Hospice service	20% co-insurance after deductible	40% co-insurance after deductible	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check up	Not Covered	Not Covered	Not Covered

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
- Chiropratic services by an out of network provider are not covered.
- 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 (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 only - 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 $5,480**
- **Patient pays $2,060**

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	$500
Co-pays	$20
Co-insurance	$1,350
Limits or exclusions	$190
Total	**$2,060**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,810**
- **Patient pays $1,590**

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	$500
Co-pays	$630
Co-insurance	$240
Limits or exclusions	$220
Total	**$1,590**

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.