



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 <u>deductible</u> ? | \$750 person / \$1500 family. For non-participating providers \$4500 person / \$9000 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 <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses? | Yes. For participating providers \$3000 person / \$6000 family. For non-participating providers \$9000 person / \$18000 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 <u>out-of-pocket limit</u> ? | 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network</u> of <u>providers</u> ? | 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 <u>specialist</u> ? | 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 . |

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

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



- **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 <u>provider's</u> 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 | \$70 co-pay/visit | 40% 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 | 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 <u>prescription drug coverage</u> 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 | \$49 co-pay/prescription | \$49 co-pay/prescription | See your "Certificate of Coverage" for details |
| | Non-preferred brand drugs | \$125 co-pay/prescription | \$125 co-pay/prescription | See your "Certificate of Coverage" for details |
| | Preferred Specialty drugs | \$300 co-pay/prescription | \$300 co-pay/prescription | See your "Certificate of Coverage" for details |
| | Non-preferred Specialty drugs | N/A | N/A | N/A |

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

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

| 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 | \$300 co-pay/visit | \$300 co-pay/visit | See your "Certificate of Coverage" for details |
| | Emergency medical transportation | 20% co-insurance after deductible | 40% co-insurance after deductible | 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 | \$70 co-pay / office visit | 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 | \$70 co-pay / office visit | 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 | 25% 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 |

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Coverage Period: Beginning on or after

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

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

| 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 | \$70 co-pay / office visit | 40% co-insurance after deductible | In Patient - Limited to 30 days per year Outpatient - Speech, Physical and Occupational - 20 visit limit combined |
| | Habilitation services | \$20 co-pay / office visit | 40% co-insurance after deductible | Limit 20 visits combined with other therapy |
| | Skilled nursing care | \$70 co-pay/visit | 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 | See your "Certificate of Coverage" for details |
| If your child needs dental or eye care | Eye exam | 0 % Coinsurance after deductible | 40 % Coinsurance after deductible | Limited to one exam per year |
| | Glasses | 0 % Coinsurance after deductible | 40 % Coinsurance after deductible | See your "Evidence of Coverage" for details |
| | Dental check up | \$25 copay per visit | \$40 copay per visit | See your "Evidence of Coverage" for details |

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

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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 **\$5750**
- Patient pays **\$1790**

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 | \$600 |
| Co-pays | \$30 |
| Co-insurance | \$1010 |
| Limits or exclusions | \$150 |
| Total | \$7540 |

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

- Amount owed to providers: **\$5,400**
- Plan pays **\$4360**
- Patient pays **\$1040**

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 | \$600 |
| Co-pays | \$0 |
| Co-insurance | \$360 |
| Limits or exclusions | \$80 |
| Total | \$5400 |

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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.

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