

 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?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or In Network: \$2,000/Individual, \$4,000/Family Out of Network: \$20,000/Individual, \$40,000/Family	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/screening /immunization. Additional details included per service category elsewhere in this SBC.	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 services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP	You don't have to meet a deductible for specific services.
What is the out-of-pocket limit for this plan?	In Network: \$8,700/Individual, \$17,400/Family Out of Network: None	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges (unless balance billing is prohibited), 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 network providers .	This plan uses a provider network . You will pay less if you use a provider , in the plan's network. You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider , for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider , before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral



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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay less)	Non-IHCP 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.	No Charge			See your "Certificate of Coverage" for details
	Specialist visit	No Charge			See your "Certificate of Coverage" for details
	Preventive care/screening /immunization	No Charge			You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge			See your "Certificate of Coverage" for details
	Imaging (CT/PET scans, MRIs)	No Charge			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	No Charge	\$15 copayment , Deductible does not apply	\$15 copayment , Deductible does not apply	See your "Certificate of Coverage" for details
	Preferred brand drugs	No Charge	\$30 copayment , Deductible does not apply	\$30 copayment , Deductible does not apply	
	Non-preferred brand drugs	No Charge	\$60 copayment , Deductible does not apply	\$60 copayment , Deductible does not apply	
	Specialty drugs	No Charge	\$250 copayment , Deductible does not apply	\$250 copayment , Deductible does not apply	

[* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.alliantplans.com].]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay less)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge			See your "Certificate of Coverage" for details
	Physician/surgeon fees	No Charge			See your "Certificate of Coverage" for details
If you need immediate medical attention	Emergency room care	No Charge			See your "Certificate of Coverage" for details
	Emergency medical transportation	No Charge			See your "Certificate of Coverage" for details
	Urgent care	No Charge			See your "Certificate of Coverage" for details
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge			See your "Certificate of Coverage" for details.
	Physician/surgeon fees	No Charge			See your "Certificate of Coverage" for details
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	and for other outpatient services		Other Outpatient services may include intensive outpatient therapy (IOP), partial hospitalization program (PHP), tests described elsewhere in the SBC.
	Inpatient services	No Charge			See your "Certificate of Coverage" for details.
If you are pregnant	Office visits	No Charge			Office Visits after confirmation of Pregnancy are subject to Coinsurance. Cost sharing does not apply for preventive services. Office Visits unrelated to Pregnancy are subject to the PCP or

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay less)	Non-IHCP Out-of-Network Provider (You will pay the most)	
					Specialist Copay. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge			See your "Certificate of Coverage" for details
	Childbirth/delivery facility services	No Charge			See your "Certificate of Coverage" for details
If you need help recovering or have other special health needs	Home health care	No Charge			Limited to 120 visits per year
	Rehabilitation services	No Charge			Limited to 40 visits per year
	Habilitation services	No Charge			Limited to 40 visits per year
	Skilled nursing care	No Charge			Limited to 60 days per year
	Durable medical equipment	No Charge			See your "Certificate of Coverage" for details
	Hospice services	No Charge			See your "Certificate of Coverage" for details
If your child needs dental or eye care	Children's eye exam	No Charge			Limited to 1 exam per year
	Children's glasses	No Charge			Limited to 1 item per year
	Children's dental check-up	Not Covered			Limited to 2 procedure per year

[* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.alliantplans.com].]

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](#).)

- Non-emergency care when traveling outside the U.S.

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

- | | | |
|--|-------------------------|---|
| • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) | • Dental care (Adult) | • Routine eye care |
| • Acupuncture | • Hearing aids | • Routine foot care |
| • Bariatric surgery | • Infertility treatment | • Weight loss programs (4 visits per year for nutritional counseling) |
| • Chiropractic care | • Long-term care | |
| • Cosmetic surgery limited to reconstructive surgery to restore function | • Private-duty nursing | |

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, 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.

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 the Minimum Value Standards? Not Applicable

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-613-2262.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-613-2262.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-613-2262.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-613-2262.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000
■ Specialist	Not Applicable	■ Specialist	Not Applicable	■ Specialist	Not Applicable
■ Hospital (facility)	Not Applicable	■ Hospital (facility)	Not Applicable	■ Hospital (facility)	Not Applicable
■ Other	Not Applicable	■ Other	Not Applicable	■ Other	Not Applicable
<p>This EXAMPLE event includes services like:</p> <p>Specialist office visits (<i>prenatal care</i>)</p> <p>Childbirth/Delivery Professional Services</p> <p>Childbirth/Delivery Facility Services</p> <p>Diagnostic tests (<i>ultrasounds and blood work</i>)</p> <p>Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Primary care physician office visits (<i>including disease education</i>)</p> <p>Diagnostic tests (<i>blood work</i>)</p> <p>Prescription drugs</p> <p>Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Emergency room care (<i>including medical supplies</i>)</p> <p>Diagnostic test (<i>x-ray</i>)</p> <p>Durable medical equipment (<i>crutches</i>)</p> <p>Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$70	The total Joe would pay is	\$720	The total Mia would pay is	\$5

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.