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, https://allstatevoluntary.com/fullyinsured/index.php or call 1-800-323-3049. 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 **https://www.healthcare.gov/sbc-glossary** or call 1-800-323-3049 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers $5,000 individual/$10,000 family; For non-participating providers $10,000 individual/$20,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family 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 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $8,700 individual/ $17,400 family; for non-participating providers $26,100 individual/ $52,200 family.	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 limits 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, penalty for not obtaining Preauthorization 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 https://allstatevoluntary.com/fullyinsured/providerdirectory/ or call 1-800-323-3049 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
		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	$40 copay/office visit; deductible does not apply	50% coinsurance	Copay applies to exam charge only. Does not include office surgery.
	Specialist visit	$60 copay/visit; deductible does not apply	50% coinsurance	Copay applies to exam charge only. See Plan Document for other services.
	Preventive care/screening/ immunization	No charge	50% coinsurance	As required under the Affordable Care Act (ACA), cost sharing does not apply to identified clinical preventive services. Any other preventive medicine services covered under your plan are subject to deductible and coinsurance. 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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.cigna.com/static/www-cigna-com/docs/individuals-families/member-	Generic drugs (Tier 1)	$20 copay/prescription retail/$60 copay/prescription mail-order. Deductible does not apply	Not covered	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$50 copay/prescription retail/$150 copay/prescription mail-order. Deductible does not apply	Not covered	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).

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)	
resources/prescription/legacy-performance-4-tier.pdf	Non-preferred brand drugs (Tier 3)	$75 copay/prescription retail/$225 copay/prescription mail-order. Deductible does not apply	Not covered	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).
	Specialty drugs (Tier 4)	30% coinsurance	Not covered	Preauthorization is required. Benefits not be covered unless they have been authorized by the Plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Non-emergency use will result in a reduction of charges.
	Emergency medical transportation	30% coinsurance	30% coinsurance	To the nearest Acute Medical Facility that can treat the sickness or injury.
	Urgent care	$75 copay/visit; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment. For transplant services that are not preauthorized, benefits will be reduced by 50% of the otherwise Covered Charges.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment.
If you are pregnant	Office visits	$60 copay/visit; deductible does not apply	50% coinsurance	Copay applies to exam charge only. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). See Plan Document for

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)	
				other services.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment. Limited to 20 visits per year.
	Rehabilitation services	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment. Combined outpatient limit of 35 visits per year physical therapy (PT), occupational therapy (OT), speech therapy (ST), and chiropractic services. Inpatient Rehabilitative services are limited to a combined maximum benefit of 21 days each Year.
	Habilitation services	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment.
	Skilled nursing care	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment. Maximum Benefit of 60 days per year.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization is required for amounts greater than $1,500. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment.
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization is required. If not received, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment.
If your child needs	Children's eye exam	No charge	50% coinsurance.	Limited to 1 exam per year. Please visit

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)	
dental or eye care			Deductible does not apply	www.vsp.com/advantageonly or call 1-800-877-7195 to locate a participating provider.
	Children's glasses	No charge	50% coinsurance. Deductible does not apply	Limited to 1 exam per year. Please visit www.vsp.com/advantageonly or call 1-800-877-7195 to locate a participating provider.
	Children's dental check-up	No charge	No charge	Limited to 2 exams 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), except for treatment of diabetes
- Routine foot care, except for treatment of diabetes
- 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, limit of 35 visits per year combined with PT/OT/ST.

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: the plan at 1-800-323-3049 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform. 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-800-323-3049 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
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:

* For more information about limitations and exceptions, see the plan or policy document at https://allstatevoluntary.com/fullyinsured/index.php.

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-323-3049.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-323-3049.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-323-3049.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-323-3049.

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	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,370**

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

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

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

Non-Discrimination Notice

National Health Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. National Health Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, orsex.

National Health Insurance Company:

- 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, please contact customer service at 1-800-323-3049 (for TTY please dial 711).

If you believe that National Health Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, nationalorigin, age, disability, or sex, you can file a grievance by mail, fax, or e-mail at the following:

Mail: National Health Insurance Company
Attn: Civil Rights Coordinator
P.O. Box 2070
Milwaukee, WI 53201-2070

E-mail: NGAHcorrespondence@ngic.com
*Please put "Grievance Review – Non-Discrimination" in the subject line of your e-mail.

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 Services200 Independence Avenue, SW
Room 509F, HHH BuildingWashington, 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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-323-3049 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-323-3049 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-323-3049 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-323-3049 (TTY: 711).

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 1-800-323-3049（TTY：711）。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-323-3049 (ATS : 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-323-3049 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-323-3049 (телетайп: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-323-3049 (رقم هاتف الصم والبكم: 117).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-323-3049 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-323-3049 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-323-3049 (TTY: 711)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-323-3049 (TTY: 711).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-323-3049 (መስማት ለተሳናቸው: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-323-3049 (TTY: 711).