The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call 1-800-323-3049 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating <u>providers</u> \$1,000 individual/\$2,000 family; For non-participating <u>providers</u> \$2,000 individual/\$4,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount.  But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	For participating <u>providers</u> \$7,500 individual/ \$15,000 family; for non-participating <u>providers</u> \$22,500 individual/ \$45,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	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 <u>network provider</u> ?	Yes. See <a href="https://allstatevoluntary.com/fullyinsured/providerdirectory/">https://allstatevoluntary.com/fullyinsured/providerdirectory/</a> or call 1-800-323-3049 for a list of <a href="network providers">network providers</a> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>non-participating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>participating provider</u> might use an <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /office visit; <u>deductible</u> does not apply	50% coinsurance	Copay applies to exam charge only. Does not include office surgery.
If you visit a health care	Specialist visit	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	50% coinsurance	Copay applies to exam charge only. *See section in Plan Certificate on the Medical Benefits for other services.
provider's office or clinic	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.
	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
If you have a test	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	Generic drugs (Tier 1)	\$20 copay/prescription retail/\$60 copay/prescription mailorder. Deductible does not apply	Full price at time of payment, then submit for reimbursement at 50% coinsurance.	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).
coverage is available at https://www.cigna.com/st atic/www-cigna-com/docs/individuals-families/member-	Preferred brand drugs (Tier 2)	\$50 copay/prescription retail/\$150 copay/prescription mailorder. Deductible does not apply	Full price at time of payment, then submit for reimbursement at 50% coinsurance.	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).

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at <a href="https://allstatevoluntary.com/fullyinsured/index.php">https://allstatevoluntary.com/fullyinsured/index.php</a>.

		What You Will Pay			
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
resources/prescription/le gacy-performance-4- tier.pdf	Non-preferred brand drugs (Tier 3)	\$75 copay/prescription retail/\$225 copay/prescription mailorder. Deductible does not apply	Full price at time of payment, then submit for reimbursement at 50% coinsurance.	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% <u>coinsurance</u>	50% coinsurance	Preauthorization is required. Benefits will be reduced by 50% of the otherwise Covered Charges for any Specialty Pharmaceuticals that are not authorized. *See sections in Plan Certificate on Medical Benefits and Outpatient Prescription Drug Benefits for additional details.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	<u>Preauthorization</u> is required. If not received, benefits will be reduced for otherwise Covered Charges by	
surgery	Physician/surgeon fees	30% coinsurance	50% coinsurance	30%, but by no more than \$1,000 per course of treatment.	
	Emergency room care	30% coinsurance	30% coinsurance	Non-emergency use will result in a reduction of charges.	
If you need immediate medical attention	Emergency medical transportation	30% coinsurance	30% coinsurance	To the nearest Acute Medical Facility that can treat the sickness or injury.	
medical attention	<u>Urgent care</u>	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	50% coinsurance	None	
	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	<u>Preauthorization</u> is required. If not received, benefits will be reduced for otherwise Covered Charges by	
If you have a hospital stay	Physician/surgeon fees	30% coinsurance	50% coinsurance	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.	
If you need mental	Outpatient services	30% coinsurance	50% coinsurance	None	
health, behavioral health, or substance abuse services	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	

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at <a href="https://allstatevoluntary.com/fullyinsured/index.php">https://allstatevoluntary.com/fullyinsured/index.php</a>.

		What You Will Pay			
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
				treatment.	
If you are pregnant	Office visits	\$60 <u>copay</u> /visit; <u>deductible</u> 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 section in Plan Certificate on Medical Benefits for other services.	
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	None	
	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 60 visits per year.	
If you need help	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. Outpatient limit of 35 visit per year combined with physical therapy (PT), occupational therapy (OT), speech therapy (ST), and pulmonary rehabilitation.	
recovering or have other special health needs	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 25 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.	

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at <a href="https://allstatevoluntary.com/fullyinsured/index.php">https://allstatevoluntary.com/fullyinsured/index.php</a>.

			What You Will Pay		
	Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Hospice services	30% coinsurance	50% coinsurance	<u>Preauthorization</u> 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.
	Marana shiid aasada	Children's eye exam	No charge	50% <u>coinsurance</u> . <u>Deductible</u> does not apply	Limited to 1 exam per year. Please visit <a href="https://www.vsp.com/advantageonly">www.vsp.com/advantageonly</a> or call 1-800-877-7195 to locate a participating <a href="provider">provider</a> .
If your child needs dental or eye care	Children's glasses	No charge	50% <u>coinsurance</u> . <u>Deductible</u> 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)

- 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 visit per year combined with PT/OT/ST and pulmonary rehabilitation.
- Hearing aids, limited to 1 per ear every 3 years

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 <u>plan</u> at 1-800-323-3049 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>. Other coverage options may be available to you, too, including buying individual insurance coverage through the <a href="health-lnsurance">Health Insurance</a> <a href="Marketplace">Marketplace</a>. For more information about the Marketplace, visit <a href="www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the <u>plan</u> at 1-800-323-3049 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) <u>www.dol.gov/ebsa/healthreform</u>.

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at <a href="https://allstatevoluntary.com/fullyinsured/index.php">https://allstatevoluntary.com/fullyinsured/index.php</a>.

## 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:**

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.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at <a href="https://allstatevoluntary.com/fullyinsured/index.php">https://allstatevoluntary.com/fullyinsured/index.php</a>.

### **About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$1,000
■ 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		
<u>Deductibles</u>	\$1,000	
<u>Copayments</u>	\$10	
Coinsurance	\$3,500	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,570	

# **Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
Other coinsurance	30%

### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$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 <u>plan's</u> overall <u>deductible</u>	\$1,000
■ 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)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,000	
Copayments	\$200	
Coinsurance	\$400	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,600	

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

#### **Non-Discrimination Notice**

Integon National 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. Integon National Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, orsex.

Integon National Insurance Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o 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:
  - o Qualified interpreters
  - o 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 Integon National Insurance Company 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 by mail, fax, or e-mail at the following:

Mail: Integon National 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 <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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).

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)。

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

خبر دار: اگر آپ ار دو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .(TTY: 711) -303-080-1-800-1-800 خبر دار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .(TTY: 711). ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-909-323-800 (رقم هاتف الصم والبكم: 117).

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).

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

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए म्फ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-323-3049 (TTY: 711) पर कॉल करें।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) و304-323-800-1 تماس بگیرید.

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

સુયના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 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).

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。1-800-323-3049 (TTY:711) まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-323-3049 (TTY: 711).