



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:   |
|---|---|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For participating <a href="#">providers</a> \$4,000 individual/\$8,000 family; For non-participating <a href="#">providers</a> \$8,000 individual/\$16,000 family.  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For participating <a href="#">providers</a> \$9,200 individual/ \$18,400 family; for non-participating <a href="#">providers</a> \$27,600 individual/ \$55,200 family.  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalty for not obtaining <a href="#">Preauthorization</a> and health care this <a href="#">plan</a> doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| <b>Will you pay less if you use a <a href="#">participating provider</a>?</b>         | 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="#">participating providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">participating provider</a> might use a <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |



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   |
|--|--|---|---|--|
|  |  | Participating Provider<br>(You will pay the least)  | Non-Participating Provider<br>(You will pay the most) |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness       | \$40 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply   | 50% <a href="#">coinsurance</a>                       | <a href="#">Copay</a> applies to exam charge only. Does not include office surgery.  |
|  | <a href="#">Specialist</a> visit                       | \$60 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply  | 50% <a href="#">coinsurance</a>                       | <a href="#">Copay</a> applies to exam charge only. *See section in <a href="#">Plan</a> Certificate on the Medical Benefits for other services.  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | 50% <a href="#">coinsurance</a>                       | As required under the Affordable Care Act (ACA), <a href="#">cost sharing</a> does not apply to identified clinical <a href="#">preventive services</a> . Any other preventive medicine services covered under your <a href="#">plan</a> are subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| <b>If you have a test</b>  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       | None   |
|  | Imaging (CT/PET scans, MRIs)                           | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       | <a href="#">Preauthorization</a> 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.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.cigna.com/static/www-cigna-com/docs/individuals-families/member-">https://www.cigna.com/static/www-cigna-com/docs/individuals-families/member-</a> | Generic drugs (Tier 1)                                 | \$20 <a href="#">copay</a> /prescription retail/\$60 <a href="#">copay</a> /prescription mail-order. <a href="#">Deductible</a> 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 <a href="#">copay</a> /prescription retail/\$150 <a href="#">copay</a> /prescription mail-order. <a href="#">Deductible</a> 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).   |

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

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|--|---|---|--|
|   |  | Participating Provider<br>(You will pay the least)  | Non-Participating Provider<br>(You will pay the most) |  |
| <a href="#">resources/prescription/legacy-performance-4-tier.pdf</a>      | Non-preferred brand drugs (Tier 3)               | \$75 <a href="#">copay</a> /prescription retail/\$225 <a href="#">copay</a> /prescription mail-order. <a href="#">Deductible</a> 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). |
|   | <a href="#">Specialty drugs</a> (Tier 4)         | 30% <a href="#">coinsurance</a>   | Not covered   | <a href="#">Preauthorization</a> is required. *See sections in <a href="#">Plan Certificate on Medical Benefits and Outpatient Prescription Drug Benefits</a> for additional details.          |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       | <a href="#">Preauthorization</a> 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% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       |  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                       | Non-emergency use will result in a reduction of charges.   |
|   | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                       | To the nearest Acute Medical Facility that can treat the sickness or injury.   |
|   | <a href="#">Urgent care</a>                      | \$75 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply  | 50% <a href="#">coinsurance</a>                       | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       | <a href="#">Preauthorization</a> 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% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       | None   |
|   | Inpatient services                               | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                       | <a href="#">Preauthorization</a> 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 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply  | 50% <a href="#">coinsurance</a>                       | <a href="#">Copay</a> applies to exam charge only. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). *See section in <a href="#">Plan</a>       |

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

| Common Medical Event  | Services You May Need                     | What You Will Pay                                  |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Participating Provider<br>(You will pay the least) | Non-Participating<br>Provider<br>(You will pay the most) |   |
|   |   |  |  | Certificate on Medical Benefits for other services.   |
|   | Childbirth/delivery professional services | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | None  |
|   | Childbirth/delivery facility services     | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | None  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | <a href="#">Preauthorization</a> 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.   |
|   | <a href="#">Rehabilitation services</a>   | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | <a href="#">Preauthorization</a> 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 20 visits per year physical therapy (PT). Limit of 20 visits per year for occupational therapy (OT). |
|   | <a href="#">Habilitation services</a>     | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | <a href="#">Preauthorization</a> 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. Limit of 20 visits per year for PT. Limit of 20 visits per year for OT.  |
|   | <a href="#">Skilled nursing care</a>      | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | <a href="#">Preauthorization</a> 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.   |
|   | <a href="#">Durable medical equipment</a> | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | <a href="#">Preauthorization</a> 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.   |
|   | <a href="#">Hospice services</a>          | 30% <a href="#">coinsurance</a>                    | 50% <a href="#">coinsurance</a>                          | <a href="#">Preauthorization</a> 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.  |
| <b>If your child needs</b>  | Children's eye exam                       | No charge  | 50% <a href="#">coinsurance</a> .                        | Limited to 1 exam per year. Please visit  |

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

| Common Medical Event | Services You May Need      | What You Will Pay                                  |  | Limitations, Exceptions, & Other Important Information  |
|----------------------|----------------------------|--|--|---|
|                      |                            | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most)                          |   |
| dental or eye care   |                            |  | <a href="#">Deductible</a> does not apply                                      | <a href="http://www.vsp.com/advantageonly">www.vsp.com/advantageonly</a> or call 1-800-877-7195 to locate a participating <a href="#">provider</a> .  |
|                      | Children's glasses         | No charge  | 50% <a href="#">coinsurance</a> .<br><a href="#">Deductible</a> does not apply | Limited to 1 exam per year. Please visit <a href="http://www.vsp.com/advantageonly">www.vsp.com/advantageonly</a> or call 1-800-877-7195 to locate a participating <a href="#">provider</a> . |
|                      | Children's dental check-up | No charge  | No charge  | Limited to 2 exams per year.  |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>   | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult), except for treatment of diabetes</li> <li>• Routine foot care, except for treatment of diabetes</li> <li>• Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Chiropractic care, limit of 26 visits per year with a participating provider</li> </ul>             | <ul style="list-style-type: none"> <li>• Hearing aids, limited to those provided to a newborn for initial amplification following a newborn hearing screening.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing, limited to the services given as part of the Home health care services benefit.</li> </ul> |

**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](http://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](http://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](http://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](#).

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

**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, kwijigo holne' 1-800-323-3049.

*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)

- The [plan's](#) overall [deductible](#) \$4,000
- [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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,600        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,670</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,000
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,820</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$4,000
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,500        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,700</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.