




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? | \$7,000 individual/\$14,000 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? | \$9,200 individual/ \$18,400 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 non-participating 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 participating provider might use an non-participating 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 |
|--|--|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | 30% coinsurance | 50% coinsurance | None |
| | Specialist visit | 30% coinsurance | 50% coinsurance | None |
| | 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-resources/prescription/legacy-performance-4-tier.pdf | Generic drugs (Tier 1) | 30% coinsurance | 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). |
| | Preferred brand drugs (Tier 2) | 30% coinsurance | 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). |
| | Non-preferred brand drugs (Tier 3) | 30% coinsurance | 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). |

* 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 (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | | | | prescription). |
| | Specialty drugs (Tier 4) | 30% coinsurance | 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 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 | 30% coinsurance | 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 | 30% coinsurance | 50% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). See Plan Document for other services. |
| | Childbirth/delivery | 30% coinsurance | 50% coinsurance | None |

* 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 (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | professional services | | | |
| | 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 60 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. Outpatient limit of 35 visit per year combined with physical therapy (PT), occupational therapy (OT), speech therapy (ST), and pulmonary rehabilitation. |
| | 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. |
| | 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 dental or eye care | Children's eye exam | 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 . |

* 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 (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | 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 .) | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty Nursing | <ul style="list-style-type: none"> • 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.) | |
|--|--|
| <ul style="list-style-type: none"> • Chiropractic care, limit of 35 visit per year combined with PT/OT/ST and pulmonary rehabilitation. | <ul style="list-style-type: none"> • 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 [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, 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](#) \$7,000
- [Specialist coinsurance](#) 30%
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$7,000 |
| Copayments | \$0 |
| Coinsurance | \$1,700 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$8,760 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$7,000
- [Specialist coinsurance](#) 30%
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,300 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,620 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$7,000
- [Specialist coinsurance](#) 30%
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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