



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> \$9,200 individual/\$18,400 family; For non-participating <a href="#">providers</a> \$18,400 individual/\$36,800 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="#">network 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="#">network 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 an <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 an <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 (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <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)	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	Covered at 100% after <a href="#">deductible</a> is met.	30% <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> 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-resources/prescription/legacy-performance-4-">https://www.cigna.com/static/www-cigna-com/docs/individuals-families/member-resources/prescription/legacy-performance-4-</a>	Generic drugs (Tier 1)	Covered at 100% after <a href="#">deductible</a> is met.	Full price at time of payment, then submit for reimbursement at 30% <a href="#">coinsurance</a> .	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)	Covered at 100% after <a href="#">deductible</a> is met.	Full price at time of payment, then submit for reimbursement at 30% <a href="#">coinsurance</a> .	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)	Covered at 100% after <a href="#">deductible</a> is met.	Full price at time of payment, then submit for	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail 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)	
<a href="#">tier.pdf</a>			reimbursement at 30% <a href="#">coinsurance</a> .	31-90-day supply (mail order prescription).
	<a href="#">Specialty drugs</a> (Tier 4)	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Benefits will be reduced by 50% of the otherwise Covered Charges for any Specialty Pharmaceuticals that are not authorized. *See sections in <a href="#">Plan Certificate on Medical Benefits and Outpatient Prescription Drug Benefits</a> for additional details.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Covered at 100% after <a href="#">deductible</a> is met.	30% <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	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Covered at 100% after <a href="#">deductible</a> is met.	Covered at 100% after <a href="#">deductible</a> is met.	Non-emergency use will result in a reduction of charges.
	<a href="#">Emergency medical transportation</a>	Covered at 100% after <a href="#">deductible</a> is met.	Covered at 100% after <a href="#">deductible</a> is met.	To the nearest Acute Medical Facility that can treat the sickness or injury.
	<a href="#">Urgent care</a>	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Covered at 100% after <a href="#">deductible</a> is met.	30% <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. For transplant services that are not preauthorized, benefits will be reduced by 50% of the otherwise Covered Charges.
	Physician/surgeon fees	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	None
	Inpatient services	Covered at 100% after <a href="#">deductible</a> is met.	30% <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 are pregnant</b>	Office visits	Covered at 100% after	30% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

\* 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)	
		<a href="#">deductible</a> is met.		See <a href="#">Plan</a> Document for other services.
	Childbirth/delivery professional services	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	Covered at 100% after <a href="#">deductible</a> is met.	30% <a href="#">coinsurance</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Covered at 100% after <a href="#">deductible</a> is met.	30% <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>	Covered at 100% after <a href="#">deductible</a> is met.	30% <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 35 visit per year combined with physical therapy (PT), occupational therapy (OT), speech therapy (ST), and pulmonary rehabilitation.
	<a href="#">Habilitation services</a>	Covered at 100% after <a href="#">deductible</a> is met.	30% <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.
	<a href="#">Skilled nursing care</a>	Covered at 100% after <a href="#">deductible</a> is met.	30% <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>	Covered at 100% after <a href="#">deductible</a> is met.	30% <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>	Covered at 100% after <a href="#">deductible</a> is met.	30% <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 (You will pay the least)	Non-Participating Provider (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> . <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> <li>• Private-duty Nursing</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 35 visit per year combined with PT/OT/ST and pulmonary rehabilitation.</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids, limited to 1 per ear every 3 years</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](#).

### 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](#).

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

### 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](#) **\$9,200**
- [Specialist coinsurance](#) **0%**
- Hospital (facility) [coinsurance](#) **0%**
- Other [coinsurance](#) **0%**

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$9,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$9,260</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) **\$9,200**
- [Specialist coinsurance](#) **0%**
- Hospital (facility) [coinsurance](#) **0%**
- Other [coinsurance](#) **0%**

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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,300
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,620</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) **\$9,200**
- [Specialist coinsurance](#) **0%**
- Hospital (facility) [coinsurance](#) **0%**
- Other [coinsurance](#) **0%**

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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