



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? | \$2,200 individual/\$4,400 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? | \$5,350 individual/ \$10,700 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 participating provider? | Yes. See https://allstatevoluntary.com/fullyinsured/providerdirectory/ or call 1-800-323-3049 for a list of participating provider . | 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 a 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 a 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 | \$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 section in Plan Certificate on the Medical Benefits 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) | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% 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). |

* 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) | |
| 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) | 20% coinsurance | Not covered | Preauthorization is required. Benefits will not be covered unless they have been authorized by the Plan . *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) | 20% 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 | 20% coinsurance | 50% coinsurance | |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | Non-emergency use will result in a reduction of charges. |
| | Emergency medical transportation | 20% coinsurance | 20% 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) | 20% 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 prior to the transplant evaluation, testing, preparative treatment, or donor search will not be covered. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 50% coinsurance | None |
| | Inpatient services | 20% 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 |

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| 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) | |
| | | | | 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 section in Plan Certificate on Medical Benefits for other services. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | 20% 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 | 20% 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 20 visits per year for physical therapy (PT). Limit of 20 visits per year for occupational therapy (OT). Limit of 20 visits per year for speech therapy (ST). |
| | Habilitation services | 20% 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 20 visits per year for physical therapy (PT). Limit of 20 visits per year for occupational therapy (OT). Limit of 20 visits per year for speech therapy (ST). |
| | Skilled nursing care | 20% 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 30 days per stay. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Preauthorization is required for amounts greater than |

* 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) | |
| | | | | \$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. Limited to a single purchase of a type of DME, including repair or replacement, every 3 years. |
| | Hospice services | 20% 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 . |
| | 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. Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> 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.) | |
|--|---|
| <ul style="list-style-type: none"> Chiropractic care. | <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.

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

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:

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](#) \$2,200
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$2,200 |
| Copayments | \$10 |
| Coinsurance | \$2,100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,370 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,200
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$900 |
| Copayments | \$900 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| 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](#) \$2,200
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$2,200 |
| Copayments | \$200 |
| Coinsurance | \$50 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,450 |

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