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, access the https://allstategoodlife.com portal or call the Allstate Benefits Center at 1–888–255–7772. 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 http://www.healthcare.gov/sbc-glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In–network: $3,000 individual/$6,000 family (embedded at $3,000)—does not apply to in– network preventive care. Out–of–network: $6,000 individual/$12,000 family—no coverage for preventive care.	Generally, you must pay all 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 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	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	In–network providers: $4,500 individual/$9,000 family (embedded at $4,500 for individual under family). Out–of–network providers: $9,000 individual/ $18,000 family.	The out–of–pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have other family members on this plan, they must 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–billed charges, and any health care services 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. For a list of network providers access https://allstategoodlife.com	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 out–of–network 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 network provider might use an out–of–network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No	You can see the specialist you choose without permission from the plan.

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
		Network Provider (You will pay the least)	Out-of-Network 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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not Covered	Preventive services are only covered through in-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior authorization of certain medical services is required. Contact Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the medical service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available through CVS Caremark is available at https://allstategoodlife.com	Generic drugs	**Preventive Medication related to ACA** $0 copay **Preventive Medication:** 1–30 day: $5 copay 31–90 day: $12.50 copay	Not covered	Must have an authorized prescription 1–30 day covers up to 30 day supply; 31–90 day supply is a mail order prescription.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Non–Preventive: 1–30 day 20% coinsurance ($5 min/$12.50 max) 31–90 day 20% coinsurance ($12.50 min/$30 max)		
	Preferred brand drugs	**Preventive Medication:** 1–30 day $10 copay 31–90 day $25 copay **Non–Preventive:** 1–30 day 20% coinsurance ($20 min/$50 max) 31–90 day 20% coinsurance ($50 min/$125 max)	Not covered	1–30 day covers up to 30 day supply; 31–90 day supply is a mail order prescription.
	Non-preferred brand drugs	1–30 day 20% coinsurance ($35 min/$87.50 max) 31–90 day 20% coinsurance ($87.50 min/$220 max)	Not covered	1–30 day covers up to 30 day supply; 31–90 day supply is a mail order prescription
	Specialty drugs	1–30 day 20% coinsurance ($87.50 min /$220 max)	Not covered	1–30 day supply Caremark Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization is required. Contact Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Services deemed not to be an Emergency Service are not covered.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Services deemed not to be an Emergency Service are not covered.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization is required. Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Prior authorization is required for partial inpatient and intensive outpatient. Contact Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the service.
	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization is required. Contact Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the service.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Maximum of 100 visits per Plan Year. Prior authorization is required for partial inpatient and intensive outpatient. Contact Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	20% coinsurance	40% coinsurance	Maximum of 120 days confinement per Plan Year (combined with In–Network and Out–of–Network days). Limits apply for Outpatient physical, occupational and speech therapy when due to injury.
	Habilitation services	20% coinsurance	40% coinsurance	Maximum of 120 days confinement per Plan Year (combined with In–Network and Out–of–Network days). Limited to 100 visits per plan year for physical, occupational and speech therapy for children under age 5 due to developmental delay.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 120 days per plan year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior authorization is required over $1,500. Contact Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the service.
	Hospice services	20% coinsurance	40% coinsurance	Includes Respite Care. Prior authorization is required. Contact Allstate Good Life® Care Coordinators. If you don't get a prior authorization, benefits could be reduced by 100% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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 (unless for anesthesia)
- Infertility Treatment
- Cosmetic Surgery
- Long Term Care
- Routine Eye Care (Adult)
- Dental Care (Adult)
- Non–emergency care when traveling outside the U.S.
- Routine Foot Care
- Hearing Aids
- Inpatient Private Duty Nursing
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric Surgery	• Chiropractic Care (26 visit limit/year)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 Department of Labor's Employee Benefits Security Administration at 1–866–444–EBSA (3272) or www.dol.gov.ebsa/heatlhreform.

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	**$3,000**
Specialist *[cost sharing]*	**$0**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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:	
Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,930
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,500**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,000**
Specialist *[cost sharing]*	**$0**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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:	
Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$510
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,570**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,000**
Specialist *[cost sharing]*	**$0**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
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.