Cafeteria Medical Plan

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IMPORTANT LEGAL AND MEDICAL PLAN NOTICES

Legal Notices

Dependent Children Under Age 26

Dependent Children under age 26 are eligible to enroll as dependents in the Allstate Medical Savings Plan, Allstate Medical Value Plan, or an HMO.

Newborns' and Mothers' Health Protection Act of 1996 Notice

Group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the mother's or newborn's attending provider may generally discharge the mother or her newborn earlier than the 48- or 96-hour period, as applicable, after consulting with the mother. In any case, plans and issuers may not require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 or 96 hours, as applicable.

Women's Health and Cancer Rights Act of 1998 Notice

In accordance with federal law, the Allstate Medical Plan provides coverage for medical and surgical procedures for breast reconstruction following a mastectomy including reconstruction of the breast on which the mastectomy was performed, surgery and construction of the other breast to produce a symmetrical appearance, prostheses, and physical complications during all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and patient.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice is being provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential information (beginning April 14, 2003). Certain Allstate employee health and welfare benefit plans under the Employment Retirement Income Security Act of 1974, as amended (ERISA), are subject to the HIPAA privacy rules. Pursuant to HIPAA privacy rules, these plans will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, plan administration or as required or permitted by law.

This notice is to remind you that a description of the plans' uses and disclosures of your protected health information and your rights and protections under HIPAA privacy rules is set forth in the HIPAA Notice of Privacy Practices which can be accessed on the Allstate Intranet (click on the MyHR tab, then click on advanced search, click on the MyHR knowledge tab, enter HIPAA, click on Search, then click on the link "HIPAA Notice of Privacy Practices"), or by contacting the office of the Plan Administrator, 2775 Sanders Road, Suite F5, Northbrook, IL 60062.

Medical Plan Notices

International Travel Coverage (Allstate Medical Savings and Allstate Medical Value Plan Options)

Benefits for Medical Care, including medicines and supplies, provided outside the U.S. (which includes its territories and possessions) are limited to Emergency or Urgent Care only. Transportation costs will be covered only to the nearest correct place where appropriate care can be given (may not be return trip to the U.S.).

If the purpose of your travel was to obtain Medical Care, no benefits are payable.

Employees residing in foreign countries are not subject to the International Travel Coverage provisions above; all claims will be processed at the Out-of-Network benefit level.

Temporary Work Assignment (Allstate Medical Savings and Allstate Medical Value Plans)

Benefits for Medical Care received outside the U.S. (including medicines and supplies) will be covered based on the In-Network schedule of benefits.

Wellbeing Assessment Surcharge

Any Employee who enrolls in any of the Allstate-sponsored Medical Plan coverage options for 2018 who does not complete the 2017 Wellbeing Assessment through Jiff by 6:00 p.m. Central Time on September 12, 2017, will be subject to a Medical Plan premium Wellbeing Assessment Surcharge of $50 per month for all of 2018.

Notice Regarding the Allstate Good Life Wellness Program

The Allstate Good Life® Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. As part of the wellness program you will be invited to complete a voluntary wellbeing assessment or "WBA" administered through Jiff by its partner for the WBA, Johnson & Johnson Health and Wellness Solutions, Inc. (J & J). The WBA asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol, glucose and triglycerides, as well as information about your height, weight, waist-circumference, and blood pressure. You are not required to complete the WBA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will avoid an annual Wellbeing Assessment surcharge of $600 for completing the WBA. Although you are not required to complete the WBA or participate in the biometric screening, only employees who do so will avoid the surcharge.

Also, other incentives may be available in 2018 for employees who participate in certain health-related activities or achieve certain health outcomes. Additional details will be provided. Additional surcharges of up to $600 may also be imposed on participants who are not tobacco-free. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive or avoid a surcharge, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Office of the Plan Administrator for the Allstate Medical Plan at 2775 Sanders Rd. Suite F5, Northbrook, IL 60062.

The information from your WBA and the results from your biometric screening will be evaluated by Jiff and their subcontractor, J & J, and will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellbeing and health risk coaching. You also are encouraged to share your results or concerns with your own doctor. The information from your WBA and results from biometric screening will also be provided to Truven, our data warehouse vendor and may be used to provide aggregate data reporting and analytics. Jiff will also report your completion of the WBA (but no other personally identifiable information) to the Allstate Benefits Center which will, in turn, provide the information to the Company so you will not be assessed the Wellbeing Assessment surcharge.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Allstate may use aggregate information it collects to design a program based on identified health risks in the workplace, the Allstate Good Life Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in any component of the wellness program, receiving an incentive, or avoiding a surcharge. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are Jiff, J & J, Truven, Total Wellness (for individuals who had on-site biometric screenings) and Premise Health (for individuals who obtained their biometric screening from an on-site wellness center) in order to evaluate the results and to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified as soon as possible.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Office of the Plan Administrator for the Allstate Medical Plan at 2775 Sanders Rd Suite F5, Northbrook, IL 60062.

Tobacco Surcharge

Any Employee and covered dependent(s) who enroll in any Medical Plan coverage option and attest to being tobacco-free will not be subject to the Tobacco Surcharge. You must actively elect your tobacco status during your initial eligibility period and in each subsequent Annual Enrollment Period.

Specific terms are used when determining the applicability of the Tobacco Surcharge. Those terms are defined as follows:

- **Tobacco products** include cigarettes, electronic cigarette (e-cig or E-cigarette), personal vaporizer (PV) or electronic nicotine delivery system (ENDS), cigars, pipes, snuff, chewing tobacco and/or any other product containing tobacco.
- **Home** means your primary residence.
- **A smoke-free indoor environment at home** is one in which no one uses or smokes “tobacco products” within the home.

In order to be considered “tobacco-free” the following requirements must be met:

- You and your covered dependents must not use or smoke tobacco products at the time of Annual Benefits Enrollment and must pledge not to use or smoke tobacco products at any time during the **Plan Year** for which you are enrolling;

  and

- You and your covered dependents must have a **smoke-free indoor environment at home** at the time of Annual Benefits Enrollment and must pledge to maintain a smoke-free indoor environment at home throughout the Plan Year for which you are enrolling;

  and

- You must actively attest to being tobacco-free on the Medical Plan enrollment screen on the *Your Benefits Resources* website (YBR) (http://resources.hewitt.com/allstate).

If you do not actively attest to your tobacco status on the *Your Benefits Resources* (YBR) website during each Annual Benefits Enrollment, you will default to tobacco user status and will be subject to the $50 per month Tobacco Surcharge. No changes to this status will be allowed once the Plan Year begins.

Wellbeing Assessment and Tobacco Surcharge for Employees in Hawaii

Due to factors including limitations on Employee contributions under the Hawaii Pre-paid Health Care Act, all Employees in Hawaii who elect "You Only" coverage will not see a separate Tobacco Surcharge. The Tobacco Surcharge for these Employees is included in their total medical Credit. Also, Employees in Hawaii are not subject to the Wellbeing Assessment Surcharge.

Tobacco Surcharge—Alternative Qualifications

Your health plan is committed to helping you achieve your best health status. A surcharge for tobacco use will be assessed against all employees who enroll in the Medical Plan and who do not attest to being tobacco-free. You might qualify for an opportunity to avoid the surcharge even if you are not tobacco-free. Contact the Allstate Benefits Center at (888) 255-7772 and we will work with you (and if you wish, your doctor) to find an alternative that is right for you in light of your health status.

THE MEDICAL PLAN

TERMS

Terms that are defined in the Glossary of this Plan are bolded and capitalized when they first appear in the text; thereafter, they will be capitalized wherever used in the text. See the Glossary section for the definitions and/or more information about these terms.

The Medical Plan consists of the *Allstate Medical Savings Plan*, the *Allstate Medical Value Plan*, and various ***Health Maintenance Organization (HMO)*** options. **Employees** may select coverage from one of these available options based on their home address and geographical area. Residents of Hawaii are only eligible for the HMO option.

The Allstate Medical Savings Plan and Allstate Medical Value Plan are **Preferred Provider Organization (PPO)** medical coverage options. These options include Premier In-Network Providers along with regular **In-Network** and **Out-of-Network** benefits. No referrals are necessary to see specialists and you do not need to select a primary care **Physician** to direct your care. There are two **Third Party Administrators (TPA)** (Aetna and Blue Cross Blue Shield of Illinois) administering these coverage options along with the mental health/substance abuse treatment program on a state-by-state basis. The TPAs act as the Third Party Administrator and claims fiduciary for all claims determinations and all levels of appeals.

The Health Maintenance Organization (HMO) Option provides services through a select group of doctors, Hospitals and other providers who are under contract with the HMO. If you meet the eligibility requirements of the Allstate Cafeteria Plan and your home ZIP code is within the HMO's service area, you may be eligible to enroll in this option. **Deductibles** and **Copayments** may apply.

NOTE

In addition, the Allstate Medical Savings and Allstate Medical Value coverage options provide Prescription Drug Services through CVS Caremark.

In-Network Benefits

Under the Savings and Value plan options, each time you seek Medical Care you must choose between In-Network or Out-of-Network service providers. If you obtain care from In-Network providers, your covered health services will be considered In-Network benefits. When you obtain care from Out-of-Network providers, your covered health services will be considered Out-of-Network benefits.

In-Network

In-Network benefits are designed to reduce your out-of-pocket costs for **Eligible Expenses**. In-Network benefits are provided in the form of covered health services you obtain from an In-Network provider. In order to receive the highest level of scheduled benefits, an In-Network provider should be utilized. Deductibles, **Out-of-Pocket Maximums**, Copayments, and **Coinsurance Levels** that apply when you obtain covered health services are shown in the "Schedule of Benefits" for each plan option and may vary by the In-Network and Out-of-Network coverage levels.

Emergency Care—The In-Network benefit level will apply if your treatment was for a true **Emergency**.

In-Network Deductible

The "Schedule of Benefits" section for each plan option shows the In-Network Deductible which applies to each Covered Person for the **Plan Year**.

NOTE

In the Allstate Medical Savings and the Allstate Medical Value coverage options, amounts applied to the In-Network Deductible include eligible Prescription Drug Services and/or Mental Health and Substance Abuse Treatment Services. See additional information regarding what applies to your Deductible.

You have separate Deductibles for In-Network and Out-of-Network services for all coverage options except HMO options. These Deductibles accumulate separately and are not combined.

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximums are shown in the "Schedule of Benefits" for each plan option.

Out-of-Network Benefits

Out-of-Network

If you are enrolled in the Allstate Medical Savings or Value Plan, you also have the option of obtaining Medical Care from an Out-of-Network provider. Out-of-Network claims will be adjudicated based on the maximum reimbursable expense as defined below.

If you receive your care from an In-Network provider, the reimbursable rates are already negotiated at a rate that does not exceed the Maximum Reimbursable Expense(s). If, however, you or your enrolled eligible dependents receive care from an Out-of-Network provider, you are responsible for paying any amount over the Maximum Reimbursable Expenses(s).

Any amount in excess of the Maximum Reimbursable Expense does not count toward your annual Deductible or your annual Out-of-Pocket Maximum.

Note: If you participate in one of the medical plans, the third party claims administrator for your particular option may use a variety of terms instead of "Maximum Reimbursable Expense." For example, the third party claims administrator may use the term "eligible expense," "usual and customary charge (U&C)," "recognized charge," or "reasonable and customary charge (R&C)."

Out-of-Network Deductible

The "Schedule of Benefits" section for each plan option shows the Out-of-Network Deductible which applies to each Covered Person for the Plan Year.

Out-of-Network Out-of-Pocket Maximums

The Out-of-Network Out-of-Pocket Maximums are shown in the "Schedule of Benefits."

Out-of-Network Medical Benefits

Out-of-Network medical benefits are payable for Eligible Expenses incurred while covered due to an Injury or **Sickness**. Out-of-Network medical benefits will be computed in this way:

- Ø First, the Deductible must be met for each Plan Year.
- Ø Next, all Eligible Expenses exceeding the Deductible will be reimbursed at the percentage indicated in the applicable "Schedule of Benefits" until the Out-of-Pocket Maximum has been reached.
- Ø Once the Out-of-Pocket Maximum has been reached, all Eligible Expenses will be reimbursed at 100% of the allowable expenses for the remainder of that Plan Year.

Maximum Reimbursable Expense is the maximum amount that is recognized for an Eligible Expense, as determined by the third party administrator. This maximum is based on (a) the amount which Participating providers have agreed to accept as payment in full for a particular Eligible Expense, (b) for Out-of-Network providers, the Maximum Reimbursable Expense will be the lesser of: (i) the provider's billed charges, or (ii) The Medicare reimbursement rate for the geographical location where the service is provided as determined by the Center for Medicare & Medicaid Services ("CMS").

If you receive your care from a Participating Provider, the reimbursable rates are already negotiated at a rate that does not exceed the Maximum Reimbursable Expense(s). If, however, you or your enrolled eligible dependents receive care from a Non-Participating Provider, you are responsible for paying any amount over the Maximum Reimbursable Expenses(s).

Any amount in excess of the Maximum Reimbursable Expense does not count toward your annual Deductible or your annual Out-of-Pocket Limit.

Note: If you participate in one of the Allstate Medical Plan self-funded coverage options, the third party administrator for your particular option may use a variety of terms instead of "Maximum Reimbursable Expense." For example, the third party administrator may use the term "eligible expense," "usual and customary charge (U&C)," "recognized charge," or "reasonable and customary charge (R&C)."

NOTE

When accessing certain Medical Plan benefits, you may be required to contact your Third Party Administrator's medical review program. Such programs are designed to encourage an efficient system of care for Covered Persons by identifying and addressing possible unmet covered health care needs.

If your Third Party Administrator's medical review provisions are not followed, Eligible Expenses will be reimbursed at substantially lower levels for all services related to a necessary non-certified/non-notified Hospital stay or surgical procedure. No benefits are payable for services that are not determined to be a covered health service.

In-Network Supplemental Options

If you participate in the Allstate Medical Savings or Value Plans, you have an additional In-Network option to consider for your Medical Care. When you obtain care through this option, you will receive the highest level of cost sharing (outlined in the "Schedule of Benefits" for the Savings and Value Plans). Applicable Deductibles, Out-of-Pocket Maximums, Copayments and Coinsurance Levels may vary based on the Medical Care obtained. Contact your third party administrator prior to receiving services if a specific specialty provider or facility is not available and discuss in-network alternate options.

Premier In-Network Providers

Allstate's Premier In-Network Providers offer Allstate Medical Savings Plan and Allstate Medical Value Plan participants an enhanced In-Network coverage tier as well as the potential for lower Out-of-Pocket costs. For more information, refer to the "Schedule of Benefits" for the Savings and Value Plan.

As a participant in the Allstate Medical Savings or Value Plan, you have the option to receive medical services (including mental health and substance abuse) at a designated Premier In-Network Provider. For the 2018 Plan Year, the NorthShore University Health System ("NorthShore") in Illinois will be a designated Premier In-Network Provider.

When you obtain services from a Premier In-Network Provider, you will receive eligible services at negotiated rates and a separate schedule of benefits will apply. Using a Premier In-Network Provider may result in lower out-of-pocket costs than from other In-Network providers.

Both the In-Network Deductible and Out-of-Pocket Maximum apply. However, Copayments for medical services do not count toward your Deductible but do count toward your Out-of-Pocket Maximum.

To find eligible Premier In-Network Providers, check www.northshore.org. The provider must be in the "NorthShore Medical Group."

NOTE

Only individuals covered through Aetna are eligible for Premier In-Network Provider pricing in 2018.

Deductibles, Coinsurance Levels and Out-of-Pocket Maximums vary depending on whether you choose Premier In-Network, In-Network or Out-of-Network Medical Care.

Telehealth Services

For Participants Enrolled in the Allstate Medical Savings Plan or Allstate Medical Value Plan whose Third Party Administrator is Blue Cross Blue Shield of Illinois (BCBSIL)

Telehealth Services, powered by MDLive, are available for participants enrolled in the Allstate Medical Savings Plan or Allstate Medical Value Plan whose Third Party Administrator is Blue Cross Blue Shield of Illinois (BCBSIL).

MDLive enables you to visit with a board-certified doctor by phone 24/7/365 or video from 7 a.m. to 9 p.m. (local time). Instead of going to the doctor's office, employees can talk with a doctor while at home, work or any place else.

MDLive's doctors can treat many non-emergency medical conditions, like:

- Allergies
- Asthma
- Cold
- Flu
- Eye/ear infections
- Joint aches
- Pink eye
- Sinus infections

MDLive's doctors can also write – and send – prescriptions (when appropriate) to a nearby in-network CVS Caremark pharmacy.

Finding a doctor is easy. Participants can search for a doctor or select the last telehealth doctor they used. They can also meet with the next available doctor or schedule a future appointment based on availability. The fee for using MDLive is $40 per consultation.

Call BCBSIL customer service if you have questions about how MDLive's telehealth solutions work or reach out to MDLive at 1-888-676-4204.

MDLive is an independent company that does not provide Blue Cross and Blue Shield of Illinois products or services. MDLive is solely responsible for the telehealth products and services it provides.

Note: The cost for services rendered by MDLive counts toward your deductible and out-of-pocket maximum.

For Participants Enrolled in the Allstate Medical Savings Plan or Allstate Medical Value Plan whose Third Party Administrator is Aetna

Telehealth Services, powered by Teladoc, are available for participants enrolled in the Allstate Medical Savings Plan or Allstate Medical Value Plan whose Third Party Administrator is Aetna.

Teladoc can provide you and your eligible dependents with 24/7/365 access to U.S. board-certified doctors and pediatricians by phone or online video. Teladoc's doctors can diagnose, recommend treatment and prescribe medication, when appropriate, for many medical issues.

The most common diagnoses treated via telemedicine are:

- Allergies
- Asthma
- Cold
- Flu
- Eye/ear infections
- Joint aches
- Pink eye
- Sinus infections

Teladocs national network includes the highest quality, state-licensed doctors. The fee for using Teladoc is $40 per consultation.

Teladoc's doctors can also write and send a prescription (when appropriate) to a nearby in-network CVS Caremark pharmacy.

Call Aetna customer service if you have any questions about how Teladoc's telemedicine solutions work or reach out to Teladoc at www.teladoc.com or call 1-855-teladoc(835-3362).

Note: The cost for services rendered by Teladoc counts toward your deductible and out-of-pocket maximum.

Eligible Expenses

Eligible Expenses for In-Network covered health services are the medical services and supplies provided by an In-Network provider, but only if those medical services and supplies are not excluded from coverage under the Medical Plan option you are enrolled in.

Eligible Expenses for Out-of-Network covered health services are the medical services and supplies supplied by an Out-of-Network provider and must be for a service or supply which is performed or prescribed by a Physician and is determined to be not excluded from coverage under the Medical Plan option you are enrolled in.

Any amount of Expense in excess of the **Reasonable and Customary Charges** is not an Eligible Expense and therefore is not reimbursable. In no event may the benefit payable exceed the amount of the Eligible Expense.

In-Network and Out-of-Network Covered Health Services

In-Network and Out-of-Network covered health services will be payable as shown in the "Schedule of Benefits" for each Medical Plan option. Please refer to the specific sections describing each Medical Plan option for details of the benefits applicable to that Medical Plan option. Benefits for Mental Health and Substance Abuse Disorders and Prescription Drugs are included in the description of each Medical Plan option.

NOTE

Services rendered at an Emergency facility that are not deemed to be an Emergency are not considered Eligible Expenses under the Allstate Medical Savings Plan or Allstate Medical Value Plan options.

Allstate Good Life Wellness Center

Premise Health Services, Inc., a third-party medical center administrator, operates the Allstate Good Life Wellness Centers in Northbrook, IL, and Irving, TX. Each Center offers preventive, urgent and chronic care services. In addition, the Northbrook location includes a pharmacy by CVS Caremark.

All Employees and their family members, regardless of their medical coverage, are eligible to use the Wellness Centers. Refer to the "Schedule of Benefits" for the Savings or the Value Plan options. Services will be subject to a separate fee schedule if the recipient is not enrolled in the Allstate Medical Savings or Allstate Medical Value Plan options. If enrolled in an HMO, contact the Wellness Center for pricing information.

The Allstate Good Life Program

The Allstate Good Life Program provides resources and activities to help you manage the health and wellbeing of you and your family. These resources and activities include, but are not limited to:

- **Biometric Screenings.** Biometric screenings can help determine certain health risk factors. The screenings measure and can include: height; weight; waist circumference; blood pressure; blood glucose; body mass index; and cholesterol, including HDL, LDL and Triglycerides. Free biometric screenings may be offered to Employees at many Allstate locations on an annual basis.
- **Wellbeing Assessment.** The Wellbeing Assessment is a confidential online questionnaire provided by a third party vendor, which asks questions about your health and wellbeing. Once you've completed your Wellbeing Assessment, the vendor will analyze your results and develop an overall wellbeing score, identify certain health risk factors, and offer recommendations to help you manage identified risks. All Employees are eligible to complete the Wellbeing Assessment. Spouses or domestic partners, if enrolled in the Allstate Medical Savings, Value, or HMO Plan, are also eligible to complete the Wellbeing Assessment.
- **Wellbeing Assessment Surcharge.** Any Employee hired prior to July 1, 2017, who enrolls in any Allstate-sponsored Medical Plan coverage option for 2018 and who does not complete the 2017 Wellbeing Assessment by 6:00 p.m. Central Time on September 12, 2017, will be subject to a Medical Plan premium Wellbeing Assessment Surcharge of $50 per month for all of 2018. If you did not report your biometric numbers on your 2017 Wellbeing Assessment, your Assessment was not considered complete and you will be charged a $600 annual medical plan surcharge in 2018 in addition to any applicable medical plan premiums. The premiums for your 2018 medical coverage are not based on the results of your biometric screening or on your existing health conditions.
- **Health Care Management Program.** If you and/or your spouse/domestic partner are enrolled in the Allstate Medical Savings or Value Plan and are identified as at risk for having certain specified health conditions, you and/or your spouse or domestic partner will have access to various services, based on your Medical third party administrator – either the Aetna In Touch Care or the Blue Cross Care Programs to help you manage the condition(s).

  The Health Care Management Program identifies individuals who are potential participants through medical and pharmacy claims. Claims information is sent directly from health plan providers to Allstate's Health Care Management Program vendor and is kept strictly confidential.

  Those who are identified will be sent a welcome letter from Allstate's Health Care Management Program vendor describing their services. The individual will subsequently receive follow-up phone calls from certified health clinicians to offer personalized health coaching and resources. Examples of services include answering questions about medications, and directing people to local health resources that they can take advantage of.

  For more information on the service, please log on to AllstateGoodLife.com.

Any challenges to or disputes regarding the non-payment of wellness incentives for a particular Plan Year must be submitted to the Office of the Plan Administrator by December 31 of that Plan Year. In addition, any challenges to or disputes regarding the inclusion of the Wellbeing Assessment Surcharge for a particular Plan Year must be submitted to the Office of the Plan Administrator by March 31 of that Plan Year. Any challenges or disputes after such dates will be barred.

WELLNESS ACTIVITIES AND INCENTIVES

If you are an active Employee enrolled in the Allstate Medical Savings, Value, or HMO Plan, or not enrolled in Allstate-sponsored medical coverage, you have the opportunity to earn *up to a maximum of $200* in **Wellness Incentives** for the 2018 Plan Year by completing approved Wellness Activities.

Your spouse or domestic partner also has the opportunity to earn *up to a maximum of $200* in Wellness Incentives for the 2018 Plan Year by completing approved Wellness Activities. However, your spouse or domestic partner must be enrolled in Allstate-sponsored medical plan coverage: either the Allstate Medical Savings, Value, or HMO Plan.

Your health plan is committed to helping you achieve your best health. Rewards for participating in the wellness incentive program are available to all Allstate employees and Esurance/AFI associates. If you think you might be unable to meet a standard for a reward under the wellness incentive program, you might qualify for an opportunity to earn the same reward by different means. Contact us at the Allstate Benefits Center and we will work with you (and, if you wish, with your doctor) to find a wellness activity with the same reward that is right for you in light of your health status.

Wellness Incentive Eligibility

In order for an Employee to be eligible to earn a Wellness Incentive for the 2018 Plan Year, the employee must meet all of the following conditions:

- have been hired prior to September 24, 2018; and
- complete at least one (1) but not more than two (2) approved Wellness Activities by October 31, 2018.

In order for a spouse or domestic partner to be eligible to earn a Wellness Incentive for the 2018 Plan Year, the spouse or domestic partner must meet all of the following conditions:

- be enrolled in an Allstate-sponsored medical plan coverage option for 2018; and
- complete at least one (1) but not more than two (2) approved Wellness Activities by October 31, 2018. Note that some Wellness Activities are only available for Employees.

NOTE

For Employees, in the event of termination of employment: The Wellness Activity must be completed prior to the earlier of the Employee's termination date or October 31, 2018, and recorded on the appropriate website prior to the earlier of the Employee's termination date or October 31, 2018. For spouses or domestic partners, in the event of termination of benefits, the Wellness Activity must be completed prior to the earlier of the date of termination of benefits or October 31, 2018, and recorded on the appropriate website prior to the earlier of the date of the termination of benefits or October 31, 2018.

Receiving Wellness Incentives

How Employees, spouses and domestic partners receive their Wellness Incentive differs depending on what Medical Plan coverage option they are enrolled in.

- Those who are enrolled in the Blue Advantage HMO or Kaiser Hawaii HMO option will have their Wellness Incentive deposited into the Employee's tax-favored Health Reimbursement Arrangement (HRA) account.
- Those who are enrolled in the Allstate Medical Savings, Allstate Medical Value, Kaiser Savings or Value options will have their Wellness Incentive deposited into the Employee's tax-favored Health Savings Account (HSA).
- Those who are enrolled in the Allstate Medical Savings or Allstate Medical Value Plan options and are enrolled in Medicare or TRICARE will have their Wellness Incentives paid in cash through payroll and taxed appropriately.
- Those employees who are not enrolled in an Allstate-sponsored medical plan coverage option will have their Wellness Incentive paid in cash through payroll and taxed appropriately.

See the sections below for more details.

Any challenges to or disputes regarding the non-payment of wellness incentives for a particular Plan Year must be submitted to the Office of the Plan Administrator by December 31 of that Plan Year. In addition, any challenges to or disputes regarding the inclusion of the Wellbeing Assessment Surcharge for a particular Plan Year must be submitted to the Office of the Plan Administrator by March 31 of that Plan Year. Any challenges or disputes after such dates will be barred.

EMPLOYEE TAX-FAVORED ACCOUNTS

Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA) is an Allstate-funded, non-interest bearing, tax-favored health account that is established for you and/or your spouse or domestic partner when you and/or your spouse or domestic partner earns Wellness Incentives.

Wellness Incentives earned by an Employee, spouse or domestic partner enrolled in the Allstate Medical HMO Plan will be deposited into the Employee's tax-favored **Health Reimbursement Arrangement (HRA)** account. There is no substitution or other alternative for how incentives are awarded.

Wellness Incentive dollars are available for use once they are deposited into the HRA. Wellness Incentives, except for those deposited for a domestic partner, are not included in the Employee's gross income and are not subject to payroll taxes. However, Wellness Incentives deposited for domestic partners are taxable to the Employee.

If your spouse or domestic partner is not enrolled in the Allstate Medical HMO Plan, he or she will not be eligible for Wellness Incentives.

The HRA can reimburse you and your dependents for eligible qualified medical, dental, vision, prescription drug and certain over-the-counter Expenses and allows unused amounts to be carried forward from year-to-year.

If you participate in a Health Care FSA and HRA, the funds in the Health Care FSA will be used first and must be exhausted before you can use the funds in the HRA.

Claim reimbursements are allowed only for qualified medical Expenses incurred while you are employed by Allstate and enrolled in an HRA-eligible Allstate Medical Plan coverage option.

NOTE

An HRA is a tax-favored trust or custodial account established by the Employer to provide tax-free reimbursement/payment of qualified medical expenses covered under the Allstate Medical Blue Advantage or Kaiser Hawaii HMO Plan option. For employees not enrolled in an Allstate sponsored medical plan coverage option, Wellness Incentives will be paid in cash through payroll and taxed appropriately.

Your HRA will become a limited-use HRA (through December 31, 2018) if you change your medical plan coverage option from the Allstate Medical Blue Advantage or Kaiser Hawaii HMO option to the Allstate Medical Savings or Allstate Medical Value Plan option.

HRA Reimbursements After Termination

Your ability to receive reimbursements from your HRA will terminate when your participation in the Allstate Medical Plan terminates. You may claim reimbursement for eligible Expenses under the HRA incurred during the period of coverage prior to the termination of your participation, provided that you (or your estate) file a claim by March 31 (postmarked) following the close of the Plan Year in which the Expense was incurred.

You will not be able to receive reimbursements for health care Expenses incurred after your participation terminates.

Remaining Unpaid Claims

If you submit a claim at the end of the year that exceeds your HRA account balance, the claim will only be reimbursed up to the amount remaining in your HRA.

Health Savings Account (HSA)

An HSA is a tax-favored account established to pay for qualified medical expenses for those who are covered under a High Deductible Health Plan (HDHP). With money from this account, you can pay for qualified healthcare expenses at the time services are rendered or in the future.

If you enroll in the Allstate Medical Savings, Allstate Medical Value, Kaiser Savings HMO, Kaiser Value HMO, Kaiser Foundation Health Plan Savings HMO, or Kaiser Foundation Health Plan Value HMO option, a tax-favored Health Savings Account (HSA) will be initiated for you at Optum. An HSA is a savings account that belongs to you. It is designed to help you save for current and future qualified health care Expenses such as medical, dental, vision, prescription drug and certain over-the-counter Expenses on a tax-favored basis. You will be required to activate your Optum Bank HSA, create your username and password, and accept the account terms and conditions before funds can be deposited into your HSA.

There are several ways for deposits to be made to your HSA depending on the coverage option you are enrolled in.

- If enrolled in the Allstate Medical Savings, Allstate Medical Value, Kaiser Savings HMO, Kaiser Value HMO, Kaiser Foundation Health Plan Savings HMO, or Kaiser Foundation Health Plan Value HMO, the Allstate Medical Plan may seed your HSA up to two times a year (January and July, as detailed below).

January Seed Amount	July Seed Amount	Total Annual Seed Amount
$250	$250	$500

- You may contribute to your HSA.
- Allstate will fund the HSA account for Wellness Incentives earned.

HSA Seeding Payments

Health Savings Account (HSA) seeding payments for 2018 for eligible Employees may occur up to twice during the Plan Year: (1) in the month of January, 2018 (the “January 2018 Seed”); and (2) in the month of July, 2018 (the “July 2018 Seed”).

An Employee meeting all of the following criteria will be considered an eligible Employee for purposes of receiving an HSA seeding:

1. Be actively at work or on a Leave of Absence and enrolled in the Allstate Medical Savings, Allstate Medical Value, Kaiser Savings HMO, Kaiser Value HMO, Kaiser Foundation Health Plan Savings or Kaiser Foundation Health Plan Value option as of January 1, 2018 (for the January 2018 seed) and actively at work or on a Leave of Absence and enrolled in either the Allstate Medical Savings Plan, Allstate Medical Value Plan, Kaiser Savings HMO, Kaiser Value HMO, Kaiser Foundation Health Plan Savings or Kaiser Foundation Health Plan Value options as of July 1, 2018 (for the July 2018 seed); and
2. Not currently enrolled in Medicare or TRICARE; and
3. Successfully opened an HSA with Optum by January 31, 2018 for the January 2018 seed and by July 31, 2018 for the July 2018 seed.

You may make pre-tax payroll deductions for the HSA only if you enroll in the Allstate Medical Savings Plan, Allstate Medical Value Plan, Kaiser Savings HMO, Kaiser Value HMO, Kaiser Foundation Health Plan Savings or Kaiser Foundation Health Plan Value options—and you are not covered by another plan that does not qualify as a High-deductible Health Plan, such as **Medicare** Part A or B, TRICARE, a spouse’s health plan or flexible spending account, or military coverage.

Wellness Incentive dollars are only available for use once they are deposited into the HSA. Wellness Incentives, except for those deposited for a domestic partner, are not included in the Employee’s gross income and are not subject to payroll taxes. However, Wellness Incentives deposited for domestic partners are taxable to the Employee.

If your spouse or domestic partner is not enrolled in the Allstate Medical Savings Plan, Allstate Medical Value Plan, Kaiser Savings HMO, Kaiser Value HMO, Kaiser Foundation Health Plan Savings or Kaiser Foundation Health Plan Value, he or she will not be eligible for Wellness Incentives.

HSAs offer the following features:

- your contributions (up to the prescribed statutory limits), investment earnings (or losses) and qualified distributions are all exempt from federal income tax, FICA (**Social Security** and Medicare) tax, and state income taxes (for most states);
- to remain tax-free, contributions must be used to pay for eligible health care Expenses, as defined by the IRS (amounts used to pay other Expenses are subject to regular income tax and, if you are under age 65, a 10% tax penalty); and
- the dollars that remain in your account at the end of the Plan Year will roll over to the next year, making your account a convenient, easy way to save and invest to pay for future medical Expenses. Even if you change jobs, or decide to retire, you can take your HSA with you.

SAVE YOUR RECEIPTS!

Whether for your own records or in the event of an IRS audit, it's a good idea to keep your receipts for any health care Expense you incur. This way, you can prove that you used your HSA to pay for eligible health care Expenses, if necessary.

Keep in mind that if you use your funds for non-eligible Expenses, you will need to claim this money on your tax return and pay both regular taxes as well as a tax penalty on this amount if you are under age 65.

Optum is the sole trustee, administrator, and fiduciary (the "HSA Administrator") with respect to the HSA. As the account owner, you are responsible for the management of your HSA investments. Your HSA is not guaranteed or insured, and is subject to investment risk, including possible loss of principal. Your HSA is not a component of the Allstate Cafeteria Plan and is not covered by ERISA.

For more information about HSAs, contact Optum Bank at (877) 470-1771.

The HSA is your bank account and you should check it frequently. Report any unusual activity to Optum Bank immediately.

THE HSA AND FLEXIBLE SPENDING ACCOUNTS

By participating in an HSA, you are only eligible to participate in the Limited Use Health Care Flexible Spending Account, which can only be used to reimburse eligible dental and vision Expenses. Additionally, your spouse's participation in a health care flexible spending account could disqualify you from establishing and making/receiving tax-favored contributions to a health savings account. For more information on health savings accounts, you may refer to IRS Publication 969 at ***www.irs.gov****.*

See the Cafeteria Plan Flexible Spending Account section to learn about a Limited Use Health Care Flexible Spending Account that is available to HSA participants.

HSA Contributions

If enrolled in the Savings or Value Plan, the annual maximum amount you can contribute to your HSA in 2018 is:

- $2,750 (you only);
- $6,000 (you plus spouse);
- $6,200 (you plus children); and
- $6,000 (you plus family)

Total contributions (from you and the Allstate Medical Plan) cannot exceed IRS statutory limits. Note the limits above have been adjusted to allow for your potential earning of wellness incentives and the Allstate Medical Plan 2018 HSA contribution amounts.

Under the Cafeteria Plan, you may make contributions to the HSA that you set up with the HSA Administrator on a pre-tax basis, up to the annual statutory maximum, through payroll deductions. You may change your HSA payroll deductions at any time during the Plan Year by calling the Allstate Benefits Center, or if you experience a Qualified Change in Status. In addition, each year during the designated Annual Enrollment period you will need to elect new HSA payroll deductions if you wish to continue to make contributions for the upcoming Plan Year.

WHERE YOUR HSA MONEY COMES FROM

Your Contributions

You can elect to make pre-tax contributions during the year, up to the calendar year maximum limit set by the IRS.

Allstate Medical Plan Contributions

The account will be funded by the Allstate Medical Plan as indicated in the chart in the "Health Savings Account (HSA)" section. It may also be funded with annual Wellness Incentives—if you or you and your covered spouse/domestic partner complete the Wellness Activities described in the previous section of this SPD.

Earnings

Your HSA will earn interest monthly, adding to your account balance. After your HSA account balance reaches a certain amount, you may select investment funds for your HSA.

Be sure to access your HSA on a regular basis. If you notice suspicious activity, contact Optum immediately.

Note: You are not eligible to enroll in an HSA, make pre-tax payroll contributions, or receive the Allstate Medical Plan Contributions if you are enrolled in Medicare or TRICARE.

HSA Catch Up Contributions

If you are age 55 or older and not enrolled in Medicare, you may make a $1,000 catch-up contribution, in addition to regular contributions, to your HSA.

Eligible Expenses

You can use your tax-favored HSA to help pay for qualified medical Expenses (as defined by the IRS) for you and your family. See IRS Publications 502 and 969 at **www.irs.gov** for more information about qualified medical Expenses and HSAs.

Qualified medical Expenses include:

- visits to the doctor for reasons other than preventive care (under the Savings Plan, preventive care is 100% covered by Allstate);
- prescription drugs, dental care, vision care, nursing care, psychiatric care and chiropractic care;
- Over the Counter drugs will only be reimbursable with a prescription from your provider;
- other medical Expenses not covered by the Plan (but eligible according to IRS publications 502 and 969);
- certain healthcare premiums while receiving unemployment compensation (i.e., under COBRA); and
- if you are over age 65, Medicare Part B, C, and D premiums and Deductibles; Copayments; and Coinsurance under any part of Medicare (premiums for Medigap policies are not qualified medical Expenses).

Withdrawals for non-medical Expenses and medical insurance premiums are taxable and if you are under age 65, an additional 20% penalty applies. Consult your tax advisor.

NOTE

HSAs are individually owned accounts (like IRAs) and are not part of a company benefit plan. Check your account frequently, if you notice any suspicious or unusual activity contact Optum immediately. The HSA is neither an ERISA plan, nor a benefit option under the Medical Plan.

You are not eligible to enroll in an HSA, make pre-tax payroll contributions, or receive the Allstate Medical Plan Contributions if you are enrolled in Medicare or TRICARE.

MEDICAL PLAN THIRD PARTY ADMINISTRATORS

There are two Medical Plan Third Party Administrators ("TPAs") to administer the Allstate Medical Savings Plan and the Allstate Medical Value Plan on a state-by-state basis: Aetna and Blue Cross Blue Shield of Illinois (BCBSIL). The applicable Third Party Administrator is based on the Employee's home address and the state in which he or she resides. Both Third Party Administrators offer a network of Participating Provider Physicians and Hospitals within a specific geographical area that provides In-Network Medical Care and benefits at a contracted rate. Provider lists are available and furnished automatically, upon request and without charge, as a separate document.

IMPORTANT

If you reside in the State of Hawaii, you will not have access to the Allstate Medical Savings Plan or Allstate Medical Value Plan. Your only option for Allstate Medical Plan coverage is through Kaiser Permanente of Hawaii—an HMO Plan.

Third Party Administrator (TPA)	Aetna	BCBSIL
States*	AK, AZ, CA, CO, DC, DE, FL, GA, IL, KS, MD, ME, MO, NH, NJ, NV, NY, OK, PA, TN, TX, WA	AL, AR, CT, IA, ID, IN, KY, LA, MA, MI, MN, MS, MT, NC, ND, NE, NM, OH, OR, RI, SC, SD, UT, VA, VT, WI, WV, WY
TPA's Website and Plan Name Used to Search for Doctors or Facilities	www.aetna.com Aetna Choice POS II (Open Access)	www.bcbsil.com Participating Provider Option – PPO (all states except WI) Blue Preferred POS – Wisconsin only
Provider Services Contact Information	(800) 892-8043	(877) 557-3418

PARTICIPATING PROVIDERS

The Allstate Medical Savings and Value Plans feature an In-Network of **Participating Providers**. By accessing care from a Physician or Hospital that is part of your Third Party Administrator's Network, you may lower your out-of-pocket Expenses and ensure that the services provided meet the plan's definition of Reasonable and Customary Charges. While you are still free to seek care and treatment from any Physician or Hospital, by accessing care from a Premier In-Network or In-Network Physician and/or Hospital, you will receive services at agreed-upon rates, which are typically lower than the community averages for those services.

Since the rate may be less than you might typically be charged, your Out-of-Pocket costs may be reduced. In addition, Premier In-Network and In-Network Provider Physicians and Hospitals have agreed that their charges will not exceed the Plan's definition of Reasonable and Customary Charges. Contact your third party administrator prior to receiving services if a specific specialty provider or facility is not available and discuss in-network alternate options.

Choosing a Provider

Under the Allstate Medical Savings and Value Plans, it is your responsibility to select the Physician or medical provider who meets the expectations and needs of you and your dependents. Treatment decisions are made by you and/or your dependents in conjunction with the Physician or medical provider. Your **Employer**, your Third Party Administrator, the **Allstate Benefits Center**, and the Allstate Cafeteria Plan are not responsible for treatment decisions, or for treatment that is not provided because the Plan does not cover the treatment in question, in whole or in part, and you elect not to receive the treatment.

NOTE

Deductibles, Coinsurance Levels and Out-of-Pocket Maximums vary depending on the coverage option you are enrolled in and whether you choose Premier In-Network, In-Network or Out-of-Network Medical Care.

ALLSTATE MEDICAL SAVINGS PLAN AND ALLSTATE MEDICAL VALUE PLAN

The Allstate Medical Savings and Value Plan provides Premier In-Network, In-Network and Out-of-Network benefits. Premier In-Network and In-Network provide access to a Network of Physicians and Hospitals within a specific geographical area for Medical Care at agreed-upon rates. Premier In-Network and In-Network services receive a higher level of coverage than services received Out-of-Network.

Each time you seek Medical Care you must choose between Premier In-Network, In-Network or Out-of-Network service providers. If you obtain care from Premier In-Network or In-Network providers, your covered health services will be considered In-Network benefits. When you obtain care from Out-of-Network providers, your covered health services will be considered Out-of-Network benefits.

In addition, the Allstate Medical Savings Plan and Allstate Medical Value Plan meet the qualifications of a **High-deductible Health Plan (HDHP)**, which means each option combines a higher Deductible with the option to set up and contribute to a **Health Savings Account (HSA)** to help pay for Eligible Expenses.

An HDHP allows you to receive Medical Care and services from any Physician or facility you choose, although your costs are generally lower and services are at a higher level of coverage if you use Premier In-Network or In-Network providers. As an HDHP participant, you do not need to select a Primary Care Physician, nor do you need referrals for a specialist.

Your Share of the Costs

Deductible

A Deductible applies to each Covered Person for each Plan Year. The Annual Deductible is shown in the "Allstate Medical Savings Plan Schedule of Benefits" and the "Allstate Medical Value Plan Schedule of Benefits" refer to the amount of Eligible Expense a Covered Person must incur during the Plan Year for Premier In-Network, In-Network, Out-of-Network Medical Care and telehealth/telemedicine services before receiving reimbursement. Only Eligible Expenses that would otherwise be covered by the Savings and Value Plan are used to compute the Deductible.

Under the Savings and Value Plans, your share of *non-preventive* prescription drug Expenses and Mental Health and Substance Abuse Eligible Expenses will apply toward the annual Deductible. Preventive drug Copayments will not apply.

Under the Savings Plan:

- The $2,000 in-network ($4,000 out-of-network) individual Deductible only applies if you have "you only" coverage.
- When the in-network Deductible amounts for a covered family equals $4,000 ($8,000 out-of-network) in a Plan Year, no further in-network Deductible, or portion thereof, needs to be satisfied by any family member for the remainder of that Plan Year.

Under the Value Plan:

- The $3,000 in-network ($6,000 out-of-network) individual Deductible applies after the individual Deductible is met).
- Coinsurance benefits begin after the individual Deductible is met ($3,000 in-network/$6,000 out-of-network).
- For all other coverage tiers, Coinsurance benefits begin for an individual after that individual's Deductible is met ($3,000 in-network/$6,000 out-of-network); and Coinsurance benefits begin for all family members after the family deductible is met ($6,000 in-network/$12,000 out-of-network).

If you have a **Qualified Change in Status** which results in a change in your Third Party Administrator (in the same Plan Year), the Deductible amount that has been satisfied may count with your new Third Party Administrator through the end of the Plan Year. Contact the Third Party Administrator.

NOTE

The deductible does not apply to immunizations and physical exams (including mammograms) which qualify as preventive care. For these services, benefits are payable at 100% up to benefit maximums for Eligible Expenses.

Coinsurance

Once the annual Deductible has been reached, you will be responsible for all Eligible Expenses at the applicable Coinsurance Levels shown in the "Allstate Medical Savings and Value Plan Schedule of Benefits."

NOTE

In no event may the medical benefit exceed maximums and limits that are shown in that schedule. Additionally, no benefit will be paid for the same Eligible Expense under more than one Allstate-sponsored benefit plan or coverage.

Out-of-Pocket Maximum

The In-Network Out-of-Pocket Maximums are shown in the "Schedule of Benefits" for each plan option. The Out-of-Pocket Maximum means the maximum amount of money a Covered Person will pay in addition to premium payments and Copayments during a Plan Year for Plan-related benefits.

The Out-of-Pocket Maximum is the amount of Eligible Expense a Covered Person must pay due to:

- application of the Deductible to the Eligible Expense; and
- application of the Coinsurance Level to the Eligible Expense.

When a Covered Person has reached the applicable Out-of-Pocket Maximum during the Plan Year as shown in the "Allstate Medical Savings and Value Plan Schedule of Benefits," future Eligible Expenses for that person will be payable at 100% for the remainder of that Plan Year.

In-Network Out-of-Pocket maximums do not include amounts you pay because of a failure to follow your Plan provider's medical review program provisions. Also, In-Network Out-of-Pocket amounts are *not* combined with Out-of-Network Out-of-Pocket amounts.

Eligible Expenses which do not meet your Third Party Administrator's medical review program guidelines and other specific Plan requirements will not be reimbursed at 100%.

Expenses **excluded** when calculating the Out-of-Pocket Maximum are:

- the portion of Eligible Expense incurred when medical review program requirements are not followed;
- any Expenses which are not Eligible Expenses; and
- Expenses for the difference in cost between a brand-name drug and a generic equivalent for which you are responsible.

Schedule of Benefits: Your Costs in the Allstate Medical Savings Coverage Option

Allstate Good Life Wellness Center—Covered Medical Services	Your Costs

Allstate Good Life Wellness Center— Covered Medical Services	Your Costs
Office Visit - Preventive Care	100% covered
Office Visit (non preventive) – New Patient	$80
Office Visit (non preventive) – Established Patient	$50
Services of a license physical therapist; or the services of a licensed occupational therapist are covered with due to an Injury (e.g., stroke or traumatic brain injury), Sickness (e.g., meningitis or encephalitis), or Autism Spectrum Disorder Note: Physical therapy services are not available in Irving, TX.	$20 initial evaluation $15 re-evaluation Combined maximum of 100 visits per Plan Year for all therapies (combined with Premier In-Network, In-Network and Out-of-Network visits). Each visit of one hour or less is considered a single visit
Other physical therapy services (i.e., hot or cold packs, electric current, ultrasound, therapeutic, manual, etc.)	$10 each

	Allstate Good Life Wellness Center— Premier In-Network/In-Network Providers	Out-of-Network Providers
Deductible (Individual/Family)	$2,000/$4,000	$4,000/$8,000
Out-of-Pocket Maximum for Medical Expenses and Prescription Drug Expenses (Individual/Family)	$3,000/$6,000	$6,000/$12,000

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited
Physician Office visit	100% for preventive care	100% for preventive care	No Coverage
Physician Office visit for surgical or non-surgical care; with or without diagnostic services (lab work and/or x-rays)	5% after Deductible	20% after Deductible	40% after Deductible
Physician Office visit for second surgical opinion	5% after Deductible	20% after Deductible	40% after Deductible
Diagnostic Services Only (labs and/or x-rays); no Physician Office visit	5% after Deductible	20% after Deductible	40% after Deductible
Chiropractic Care	5% after Deductible Maximum of 26 visits per Plan Year (combined with In-Network and Out-of-Network visits)	20% after Deductible Maximum of 26 visits per Plan Year (combined with Premier In-Network and Out-of-Network visits)	40% after Deductible Maximum of 26 visits per Plan Year (combined with Premier In-Network and In-Network visits)

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Speech therapy rendered by a Physician or licensed speech therapist; or the services of a licensed physical therapist; or the services of a licensed occupational therapist are covered when due to an Injury (e.g. stroke or traumatic brain injury), Sickness (e.g. meningitis or encephalitis), or Autism Spectrum Disorder	5% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Good Life Wellness Center, In-Network and Out-of-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	20% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Good Life Wellness Center, Premier In-Network and Out-of-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	40% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Good Life Wellness Center, Premier In-Network and In-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.
Speech, physical or occupational therapy rendered by a Physician or licensed therapist when due to developmental delays in children less than age 5	5% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with In-Network and Out-of-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	20% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Premier In-Network and Out-of-Network visits). Each visit of one hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	40% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Premier In-Network and In-Network visits). Each visit of one hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.
Routine pre-natal care	5% after Deductible	20% after Deductible	40% after Deductible
Charges made by a Hospital for: Ø Room and Board for each day of a Hospital stay, but only up to the Hospital's semi-private room rate; Ø private room certified by your Third Party Administrator; Ø a stay in an intensive care or isolation unit; Ø Miscellaneous Services; or Ø the 48-hour period following a normal vaginal delivery or for the 96-hour period following a Cesarean section	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Physician visits while you are hospitalized as an inpatient	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Services of a Physician for inpatient surgery and outpatient surgery in either a Hospital-based or freestanding surgicenter	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Services in a Hospital-based or freestanding surgicenter (not a Physician's office) or as an outpatient at a Hospital for care in connection with and on the day of surgery	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Allergy shots	5% after Deductible	20% after Deductible	40% after Deductible
Transplant Program and travel benefits. Travel benefits are available only for Expenses that have been incurred in connection with care provided through the Transplant Program Contact your Third Party Administrator's medical review program for complete details	0% after Deductible	0% after Deductible	The Transplant Program and travel benefits are only available on an In-Network basis
X-rays, routine chest x-rays, laboratory examinations, or diagnostic tests done on an outpatient basis	5% after Deductible	20% after Deductible	40% after Deductible
X-ray, laboratory examinations, or diagnostic tests done while confined in a Hospital on an inpatient basis	5% after Deductible	20% after Deductible	40% after Deductible
Emergency room services In-Network benefit level will apply if your In-Network provider has directed you to the Emergency facility or if your Third Party Administrator's medical review program determines that the Emergency facility treatment was necessary	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)
Urgent care / Ambulatory Care Centers; includes services and supplies	20% after Deductible	20% after Deductible	20% after Deductible

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Ground transportation by a licensed professional ambulance service to and from a local Hospital	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Emergency transportation that is: Ø provided to the person being transported because of an Injury or Sickness; Ø consistent with the physical needs of that person; Ø in connection with a covered health service treatment which is unavailable locally; Ø within or between the United States, Mexico, Puerto Rico, and Canada; and Ø from the place where an Injury is sustained or Sickness is contracted to the nearest facility qualified to provide necessary treatment. Contact your Third Party Administrator's medical review program for complete details	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Services of a registered nurse or a licensed practical nurse, if such care is furnished when: Ø intensive nursing care, requiring the skill level and training of a registered nurse or a licensed practical nurse, is needed in the treatment of an Injury or Sickness; and Ø the care could not be properly provided by an individual who does not have the professional qualifications of a registered nurse or a licensed practical nurse. Private duty nursing services are not covered when: Ø the patient is confined in a Hospital, Extended Care Facility or other health care institution; or Ø the registered nurse or licensed practical nurse lives in the Covered Person's home or is a member of the Covered Person's family.	5% after Deductible Plan Year maximum of 70 eight-hour visits	20% after Deductible Plan Year maximum of 70 eight-hour visits	40% after Deductible Plan Year maximum of 70 eight-hour visits
Casts, splints, surgical dressings, or other supplies when deemed to be a covered health service	5% after Deductible	20% after Deductible	40% after Deductible
Crutches, wheelchair, Hospital bed, or Durable Medical Equipment up to the lesser of the purchase price or rental cost of such item deemed to be a covered health service	5% after Deductible	20% after Deductible	40% after Deductible
Prosthetic or Orthopedic Devices such as artificial limbs, eyes, or braces including the replacement of these devices deemed to be a covered health service	5% after Deductible	20% after Deductible	40% after Deductible

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Blood transfusions, including the cost of whole blood or plasma not donated or replaced, and autologous blood donations	5% after Deductible	20% after Deductible	40% after Deductible
The first pair of glasses or contact lenses, but not both, needed after cataract surgery, cornea transplantation, or cornea grafting	5% after Deductible	20% after Deductible	40% after Deductible
The routine care or treatment of a newborn child while the child is necessarily confined in a Hospital	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Room and Board and Miscellaneous Services for an eligible stay in an Extended Care Facility. A stay in an Extended Care Facility is eligible only if a Hospital stay would otherwise be needed and the stay has been approved by your PCP or your Third Party Administrator's medical review program	5% after Deductible Maximum of 120 days confinement per Plan Year (combined with In-Network and Out-of-Network days)	20% after Deductible Maximum of 120 days confinement per Plan Year (combined with Premier In-Network and Out-of-Network days)	40% after Deductible Maximum of 120 days confinement per Plan Year (combined with Premier In-Network and In-Network days)
Charges for care by a Home Health Care Agency	5% after Deductible Maximum of 100 visits* per Plan Year (combined with In-Network and Out-of-Network visits) *Proof of medical necessity may be required by the medical TPA.	20% after Deductible Maximum of 100 visits* per Plan Year (combined with Premier In-Network and Out-of-Network visits) *Proof of medical necessity may be required by the medical TPA.	40% after Deductible Maximum of 100 visits* per Plan Year (combined with Premier In-Network and In-Network visits) *Proof of medical necessity may be required by the medical TPA.

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Charges made by an Alternative Birthing Center for Medical Care received in connection with a birth up to and including the 48-hour period following delivery. Also included are the services of a Nurse-Midwife if: Ø the Nurse-Midwife is acting under the direction of a Physician; and Ø the services are provided in an Alternative Birthing Center.	5% after Deductible	20% after Deductible	40% after Deductible
Charges for a Hospice Care Program including respite care when Covered Expenses include: Ø Room and Board and Miscellaneous Services for a stay in a Hospice; Ø skilled nursing care, home health aid care, and Miscellaneous Services when the Hospice Care Program is provided in the patient's or family's home; Ø counseling for the patient; and Ø counseling for the patient's family, if recommended by a Physician. Contact your Third Party Administrator's medical review program for complete details. All treatment and services must be rendered and billed by the Hospice Care Program	5% after Deductible	20% after Deductible	40% after Deductible

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Replacement, by wig or toupee based on Medical Necessity, of hair lost as a result of a Sickness or Injury. However, no benefit will be payable for replacement made necessary as a result of genetic baldness	5% after Deductible	20% after Deductible	40% after Deductible
The services of a registered dietitian for nutritional counseling when acting under the direct supervision of a Physician and when received for the direct treatment of a Sickness	5% after Deductible Maximum of two sessions per Plan Year (combined with In-Network and Out-of-Network sessions)	20% after Deductible Maximum of two sessions per Plan Year (combined with Premier In-Network and Out-of-Network sessions)	40% after Deductible Maximum of two sessions per Plan Year (combined with Premier In-Network and In-Network sessions)
Prescription Drug Program - CVS Caremark	Refer to the Prescription Drug Services section		
Mental Health and Substance Abuse Treatment	Refer to Mental Health and Substance Abuse (MH/SA) Treatment Services section		

NOTE

Your share of eligible medical services Expenses, eligible non-preventive prescription drug Expenses, and eligible Mental Health and Substance Abuse Treatment services Expenses (such as Deductibles and Coinsurance) will apply toward the Deductible and out-of-pocket maximum accumulators for the Allstate Medical Savings Plan.

Acupuncture services are only covered under the Plan for anesthesia purposes.

Specific program exclusions may apply. Refer to the General Medical Plan Exclusions; Prescription Drug Program Exclusions; and Mental Health and Substance Abuse Treatment Program Exclusions sections for additional information.

Schedule of Benefits: Your Costs in the Allstate Medical Value Coverage Option

Allstate Good Life Wellness Center—Covered Medical Services	Your Costs
Office Visit - Preventive Care	100% covered
Office Visit (non preventive) – New Patient	$80
Office Visit (non preventive) – Established Patient	$50
Services of a license physical therapist; or the services of a licensed occupational therapist are covered with due to an Injury (e.g., stroke or traumatic brain injury), Sickness (e.g., meningitis or encephalitis), or Autism Spectrum Disorder **Note:** physical therapy services are not available in Irving, TX.	$20 Initial Evaluation $15 Re-evaluation Combined maximum of 100 visits per Plan Year for all therapies (combined with Premier In-Network, In-Network and Out-of-Network visits). Each visit of an hour or less is considered a single visit
Other Physical Therapy Services (hot or cold packs, electric current, ultrasound, therapeutic, manual, etc)	$10 each

	Allstate Good Life Wellness Center— Premier In-Network/In-Network Providers	Out-of-Network Providers
Deductible (Individual/Family)	$3,000/$6,000 (embedded at $3,000)	$6,000/$12,000
Out-of-Pocket Maximum for Medical Expenses and Prescription Drug Expenses (Individual/Family)	$4,500/$9,000 (embedded at $4,500)	$9,000/$18,000

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited
Physician Office visit	100% for preventive care	100% for preventive care	No Coverage
Physician Office visit for surgical or non-surgical care; with or without diagnostic services (lab work and/or x-rays)	5% after Deductible	20% after Deductible	40% after Deductible
Physician Office visit for second surgical opinion	5% after Deductible	20% after Deductible	40% after Deductible
Diagnostic Services Only (labs and/or x-rays); no Physician Office visit	5% after Deductible	20% after Deductible	40% after Deductible
Chiropractic Care	5% after Deductible Maximum of 26 visits per Plan Year (combined with In-Network and Out-of-Network visits)	20% after Deductible Maximum of 26 visits per Plan Year (combined with Premier In-Network and Out-of-Network visits)	40% after Deductible Maximum of 26 visits per Plan Year (combined with Premier In-Network and In-Network visits)
Speech therapy rendered by a Physician or licensed speech therapist; or the services of a licensed physical therapist; or the services of a licensed occupational therapist are covered when due to an Injury (e.g., stroke or traumatic brain injury), Sickness (e.g., meningitis or encephalitis), or Autism Spectrum Disorder	5% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Good Life Wellness Center, In-Network and Out-of-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	20% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Good Life Wellness Center, Premier In-Network and Out-of-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	40% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Good Life Wellness Center, Premier In-Network and In-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Speech, physical or occupational therapy rendered by a Physician or licensed therapist when due to developmental delays in children less than age 5	5% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with In-Network and Out-of-Network visits). Each visit of an hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	20% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Premier In-Network and Out-of-Network visits). Each visit of one hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.	40% after Deductible Combined maximum of 100 visits* per Plan Year for all therapies (combined with Premier In-Network and In-Network visits). Each visit of one hour or less is considered a single visit *Proof of medical necessity may be required by the medical TPA.
Routine pre-natal care	5% after Deductible	20% after Deductible	40% after Deductible
Charges made by a Hospital for: Ø Room and Board for each day of a Hospital stay, but only up to the Hospital's semi-private room rate; Ø private room certified by your Third Party Administrator; Ø a stay in an intensive care or isolation unit; Ø Miscellaneous Services; or Ø the 48-hour period following a normal vaginal delivery or for the 96-hour period following a Cesarean section	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Physician visits while you are hospitalized as an inpatient	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Services of a Physician for inpatient surgery and outpatient surgery in either a Hospital-based or freestanding surgicenter	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Services in a Hospital-based or freestanding surgicenter (not a Physician's office) or as an outpatient at a Hospital for care in connection with and on the day of surgery	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Allergy shots	5% after Deductible	20% after Deductible	40% after Deductible
Transplant Program and travel benefits. Travel benefits are available only for Expenses that have been incurred in connection with care provided through the Transplant Program Contact your Third Party Administrator's medical review program for complete details	0% after Deductible	0% after Deductible	The Transplant Program and travel benefits are only available on an In-Network basis
X-rays, routine chest x-rays, laboratory examinations, or diagnostic tests done on an outpatient basis	5% after Deductible	20% after Deductible	40% after Deductible
X-ray, laboratory examinations, or diagnostic tests done while confined in a Hospital on an inpatient basis	5% after Deductible	20% after Deductible	40% after Deductible
Emergency room services In-Network benefit level will apply if your In-Network provider has directed you to the Emergency facility or if your Third Party Administrator's medical review program determines that the Emergency facility treatment was necessary	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)
Urgent care / Ambulatory Care Centers; includes services and supplies	20% after Deductible	20% after Deductible	20% after Deductible
Ground transportation by a licensed professional ambulance service to and from a local Hospital	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Emergency transportation that is: Ø provided to the person being transported because of an Injury or Sickness; Ø consistent with the physical needs of that person; Ø in connection with a covered health service treatment which is unavailable locally; Ø within or between the United States, Mexico, Puerto Rico, and Canada; and Ø from the place where an Injury is sustained or Sickness is contracted to the nearest facility qualified to provide necessary treatment. Contact your Third Party Administrator's medical review program for complete details	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)	20% after Deductible (Services deemed not to be an Emergency are not covered)

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Services of a registered nurse or a licensed practical nurse, if such care is furnished when: Ø intensive nursing care, requiring the skill level and training of a registered nurse or a licensed practical nurse, is needed in the treatment of an Injury or Sickness; and Ø the care could not be properly provided by an individual who does not have the professional qualifications of a registered nurse or a licensed practical nurse. Private duty nursing services are not covered when: Ø the patient is confined in a Hospital, Extended Care Facility or other health care institution; or Ø the registered nurse or licensed practical nurse lives in the Covered Person's home or is a member of the Covered Person's family.	5% after Deductible Plan Year maximum of 70 eight-hour visits	20% after Deductible Plan Year maximum of 70 eight-hour visits	40% after Deductible Plan Year maximum of 70 eight-hour visits
Casts, splints, surgical dressings, or other supplies when deemed to be a covered health service	5% after Deductible	20% after Deductible	40% after Deductible
Crutches, wheelchair, Hospital bed, or Durable Medical Equipment up to the lesser of the purchase price or rental cost of such item deemed to be a covered health service	5% after Deductible	20% after Deductible	40% after Deductible
Prosthetic or Orthopedic Devices such as artificial limbs, eyes, or braces including the replacement of these devices deemed to be a covered health service	5% after Deductible	20% after Deductible	40% after Deductible

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Blood transfusions, including the cost of whole blood or plasma not donated or replaced, and autologous blood donations	5% after Deductible	20% after Deductible	40% after Deductible
The first pair of glasses or contact lenses, but not both, needed after cataract surgery, cornea transplantation, or cornea grafting	5% after Deductible	20% after Deductible	40% after Deductible
The routine care or treatment of a newborn child while the child is necessarily confined in a Hospital	5% after Deductible	20% after Deductible	40% after Deductible (50% for all services related to a non-certified Hospital stay)
Room and Board and Miscellaneous Services for an eligible stay in an Extended Care Facility. A stay in an Extended Care Facility is eligible only if a Hospital stay would otherwise be needed and the stay has been approved by your PCP or your Third Party Administrator's medical review program	5% after Deductible Maximum of 120 days confinement per Plan Year (combined with In-Network and Out-of-Network days)	20% after Deductible Maximum of 120 days confinement per Plan Year (combined with Premier In-Network and Out-of-Network days)	40% after Deductible Maximum of 120 days confinement per Plan Year (combined with Premier In-Network and In-Network days)
Charges for care by a Home Health Care Agency	5% after Deductible Maximum of 100 visits* per Plan Year (combined with In-Network and Out-of-Network visits) *Proof of medical necessity may be required by the medical TPA.	20% after Deductible Maximum of 100 visits* per Plan Year (combined with Premier In-Network and Out-of-Network visits) *Proof of medical necessity may be required by the medical TPA.	40% after Deductible Maximum of 100 visits* per Plan Year (combined with Premier In-Network and In-Network visits) *Proof of medical necessity may be required by the medical TPA.

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Charges made by an Alternative Birthing Center for Medical Care received in connection with a birth up to and including the 48-hour period following delivery. Also included are the services of a Nurse-Midwife if: Ø the Nurse-Midwife is acting under the direction of a Physician; and Ø the services are provided in an Alternative Birthing Center.	5% after Deductible	20% after Deductible	40% after Deductible
Charges for a Hospice Care Program including respite care when Covered Expenses include: Ø Room and Board and Miscellaneous Services for a stay in a Hospice; Ø skilled nursing care, home health aid care, and Miscellaneous Services when the Hospice Care Program is provided in the patient's or family's home; Ø counseling for the patient; and Ø counseling for the patient's family, if recommended by a Physician. Contact your Third Party Administrator's medical review program for complete details. All treatment and services must be rendered and billed by the Hospice Care Program	5% after Deductible	20% after Deductible	40% after Deductible

Covered Medical Service	Premier In-Network Providers	All Other In-Network Providers	Out-of-Network Providers
Replacement, by wig or toupee based on Medical Necessity, of hair lost as a result of a Sickness or Injury. However, no benefit will be payable for replacement made necessary as a result of genetic baldness	5% after Deductible	20% after Deductible	40% after Deductible
The services of a registered dietitian for nutritional counseling when acting under the direct supervision of a Physician and when received for the direct treatment of a Sickness	5% after Deductible Maximum of two sessions per Plan Year (combined with In-Network and Out-of-Network sessions)	20% after Deductible Maximum of two sessions per Plan Year (combined with Premier In-Network and Out-of-Network sessions)	40% after Deductible Maximum of two sessions per Plan Year (combined with Premier In-Network and In-Network sessions)
Prescription Drug Program - CVS Caremark	Refer to the Prescription Drug Services section		
Mental Health and Substance Abuse Treatment	Refer to Mental Health and Substance Abuse (MH/SA) Treatment Services section		

NOTE

Your share of eligible medical services Expenses, eligible non-preventive prescription drug Expenses, and eligible Mental Health and Substance Abuse Treatment services Expenses (such as Deductibles and Coinsurance) will apply toward the Deductible and out-of-pocket maximum accumulators for the Allstate Medical Value Plan.

Acupuncture services are only covered under the Plan for anesthesia purposes.

Specific program exclusions may apply. Refer to the General Medical Plan Exclusions; Prescription Drug Program Exclusions; and Mental Health and Substance Abuse Treatment Program Exclusions sections for additional information.

PREVENTIVE CARE COVERAGE

Preventive Care Benefits

Preventive care is designed to detect health problems early — or to prevent them from occurring.

The Allstate Medical Savings and Value Plans will cover 100% of certain In-Network preventive care services provided by a Premier In-Network or In-Network Provider. You will not have to meet your Deductible first. In order for these services to be processed accurately under the provisions of the Plan, the provider of services must submit these claims using preventive coding. In some circumstances you may need to contact your provider to ensure that your preventive care benefits are correctly applied. You can also reach out to Advocacy Services at 888-622-1200 for additional assistance.

Specific preventive services required to be covered by the Plan can change each year as recommendations are updated. The Plan will cover newly recommended preventive services by the Plan Year beginning on or after one year from the date when the recommendation was issued. The U.S. Preventive Services Task Force (USPSTF) recommendations are considered effective on the last day of the month in which they are issued.

If an attending provider of services determines that a recommended preventive service is medically appropriate for a Covered Person under the Medical Plan, and such Covered Person otherwise satisfies the criteria in the relevant recommendation or guideline as well as all other applicable coverage requirements, coverage will be provided for the recommended preventive service, without cost sharing and regardless of sex assigned at birth, gender identity, or gender of such Covered Person otherwise recorded by the Medical Plan.

Unless specified otherwise, a particular preventive care benefit is limited to once per Plan Year. The list of services considered preventive care and covered at 100% In-Network is based on the USPSTF.

NOTE

If preventive care screening is billed by the provider with a medical diagnosis and not as preventive, the expenses associated with the screening will not be considered preventive and will not be covered 100% under the Plan.

Preventive Care services provided by an Out-of-Network provider are not covered under the provisions of the Plan.

Key Features of Preventive Coverage

- Office visits. If preventive services are not billed separately from an office visit, then the primary purpose of the visit (e.g., preventive care or treatment) determines whether any cost sharing applies.
- Reasonable medical management. The Plan will rely on reasonable medical-management techniques to determine the frequency, method, treatment, or setting for a particular preventive service, unless a recommendation or guideline specifically addresses these details.
- Additional preventive services. The Plan may cover preventive services besides the ACA-mandated ones and may impose cost sharing for those additional services. Cost sharing also can apply for any treatment that is not a required preventive service, even if the treatment results from the preventive care.

The following is a list of items that are considered preventive care, and covered at 100% provided by a Premier In-Network or In-Network Provider:

Well-Child Care

Well-child care includes routine office visits and examinations, as follows:

- Seven visits 0 – 12 months
- Three visits 13th – 24th months
- Three visits 25th – 36th months
- One visit per year from 37 months through age 18

Included **Screenings** and immunizations associated with the above routine office visits are as follows:

- Screenings:
  - Lead level testing, one between ages 9 to 12 months and one at 24 months or after
  - Vision Screening when done as part of well-child care office visit listed above
  - Hearing Screening when done as part of well-child care office visit listed above
  - Pap and routine pelvic exam annually beginning at age 18 or the onset of sexual activity, whichever comes first
- Pathologies, labs, and EKGs that are ordered as part of the preventive care visit and considered preventive care by your Physician
- Immunizations:
  - Two doses of Hepatitis A
  - Three doses of Hepatitis B
  - Six doses of Diphtheria, Tetanus, Pertussis (DtaP)

- Four doses of Hemophilus Influenza type b
- Four doses of Polio
- Four doses of Pneumococcal Conjugate
- Two doses of Varicella
- Two doses of Measles, Mumps, Rubella
- Three doses of Rotavirus
- Meningococcal
- Three doses of Human Papillomavirus (for females and males age 9 through age 26)
- One dose of Influenza Vaccine (flu shot) annually; children age 8 or less who are receiving the influenza vaccine for the first time should receive two doses separated by at least four weeks

Well-Adult Care

Well-adult care includes one annual routine office visit and examination after age 18. Included immunizations and screenings associated with these routine office visits are as follows:

- Immunizations
  - Tetanus/Diphtheria (Td) Booster one every ten years
  - Influenza Vaccination (flu shot) one per Plan Year
  - Pneumococcal Vaccination (Pneumovax) one dose per Plan Year for persons age 65 and over
- Screenings
  - Cholesterol Screening including triglycerides, LDL, HDL, or lipid panel one per Plan Year
  - Mammogram one per Plan Year
  - Well-woman exam (includes Pap and routine pelvic exam) one per Plan Year
  - Bone density test for osteoporosis one per Plan Year for women
  - Colorectal Cancer Screenings beginning at age 50 or due to family history, you have the choice of the following:
    - Fecal occult blood test (FOBT) one per Plan Year and flexible sigmoidoscopy one every five years
    - Colonoscopy one every 10 years (or more frequently if required by your Physician to continue preventive screenings) including required consultation prior to the preventive colonoscopy, anesthesia services performed in connection with the preventive colonoscopy if the attending provider of services determines that anesthesia would be medically appropriate for the Covered Person, and any pathology exam on a polyp biopsy due to a polyp removal during the preventive colonoscopy
    - Double contrast barium enema one every five years
    - Digital rectal examination (DRE) and prostate specific antigen (PSA) test one per Plan Year
- The following may be included as part of the preventive care benefit:
  - Pathologies
  - Labs
  - EKGs that are ordered as part of your preventive care visit and considered preventive care by your Physician

Women's Preventive Health Care

The Medical Plan also covers, without cost sharing, well-woman preventive health care services for dependent children when an attending provider of services determines that well-woman preventive services are age- and developmentally-appropriate for the dependent.

Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Anemia	Screening on a routine basis	Annually
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling, by a trained provider (acting within the scope of his/her license) and costs for renting or purchasing breastfeeding equipment, during pregnancy and/or for the duration of the breastfeeding	In conjunction with each birth During pregnancy and/or for the duration of the breastfeeding, provided the individual remains enrolled in the Plan
Contraceptive methods and counseling	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity	As prescribed. See Prescription Drug Coverage section of this SPD for specific coverage guidelines
Counseling and screening for human immune-deficiency virus	Counseling and screening for human immune-deficiency virus infection for all sexually active women	Annually
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women	Annually
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology results	Screening should begin at 30 years of age and should occur no more frequently than every 3 years
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence	Annually
Screening for gestational diabetes	Screening for gestational diabetes	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk of developing gestational diabetes
Urinary tract infection screening	Screening for urinary tract infection	As prescribed
Well-woman visits	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines	Annually

Additional well-woman visits may be covered if recommended by a physician based upon the woman's health status, needs and other risk factors. Check with your third party medical administrator before receiving these services.

U.S. Preventive Services Task Force (USPSTF)

The USPSTF recommendations are considered effective on the last day of the month in which they are issued. As a general rule, the Plan will cover a recommended preventive service without cost sharing for the entire Plan Year the recommendation is in effect. However, the Plan may immediately eliminate free coverage of a particular preventive service during the Plan Year in either of two situations:

1. The A or B recommendation for that preventive service is downgraded to a D, meaning strong evidence indicates the service provides no net benefit or its harms outweigh its benefits. If the recommendation is downgraded to a C, however, cost-free coverage of the service will continue through the end of the Plan Year of the downgrade — but not in later Plan Years.
2. The preventive item or service is subject to a safety recall or has been determined to pose a significant safety concern by a federal agency with regulatory authority over these matters.

In addition, the following are also considered preventive care based on the USPSTF A and B recommendations. This list is subject to revisions based on USPSTF changes. Unless otherwise specified, a particular preventive care benefit is limited to one per Plan Year.

Topic	Description
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
Blood pressure screening: adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decision-making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.

Topic	Description
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.
Dental care prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.

Topic	Description
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Preeclampsia: screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.

Topic	Description
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
Syphilis screening: nonpregnant persons	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.
Visual acuity screening: children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

GENERAL MEDICAL PLAN EXCLUSIONS

In cases of a life-threatening Sickness for which all other conventional treatment has been exhausted, the Medical Plan may consider certain experimental or investigational treatments to be an Eligible Expense. You must obtain authorization for benefits from your Third Party Administrator's medical review program before receiving such treatments for procedures to be considered a covered health service.

Applicable to the Allstate Medical Savings and Allstate Medical Value Plans

In addition to exclusions that may be listed in the specific Medical Plan descriptions, no benefit will be paid under the Allstate Medical Savings or Allstate Medical Value Plans for Expenses incurred for or in connection with the following even if the Expenses are recommended or prescribed by a provider or are the only treatment for your condition:

- Charges for care or treatment that are not Covered Health Services, as defined
- Charges which exceed the allowance for services and supplies as shown in the SPD

- Medical care, including medicines and supplies, provided outside the U.S. (which includes its territories and possessions) unless deemed to be Emergency or Urgent Care and the purpose of your travel was not to obtain the Medical Care
- Sickness or Injury for which the Covered Person is not under the regular care of a Physician

Benefits also will not be paid for the following Expenses or services:

Alternative Treatments

- Acupuncture services which are not an alternative to anesthesia
- Alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health; such as acupressure, aromatherapy, hypnotism, massage therapy and rolfing
- Services received from a naturopath; holistic or homeopathic care
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies

Ambulance Service

- Ambulance Service if not required for your physical condition; or any form of transportation other than a professional ambulance service

Charges Incurred while in the Military or Paid By Other Coverages

- Health services as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act or ware or terrorism in a non-war zone
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation

  If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or **Mental Illness** that would have been covered under workers' compensation or similar legislation had that coverage been elected
- Military service for any country or organization, including service with military forces as a civilian whose duties do not include combat
- Sickness or Injury as a result of war or act of war
- Services of a Physician employed by any government unless the charge must be paid by the Covered Person
- Services or supplies from a government-owned or operated Hospital unless the charge must be paid by the Covered Person

Comfort or Convenience

- Devices and computers to assist in communication and speech
- Modifications made to a home to accommodate a health need. Examples include but are not limited to, property, such as ramps, elevators, spa, swimming pools, air conditioners, and automotive devices such as car hand controls
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: television, telephone, beauty or barber service, air conditioners or purifiers, batteries or battery chargers, and dehumidifiers or humidifiers

Cosmetic/Physical Appearance

- **Cosmetic Procedures**, including surgery and medication, unless the surgery or medication is initiated as soon as medically feasible, and is required for:
  - the restoration of appearance to the pre-Injury state;
  - the restoration of appearance to the pre-Sickness state; or
  - reconstruction made necessary because of a congenital disease or abnormality of a covered dependent child which has resulted in improper functioning of the afflicted part.
- Liposuction
- Nutritional procedures
- Pharmacological regimens
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. NOTE: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
- Services of a personal trainer
- Skin abrasion procedures performed as a treatment for acne
- Treatments for scar or tattoo removal

Dental

- Preventive care, Diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include the following:
  - Extraction, restoration and replacement of teeth
  - Medical or surgical treatments of dental conditions
  - Services to improve dental clinical outcomes
- **Dental Care** or **Treatment**, unless the Expense is for:
  - repair or replacement of a **Sound Natural Tooth** required as a direct result of an Injury, and the repair or replacement is performed within one year of the Injury or damage;
  - removal of tumors or cysts;
  - prescription drugs ordered in connection with Dental Treatment and in accordance with the Prescription Drug Program;
  - Room and Board and Miscellaneous Services, including the professional services of an anesthesiologist for Hospital confinements as an inpatient, or outpatient for the Dental Care or Treatment;
  - treatment of any organic pathological cause for temporomandibular joint (TMJ) syndrome;
  - oral biopsies of tissue found in the mouth other than a tooth biopsy; or
  - dental services in case of accident, see General Medical Program Information section.
- Dental implants and dental braces.

Experimental, Investigational or Unproven Services and Drugs

- Experimental or Investigational services and Unproven Services are excluded. This includes care, treatment, drugs, or medicines that are Experimental or Investigational Services or Unproven Services. The fact that an Experimental or Investigation Service or an Unproven Service, treatment devise or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Family Planning (Infertility/Reproductive)

- Artificial reproductive techniques including, but not limited to: artificial insemination, in-vitro fertilization or gamete intra-fallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT)
- Reversal of voluntary sterilization
- Surrogate parenting; fees or direct payment to a donor for sperm or ovum donations; monthly fees for maintenance and/or storage of frozen embryos
- Health services associated with the use of non-surgical or drug-induced Pregnancy termination; fetal reduction surgery

Foot Care, Orthotics, Orthopedic Shoes or Supportive Devices for the Feet

- Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
  - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
  - Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies unless prescribed to treat a disease or illness of the foot

General Medical

- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services
- Acupuncture and Acupuncturist services
- Autism intensive behavioral therapies such as applied behavioral analysis and any treatments or specialized services not backed by credible research
- Breast reduction surgery that is determined to be a Cosmetic Procedure.
  - This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998.
- Charges for completing claim forms, reports, or medical record
- Charges for failure to keep a scheduled office visit, telephone consultations, and supervision of care plan when no direct medical treatment is provided
- Charges in excess of any specified limitation
- Charges by a provider sanctioned under a federal program for reasons of fraud, abuse or medical competency
- Chelation therapy, except to treat heavy metal poisoning
- Court-ordered treatment unless determined to be a covered health service
- Custodial Care or maintenance care
- Domiciliary care, rest cures, psychosurgery
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan

- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends
- Medical devices developed as a part of any "Human Genome Project" research are explicitly excluded from coverage unless specifically listed in the SPD as covered whether administered on an inpatient or outpatient basis.
- Megavitamin and nutrition based therapy
- Medical treatments that are unlikely to result in significant, measurable improvement in the patient's medical condition within a reasonable period of time and/or that are mainly for maintenance, or preventive care
- Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs, except nutritional counseling deemed a covered health service
- Routine care and care or treatment designed to prevent the onset of a disease, even if performed by a Physician (exclusion applies only to Expenses which exceed the Preventive Care Benefit Limits in the applicable "Schedules of Benefits")
- Services or supplies provided by a person who:
  - lives in the Covered Person's home; or
  - is the Covered Person's spouse, child, brother, sister or parent.

  This includes any service the provider may perform on himself or herself.
- Treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea; appliances for snoring
- Vitamin Shots (i.e., vitamin B, D, etc.) are excluded from coverage (they are not considered covered expenses under Preventive Coverage Benefits)

Hearing Care

- Hearing aids or exams for their prescription or fitting

Hormone Therapy

- Growth hormone therapy

Motor Vehicle Accidents

- Charges incurred due to injuries received in any motor vehicle accident for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage

Nutrition

- Food of any kind. Foods that are not covered include:
  - enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded
  - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes
  - oral vitamins and minerals
  - meals you can order from a menu, for an additional charge, during an Inpatient Stay, and
  - other dietary and electrolyte supplements
- Megavitamin and nutrition-based therapy
- Nutritional counseling for either individuals or groups including weight loss programs, health clubs, and spa programs

Obesity

- Exercise programs, prescription weight-loss medications, food/diet supplements and routine monitoring as part of overall weight control programs whether or not prescribed by a Physician, including, but not limited to: OptiFast, Medifast, Diet Center, Nutrisystems, Jenny Craig, or Weight Watchers
- Non-surgical treatment of obesity, including morbid obesity
- Surgical treatment of obesity is excluded except for severe morbid obesity (with a BMI greater than 40) or based on the Administrator's clinical criteria. Check with your Third Party Administrator.

Private Duty Nursing

- Private duty nursing services when the patient is confined in a Hospital, Extended Care Facility, or other inpatient health care institution

Speech/Physical Therapy and Other Classes

- The improvement of educational skills or correction of learning disabilities
- Speech therapy, occupational therapy or physical therapy (whether rendered by a Physician, licensed therapist, or otherwise), unless such therapy is deemed to be a Covered Health Service and is for the treatment of an impediment or dysfunction that resulted from an Injury or Sickness (such as stroke, cancer, disorders, or Congenial Anomaly, or is due to development delays in children less than five years of age, or related to Autism Spectrum Disorder)
- Speech therapy to treat stuttering, stammering, or other articulation disorders

Transplants

- Transplant Expenses for:
  - health services for organ and tissue transplants, except those deemed a covered health service;
  - health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Medical Plan or other plan);
  - health services for transplants involving mechanical or animal organs;
  - any solid organ transplant that is performed as a treatment for cancer; or
  - any multiple organ transplants not deemed a covered health service, unless determined by Third Party Administrator to be a proven procedure for the involved diagnoses

Travel

- Travel or transportation Expenses, even though prescribed by a Physician, are generally not covered. Some travel Expenses related to covered services rendered at United Resource Networks participating programs or Designated Facilities may be reimbursed at our discretion. For travel expenses related to transplants, see the Transplant section of the General Medical Program Information section.
- Health services provided in a foreign country, unless required as an Emergency Health Service

Vision

- Eye refractions, surgical correction of refractive errors, glasses, contact lenses, or exams for their prescription or fitting. The first pair of either glasses or contact lenses needed after cataract surgery or cornea transplantation or grafting are covered

NOTE

Additional exclusions apply to the Prescription Drug Program and the Mental Health and Substance Abuse Treatment Program. Refer to the descriptions of those programs for a listing of exclusions.

GENERAL MEDICAL PROGRAM INFORMATION

Medical Review Program

The Medical Plan includes a medical review program, which is administered as applicable by the Third Party Administrators described in the "Medical Plan" section. This program is designed to encourage personalized, efficient care for you and your covered dependents by identifying and addressing possible unmet covered health care needs.

The medical review program may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. These activities are not a substitute for the medical judgment of your Physician. The ultimate decision as to what Medical Care Covered Persons actually receive must be made by the Covered Person and his or her Physician.

NOTE

Special medical review program rules also apply to Eligible Expenses incurred under the Mental Health and Substance Abuse Treatment Program. Refer to your Medical Plan's Mental Health and Substance Abuse (MH/SA) section for details.

Covered Health Service(s)

Covered health services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing, or treating a Sickness, Injury, Mental Health Disorder, Substance Abuse Disorder, or symptoms. Covered health services must be provided:

- when the Medical Plan is in effect;
- prior to the date that any of the individual termination conditions set forth in this Summary Plan Description occur; and
- only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Medical Plan.

A covered health service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
  - Well-conducted, randomized, controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
  - It is the most cost-effective method and yields a similar outcome to other available alternatives.
  - It is a health service or supply that is described in this section and which is not otherwise excluded in the "General Exclusions" section (including **Experimental or Investigational Services** and **Unproven Services**).

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted, randomized trials or cohort studies, as described.

Dental Services - Accident Only

Dental services may be covered by the Plan in case of an "accident" when all of the following are true:

- Treatment is necessary because of accidental damage;
- Dental damage does not occur as a result of normal activities of daily living or extraordinary use of teeth;

- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry; and
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury).

The Plan also covers dental care (oral examination, x-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures;
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- Direct treatment of acute traumatic Injury, cancer, or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental injury only for:

- Emergency examination;
- Necessary diagnostic X-rays;
- Endodontic (root canal) treatment;
- Temporary splinting of teeth;
- Prefabricated post and core;
- Simple minimal restorative procedures (fillings);
- Extractions;
- Post-traumatic crowns if such are the only clinically acceptable treatment; and
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Effect of Medical Review on Benefits

If your Third Party Administrator's medical review program is not contacted for the services listed below, a reduced Coinsurance factor will be applied or no payment will be made, as shown in the "Schedule of Benefits" for your plan option.

If medical review program authorization is not obtained before a Hospital admission, authorization will take place during or after the Hospital admission. Your benefits will be reduced according to the "Schedule of Benefits" for your coverage option for the days prior to and including the day you call your Third Party Administrator's medical review program.

All medical review requirements must be met, even if your plan option is the secondary plan.

Requirements

Medical review is triggered when the program receives notification of an upcoming treatment or service. The notification process serves as a gateway to medical review activities and is an opportunity for the Covered Person to let the Third Party Administrator know that he/she is planning to receive specific health care services. The services requiring notification include:

- Congenital Heart Disease services
- Inpatient facility admissions
- Home health care services—inpatient
- Hospice services
- Durable Medical Equipment

- Maternity care that exceeds the federally mandated delivery timeframes
- Transplant services
- Dental services due to an accident
- Reconstructive procedures, including the following (may be considered either reconstructive and covered, or cosmetic and excluded):
  - breast reduction and reconstruction (except for cancer surgery);
  - vein stripping, ligation and sclerotherapy; and
  - upper lid blepharoplasty services.

Medical review program notification must be done:

- at least five days prior to each admission except when the admission is due to pregnancy, in which case you must contact your medical review program only if the admission will exceed 48 hours for a normal vaginal delivery or 96 hours for a Cesarean delivery;
- if during Outpatient Treatment you are admitted as an inpatient, you must call your medical review program within 48 hours; and
- in the case of an Emergency, within 48 hours following the day of admission (not counting Saturdays, Sundays, and holidays). You must call your medical review program even if you are discharged within the 48-hour period.

However, in some cases, it may not be possible to provide the information when it is due. In these cases, the information must be provided as soon as it is reasonably possible.

It is recommended that Covered Persons always carry their Medical ID card. You can also contact your medical review program at:

- Aetna Member Services at (800) 892-8043, as found on the back of your Medical ID card.
- Blue Cross and Blue Shield of Illinois (BCBSIL) Member Services at (800) 635-1928, as found on the back of your Medical ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Network providers are generally responsible for obtaining prior authorization from Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from Personal Health Support before you receive these services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support has not provided prior authorization.

The services that require Personal Health Support authorization are:

- breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- clinical trials;
- congenital heart disease surgeries;
- dental services — accident only;
- durable medical equipment for items that will cost more than $1,000 to purchase or rent;
- home health care;
- hospice care — inpatient;
- hospital inpatient stay;
- maternity care that exceeds the delivery timeframes;
- mental health services — inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management;
- neurobiological disorders — mental health services for autism spectrum disorders —inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management;
- reconstructive procedures, including breast reconstruction surgery following mastectomy;
- skilled nursing facility/inpatient rehabilitation facility services;
- substance use disorder services — inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management;
- surgery — diagnostic catheterization and electrophysiology implant and sleep apnea surgeries;
- therapeutics — outpatient dialysis treatments, intensity modulated radiation therapy and MR-guided focused ultrasound; and
- transplantation services.

When you choose to receive services from non-network providers, The Plan urges you to confirm with the Third Party Administrator that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- the cosmetic procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- the experimental, investigational or unproven services exclusion; or
- any other limitation or exclusion of the Plan.

Predetermination of Medical Benefits

Aetna

Contact Aetna Member Services at the number on your Medical ID card for information regarding the Predetermination of Medical Benefits. If desired, an estimate of payable medical benefits may be requested in writing by your Third Party Administrator prior to services being rendered.

Blue Cross Blue Shield of Illinois (BCBSIL)

Contact BCBSIL Customer Service at (877) 557-3418 for predetermination of Medical Benefits and/or Durable Medical Equipment. A pre-determination is only an estimate of Eligible Expenses. It is not a guarantee of benefits. An estimate of payable medical benefits can also be requested in writing prior to services being rendered at the following address:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4412

Requests for predetermination of benefits should be made one month prior to services being rendered.

Transplant Program

Aetna Transplant Services

NOTE

Refer to the "Schedule of Benefits" for details about transplant Expense maximums, if applicable.

Covered Expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The Network level of benefits is paid for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from an Aetna network facility that is not designated as an IOE for the transplant being performed will also be covered at the network level of benefits for services and supplies. Non-Aetna network facilities will not be covered.

The plan covers:

- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility or Physician for the medical and **Surgical Expenses** of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; Home Health Care Expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient Expenses directly related to a transplant.

Covered transplant Expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant Expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant Expenses; Home Health Care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any Covered Expenses you incur from an IOE facility will be considered network care Expenses.

Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Network of Transplant Specialist Facilities

Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits may vary if an IOE facility or non-IOE or Out-of-Network provider is used. In addition, some Expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Blue Cross Blue Shield of Illinois (BCBSIL)

Human Organ Transplants

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described here will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described here will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor.
- The transportation of the donor organ to the location of the transplant Surgery.

Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.
- Benefits will not be provided for the following:
  - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
  - Travel time and related Expenses required by a Provider.
  - Drugs which do not have approval of the Food and Drug Administration.
  - Storage fees.
  - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

There is a $10,000 Lifetime Maximum for Transportation and Lodging. Travel related to transplants is subject to IRS guidelines.

Contact BCBSIL Member Services at (800) 635-1928 for additional program information.

Notify Your Medical Review Program

You must notify your medical review program as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify the medical review program, benefits will be subject to a $500 penalty.

Healthy Pregnancy Program

Aetna Beginning Right℠ Maternity Program

If you are Pregnant or planning to get Pregnant, join Aetna's Beginning Right maternity program today, and get information on prenatal and newborn care, labor and delivery and more.

To enroll in the Beginning Right program:

- Call Aetna toll free at (800) CRADLE-1 [(800) 272-3531], weekdays from 8 a.m. to 7 p.m., Eastern Time; or
- Log in to our secure Aetna Navigator member website at www.aetna.com. After logging in, click on *Benefits* and then *Health Programs*.

Blue Cross Blue Shield of Illinois (BCBSIL) Special Beginnings® Program

We understand how important it is to take care of yourself and your growing baby. That's why we are pleased to offer Special Beginnings, a confidential maternity program designed to help you better understand and manage your pregnancy.

Expectant mothers receive the support they need from early pregnancy until six weeks after delivery, including:

- Pregnancy risk factor identification and ongoing communication/monitoring
- Education material covering pregnancy and infant care topics
- Personal telephone contact with program staff
- Assistance in managing high-risk conditions such as gestational diabetes and preeclampsia
- Access to an online resource with maternity tools, articles and information.

Getting started is easy — call toll-free (888) 421-7781, 8:00 a.m. – 6:30 p.m., CT. You will then be contacted by phone or mail to complete a confidential questionnaire, which asks about your medical and obstetrical history, your current pregnancy and information about your lifestyle that could affect your baby. The information provided allows us to determine your risk level and assign an appropriate level of ongoing communication/monitoring by program staff.

After you are enrolled, you will receive a complimentary educational book about having a healthy pregnancy and baby.

The first step to having a healthy baby is getting prenatal care, so be sure to enroll in the program as soon as you find out you are pregnant.

Special Beginnings is not a substitute for professional medical guidance. It is important to share any health concerns with your Physician.

Tot Tracker App

Stay on top of your child's milestones, upcoming vaccinations and growth measurements. The Tot Tracker app tracks children's progress up to three years old.

Tot Tracker includes:

- A diary feature to track sleep, feedings and doctor's appointments
- Tracking tool for completed milestones, with Upcoming Milestones feature
- Recommended vaccinations
- Growth chart and growth tracking tool to log height, weight and head circumference

Use Tot Tracker to take photos, videos and audio clips of your child's most treasured moments and share them with friends and family on Facebook and Twitter.

Duty Calls App

The Duty Calls app is designed to help dads better support their partner during pregnancy.

Duty Calls is unique as it offers many features to assist expectant fathers, including:

- Countdown Timer to the big day
- Task List pre-populated with activities fathers will likely need to complete before the baby comes
- Development Capture Tool, with the ability to take photos, videos and audio clips during important pregnancy milestones and share them through social network
- Knowledge Library with information on what to do and not to do during pregnancy and what is happening with your partner and new baby during each week of pregnancy
- Contraction Timer to track your partner's contractions
- Note Pad to jot down important information during doctor's visits
- Binder to organize and gather information using Duty Calls
- Quick access to your Support Team via phone, email or social media to keep them up to date with developments during pregnancy

Nurse Information Line

Aetna

Aetna's Informed Health® Line is a toll-free nurse line that enables you to talk to one of our registered nurses. With one simple call, you can learn about health conditions you or family members have, find out more about a medical test or procedure, and come up with questions to ask your doctor. This service is available 24 hours a day by calling (800) 556-1555.

Blue Cross Blue Shield of Illinois (BCBSIL) 24/7 Nurseline

The 24/7 Nurseline is staffed by registered nurses 24 hours a day, 7 days a week, ready to help when you or a family member has a health problem or question. In addition to helping you identify health care options, you can learn more about 1,200 health topics over the phone through the AudioHealth Library®, an audio library system.

Simply call (800) 299-0274 and follow the prompts to:

- Speak with a registered nurse.
- Access the AudioHealth Library in English or Spanish.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES (ALLSTATE MEDICAL SAVINGS AND VALUE PLANS)

The Third Party Administrator for the Mental Health and Substance Abuse (MH/SA) Treatment Services is the same administrator as your Medical Plan Third Party Administrator (i.e., Aetna or BCBSIL).

Call the Member Services telephone number on the back of your Medical ID card for additional information and confirmation of benefits.

Mental Health and Substance Abuse (MH/SA)

Network providers will contact the Medical Third Party Administrator for confirmation of coverage. If you choose to receive MH/SA Services from a non-Network provider, you should contact your Medical Third Party Administrator to understand your out-of-network benefits under the plan. Below are a few examples of MH/SA Services:

- Hospital inpatient stay
- Residential Treatment Centers
- Partial hospitalization
- Intensive outpatient programs
- Outpatient electro-convulsive treatment
- Psychological testing

MH/SA Schedule of Benefits—Your Costs

The Mental Health and Substance Abuse Treatment Program benefits are subject to the same Deductibles, Coinsurance, and Out-of-Pocket Maximums as other eligible health care Expenses under the Allstate Medical Savings or Value Plan.

For residents of Illinois, certain NorthShore providers are designated as Premier In-Network Providers for mental health and substance abuse care. Contact NorthShore by dialing (847) 425-6400. NorthShore will assist callers and assign an appropriate NorthShore provider based on an assessment. Coinsurance and Medical Plan Deductibles apply to certain services as shown in the following Schedule of Benefits.

To locate a participating Provider in your area, call your medical plan Third Party Administrator (i.e., Aetna or BCBSIL) or access their website.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

In compliance with the Mental Health Parity Act of 2008, the Mental Health and Substance Abuse Treatment Program no longer places special, separate limits on the number of outpatient visits or inpatient days for mental health and Substance Abuse treatment—and eligible services are covered in the same way as other eligible health care services.

Coverage Description *Medical Plan Option*	Premier In-Network Provider (NorthShore) *Savings and Value*	In-Network *Savings and Value*	Out-of-Network *Savings and Value*
Mental Health			
Combined with Substance Abuse	Yes	Yes	Yes
Inpatient Treatment	5% after Deductible	20% after Deductible	40% after Deductible; 50% for all services related to a non-certified Hospital stay
Outpatient Treatment	5% after Deductible	20% after Deductible	40% up to discounted Reasonable and Customary Charges after Deductible
Substance Abuse			
Detox: Inpatient Treatment	5% after Deductible	20% after Deductible	40% after Deductible; 50% for all services related to a non-certified Hospital stay
Detox: Outpatient Treatment	5% after Deductible	20% after Deductible	40% up to discounted Reasonable and Customary Charges after Deductible
Rehab: Inpatient Treatment	5% after Deductible	20% after Deductible	40% after Deductible; 50% for all services related to a non-certified Hospital stay
Rehab: Outpatient Treatment	5% after Deductible	20% after Deductible	40% up to discounted Reasonable and Customary Charges after Deductible

No benefits are payable for:

- Ø Days not certified by the Program.
- Ø Non-Emergency admissions if Member Services was not contacted prior to admission. However, if you contact Member Services after a non-emergency admission during a confinement, benefits will begin the next day if the non-emergency confinement is determined to be Medically Necessary.
- Ø Emergency admissions when Member Services is not notified within 48 hours of the admission, excluding weekends and holidays. However, if you contact Member Services, coverage will begin the day after the admission is authorized.

Inpatient Treatment

Inpatient Treatment and Alternative Levels of Care considered as Inpatient Treatment are defined as:

- **Acute Inpatient, Detoxification, Substance Abuse Rehabilitation—**Acute Inpatient mental health or Substance Abuse services provided in a Hospital setting which offers intensive 24-hour nursing care, Physician coverage and access to Emergency Medical Care. This is considered the most intensive level of care. Available for adults, adolescents and children. Specialty programs include geriatric psychiatric care, eating disorder programs, etc.
- **Residential Treatment Program—**A structured, 24-hour therapeutic living environment with less-intensive 24-hour nursing coverage and regular medical supervision. Less intensive than acute inpatient, but still 24-hour care is provided.

Outpatient Treatment

Outpatient treatment includes:

- **MDs, DOs and APRNs (Advance Practice Nurses)—**evaluations, medication management, occasionally psychotherapy services
- **PhDs—**evaluations, psychological testing and psychotherapy services
- **Masters-Licensed Counselors/Clinical Social Workers—**evaluations and psychotherapy services

Services range from 15 minutes (routine post-stabilization medication checks) to multiple-hour psychiatric/psychological evaluations.

Behavioral Health – Outpatient – "All Other"

- **Partial Hospitalization Program (PHP) or Day Hospital Program**—intensive care provided in an outpatient setting. A patient typically receives services five to eight hours a day for five days a week. In lieu of, or after, acute inpatient hospitalization.
- **Intensive Outpatient Program (IOP)** flexible formalized treatment program, provided in an outpatient setting. Includes individual and group treatment three hours a day for three days a week. Treatment is most commonly provided in the evening.
- Ambulatory detoxification
- Applied Behavior Analysis for the treatment of autism spectrum disorder (may be an excluded benefit, check with carrier)
- Electroconvulsive therapy (ECT)
- Home health care
- Medical treatment for withdrawal symptoms
- Neuropsychological testing
- Outpatient detoxification
- Outpatient monitoring of injectable therapy
- Psychological testing
- Transcranial magnetic stimulation
- 23-hour observation
- Vagus nerve stimulation (normally an excluded benefit)

Whether you are seeing a participating Provider or a non-participating provider, the following services *must always be pre-certified*:

- Partial Hospitalization
- Intensive Outpatient Program
- Biofeedback

- EMDR (eye movement desensitization and reprocessing)
- Outpatient ElectroConvulsive Therapy (ECT)—ECT is appropriate for treating some conditions and is typically used when treatment fails to alleviate symptoms that create health risks for the patient. ECT requires prior authorization to ensure the member can be safely treated in an outpatient setting and does not require a more intensive level of care.
- Court-ordered treatment unless determined to be Medically Necessary
- Psychological testing—Due to the broad range of provider discretion in ordering psychological testing and the potential for ordering these services without clinical justification, prior authorization is required.

MH/SA Exclusions

No benefit will be paid for Expenses incurred for or in connection with the following services or treatment:

Alternative Treatments

- Aversion therapy
- Bioenergetics therapy
- Carbon dioxide therapy
- Confrontation therapy
- Crystal healing treatment
- Expressive therapies (art, poetry, movement, psychodrama) as separately billed services
- Guided imagery
- Hyperbaric or Normobaric oxygen therapy
- Marathon therapy
- Megavitamin therapy
- Primal therapy
- Rolfing
- Sedative action electrostimulation therapy
- Sensitivity training
- Sex therapy (without a **DSM-V** diagnosis)
- Transcendental meditation
- Z therapy, also known as holding therapy

Nutrition and Health Education

- Eating disorder and gambling programs based solely on the 12-step model
- Environmental ecology treatments
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism, when there is a diagnosed nutritional deficiency

Provider Consultations and Counseling

- Consultation with a mental health professional for adjudication of marital, child support, and custody cases and adoptive home study or related services, or as part of the protocol for major surgery (e.g. transplants)
- Religious, career, pastoral and financial counseling
- Treatment of sexual addiction, co-dependency or other behavior that does not have a DSM-V diagnosis

Seminars and Training

- Educational evaluation and therapy
- EST (Erhard Seminar Training) or similar motivational services
- Therapy for personal growth or professional training
- Training analysis (traditional, orthodox)
- Vocational assessment

Other Exclusions

- Cult deprogramming
- Custodial Care
- Developmental Disabilities, including Autism Spectrum Disorder
- Hemodialysis for schizophrenia
- Hypnosis when this is the only service rendered
- Therapeutic boarding schools
- Wilderness programs, therapeutic camps, or similar residential treatment programs

NOTE

Allstate Medical Savings and Value options coverage Exclusions also apply to the Mental Health and Substance Abuse Treatment Program. Receipt of benefits under the Mental Health and Substance Abuse Treatment Program does not waive any of the exclusions which apply to Medical Plan coverage and will not affect payments of other benefits under that Plan.

PRESCRIPTION DRUG SERVICES (CVS CAREMARK)

Prescription Drug Services are administered by CVS Caremark and offer the following benefits under the Allstate Medical Savings and Value Plan options.

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is subject to change. Drugs that are excluded from the Plan's Formulary are not covered under the Plan unless approved in advance through a Formulary exception review.

If approved through that process, the applicable Formulary co-pay would apply for the approved drug based on the Plan's cost share structure. Absent such approval, Covered Persons selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan.

Covered medications are dispensed as follows:

- The first option is always a generic drug;
- The second option is always a Plan-preferred brand-name (formulary) drug; and
- The final option is a non-Plan-preferred brand-name (non-formulary) drug.

You are required to pay the applicable Copayment amount for each generic prescription filled and the Coinsurance amount (minimum/maximum Copayment may apply) for each preferred and non-preferred medication filled at an In-Network retail pharmacy, specialty pharmacy or CVS Caremark's mail-order service. All prescriptions will be filled with the appropriate generic equivalent if available unless the Physician or patient requests the brand-name to be dispensed. If you purchase a brand-name medication when a generic is available, you will pay the brand-name Copayment, plus the difference between the brand-name and the generic medications.

To locate a participating retail pharmacy in your area, call the CVS Caremark Customer Care Team. For information regarding the medications that are Plan-preferred because they are on the Preferred Prescription® formulary, contact CVS Caremark at (888) 293-5404 or register and log in to the CVS Caremark website at Caremark.com and click on "Covered Drug List (Formulary)."

Eligible Expenses

Eligible Expenses for prescription medications (excluding food supplements) that can lawfully be obtained only through a written prescription from a Physician, and which are approved by the Food and Drug Administration (FDA), will be reimbursed under the Retail, Mail-order or Specialty Pharmacy Prescription Drug Program as described in this section.

If you chose a brand-name Plan-preferred (formulary) or a brand-name non-Plan-preferred (non-formulary) drug and a generic drug is available, you will pay the difference between the brand-name and generic and be required to pay the applicable brand-name Copayment amount. However, in no case will you pay more than the actual cost of the drug.

Formulary Medications

Certain formulary medications may not be covered without a prior authorization for medical necessity. If you continue using a drug on the formulary drug list which require prior authorization approval for medical necessity, you may be required to pay the full cost of the drug without any reimbursement under the Plan. If prior authorization for medical necessity is required, ask your doctor to consider a generic or the brand formulary options.

Go to Caremark.com for the most current formulary drug list. Also, note that just because a drug is included on the formulary drug list does not mean that the drug is automatically covered by the Plan. Be sure to check the Prescription Drug Exclusions list, which is included in the SPD.

NOTE

Formulary exceptions from CVS Caremark may be requested by a member or provider on the basis that the drug requested is:

1) medically necessary and essential to the Covered Person's health and safety, and/or

2) all formulary drugs comparable to the excluded drug have been tried and failed by the Covered Person.

Preventive Medications related to the Affordable Care Act (ACA)

The plan covers the following preventive medications under the ACA – both prescription and over-the-counter (OTC) – at a $0 Copayment. To receive preventive medications at a $0 Copayment, you must have an authorized prescription for the medication and it must be dispensed by a participating retail, mail pharmacy, or an Allstate Good Life Pharmacy. Note that just because a drug is included on the list below does not mean that the drug is automatically covered by the Plan. Be sure to check the Prescription Drug Exclusions list, which is included in the SPD.

- Aspirin – an OTC product for cardiovascular protection and Preeclampsia
- Bowel Preps – for Age greater than 49 and less than 76 years
- Folic acid – OTC dose of 400 to 800 mg/day
- Fluoride – a prescription product to prevent dental cavities
- Iron supplements – an OTC product to treat/prevent anemia

- Raloxifene – when the medication is prescribed to prevent breast cancer, you receive pre-authorization from CVS Caremark, and you meet the following requirements: (i) are age 35 or older; (ii) have never been diagnosed with breast cancer; and (iii) are at high risk for developing breast cancer. To receive pre-authorization, you or your physician must call CVS Caremark at (888) 293-5404.
- Smoking cessation products – some OTC and some prescription products
  - Chantix
  - Nicorette Gum/Lozenge
  - Nicotine Transdermal System
  - Nicotrol Inhaler
  - Nicotrol NS
  - Zyban
- Soltamox – when the medication is prescribed to prevent breast cancer, you receive pre-authorization from CVS Caremark, and you meet the following requirements: (i) are age 35 or older; (ii) have never been diagnosed with breast cancer; (iii) are at high risk for developing breast cancer; and (iv) not able to take a medication in pill form (i.e., Tamoxifen or Raloxifene). To receive pre-authorization, you or your physician must call CVS Caremark at (888) 293-5404.
- Tamoxifen – when the medication is prescribed to prevent breast cancer, you receive pre-authorization from CVS Caremark, and you meet the following requirements: (i) are age 35 or older; (ii) have never been diagnosed with breast cancer; and (iii) are at high risk for developing breast cancer. To receive pre-authorization, you or your physician must call CVS Caremark at (888) 293-5404.
- Statin – low to moderate dose statins; generics only (no high dose or brand statins); for men and women ages 40 through 75 years old
- Vitamin D – Single entity vitamin D2 or D3 containing less than or equal to 1,000IU AND dual combination agents containing calcium and vitamin D2 or D3
- Contraceptive methods for women – coverage includes at least one form of contraception in each of the following methods that the FDA has identified:
  - Sterilization Surgery for Women
  - Surgical Sterilization Implant for Women
  - Implantable Rod
  - IUD Copper
  - IUD w/ Progestin
  - Shot/Injection
  - Oral Contraceptives (Combined Pill)
  - Oral Contraceptives (Progestin only)
  - Oral Contraceptives Extended/Continuous Use
  - Patch
  - Vaginal Contraceptive Ring
  - Diaphragm with Spermicide
  - Sponge with Spermicide
  - Cervical Cap with Spermicide
  - Female Condom

- Spermicide Alone
- Emergency contraception (Plan B/Plan B One Step/Next Choice)
- Emergency contraception (Ella)

If multiple services and FDA-approved items within a contraceptive method are medically appropriate for an individual, the Plan may use reasonable medical management techniques to determine which specific products to cover without cost sharing with respect to that individual (subject to the exceptions process, explained below). The Plan may impose cost sharing (including full cost sharing) on some items and services, such as brand-name contraceptives, where other specific items and services (such as generics) are available within the chosen contraceptive method.

Exceptions Process – If the Plan utilizes reasonable medical management techniques within a specified method of contraception, the participant or a provider (or other individual acting as a participant's authorized representative) may request an exception by contacting CVS Caremark Customer Care at (888) 293-5404.

If a participant's attending provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that participant, the Plan will cover that service or item without cost sharing. In determining medical necessity, the Plan will defer to the determination of the attending provider.

Prescription Drug Benefits for the Savings and Value Plan Options

Good Life Pharmacy Schedule of Benefits

Preventive:	**Your Cost**
1 - 30-day supply	
Generic	$3 Copayment
Formulary and Non-Formulary	$8 Copayment
31- 90-day supply	
Generic	$9 Copayment
Formulary and Non-Formulary	$24 Copayment
Non-Preventive:	**Your Cost**
1 - 90-day supply	
Generic	15% after Deductible
Formulary and Non-Formulary	15% after Deductible
Specialty Medications*:	**Your Cost**
1 - 30-day supply	
Generic	15% after Deductible
Formulary and Non-Formulary	15% after Deductible

* Note, not all Specialty Medications can be filled at the Allstate Good Life Pharmacy.

Retail Prescription Drugs

To utilize this benefit, present your Prescription Drug ID card, prescription, and Copayment and/or Coinsurance to any participating retail pharmacy. The Copayment and/or Coinsurance are applicable to each Covered Person for each eligible prescription or supply.

The Prescription Drug Copayment and/or Coinsurance applies toward satisfying your Deductible and Out-of-Pocket Maximums under the Allstate Medical Savings and Allstate Medical Value Plans.

Retail Schedule of Benefits

Preventive:	Your Cost
1 - 30-day supply – all in-network retail pharmacies	
Generic	$5 Copayment
Formulary and Non-Formulary	$10 Copayment
31- 90-day supply – CVS Pharmacy only	
Generic	$12.50 Copayment
Formulary and Non-Formulary	$25 Copayment
Non-Preventive:	**Your Cost**
1 - 30-day supply – all in-network retail pharmacies	
Generic	20% after Deductible
Formulary and Non-Formulary	20% after Deductible
31- 90-day supply – CVS Pharmacy only	
Generic	20% after Deductible
Formulary and Non-Formulary	20% after Deductible

Prescription Drug Exclusions

No benefits are payable for:

- the difference in cost between a brand-name drug and a generic equivalent (in excess of the Copayment and/or Coinsurance) when a generic equivalent is available;
- over-the-counter medications except as noted;
- medications for non-FDA approved indications;
- medications developed as a part of any "Human Genome Project" research are explicitly excluded from coverage unless specifically listed in the SPD as covered whether administered on an inpatient or outpatient basis.
- prescriptions for:
  - allergy serums;
  - anti-obesity preparations;
  - biologicals;
  - drugs for cosmetic purposes only;
  - drugs labeled "Caution—limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
  - drugs whose sole purpose is to promote or stimulate hair growth;
  - fertility agents;
  - glucowatch products;
  - homeopathics;
  - immunization agents and vaccines (non-generic);
  - insulin pumps;
  - Jublia;
  - Mifeprex;
  - non-federal legend drugs;

- non-sedating antihistamines;
- periodontal products;
- therapeutic devices or appliances, including hypodermic needles, ostomy supplies, and durable medical equipment;

Ø any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order; and

Ø medicines/medications for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.

As new drugs are developed or when current drugs receive FDA approval for new or alternative uses, the Plan, upon knowledge of those new drugs or reclassification of drugs, reserves the right to review the drug's (or class of drugs) eligibility under the Medical Plan. As a result of the review, the Medical Plan reserves the right to exclude, discontinue, or limit coverage of those drugs or class of drugs within a reasonable time following such review. Any benefit payments made for those drugs shall not invalidate the Medical Plan's right to make a determination at a later date.

To determine if a prescription drug requires prior authorization, is limited in coverage or excluded under the Medical Plan, call CVS Caremark Customer Care at (888) 293-5404.

Mail-order Prescription Drugs for Long-Term Medications

Prescriptions for certain long-term drugs or medicines must be obtained by utilizing the CVS Caremark mail-order service or local CVS Pharmacy, unless you utilize an Allstate Good Life Pharmacy. Typically this is necessary if you or your covered family members require medications to treat chronic medical conditions.

It is important that you use the mail-order service, CVS Pharmacy or the Allstate Good Life Pharmacy to get your *long-term* drugs (such as maintenance medications used to treat high blood pressure or high cholesterol). Otherwise you may be required to pay the full cost of the drug if you continue to purchase them at a retail pharmacy after the third time you fill your prescription. All *short-term* drugs or medications, such as antibiotics, should be filled at a participating retail pharmacy.

For long-term medications, you will be permitted up to three fills at a retail pharmacy. If you do not convert your prescription to mail-order, CVS Pharmacy or the Allstate Good Life Pharmacy and continue to refill at a retail pharmacy other than through a CVS Pharmacy or an Allstate Good Life Pharmacy, you will be subject to 100% of the cost of the prescription. If you are unsure whether your medication is considered a long-term or short-term drug or medicine or wish to speak with a CVS Caremark Pharmacist who can discuss how medications are used to treat specific conditions, call the CVS Caremark Customer Care at (888) 293-5404.

When you use the CVS Caremark mail-order service (for your long-term medications), you can get up to a 90-day supply of medication delivered to you for the applicable mail-order Copayment. Standard shipping is free.

To get started using mail-order, call CVS Caremark Customer Care at (888) 293-5404. CVS Caremark can contact your doctor to discuss moving your retail prescription to a 90-day prescription by mail. Or, you can ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to one year (if appropriate) then mail the new prescription with a mail-order form to CVS Caremark. Mail-order forms may be obtained online at Caremark.com or by contacting CVS Caremark.

Medications will usually arrive within eight days after CVS Caremark receives your order. If your doctor faxes the prescription, you'll be billed later. Please make sure you have a two-week supply of medication on hand while waiting for your medication to arrive. If necessary, ask your doctor for a 14-day prescription that you can fill at a participating retail pharmacy.

Long-Term Medications - Mail-order Schedule of Benefits

Preventive:	Your Cost
1 - 90-day supply	
Generic	$12.50 Copayment
Formulary and Non-Formulary	$25 Copayment
Non-Preventive:	**Your Cost**
1 - 90-day supply	
Generic	20% after Deductible
Formulary and Non-Formulary	20% after Deductible

Under Prescription Drug Services, long-term medications or medicines are limited to one initial 30-day supply plus two refills through a participating retail pharmacy. After the third fill you *must* use the Mail-order services (the CVS Caremark pharmacy), a CVS Pharmacy or the Allstate Good Life Pharmacy. If you continue to obtain any subsequent refills through a retail pharmacy (other than a CVS Pharmacy or an Allstate Good Life Pharmacy), you will be responsible for 100% of the cost. All other limitations and exclusions apply.

Mail-order Prescription Drug Exclusions

No benefits are payable for:

- a prescription order that exceeds a 90-day supply;
- the difference in cost between a brand-name drug and a generic equivalent (in excess of the Copayment and/or Coinsurance) when a generic equivalent is available;
- over-the-counter medications except as noted;
- medications for non-FDA-approved indications;
- prescriptions that are limited or excluded under the Medical Plan:
  - allergy serums;
  - anti-obesity preparations;
  - biologicals;
  - blood or blood plasma products;
  - drugs labeled “Caution—limited by Federal Law to investigational use,” or experimental drugs, even though a charge is made to the individual;
  - drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only (B52);
  - fertility agents;
  - glucowatch products;
  - homeopathics;
  - insulin pumps;
  - Jublia
  - Mifeprex;
  - non-federal legend drugs;
  - non-sedating antihistamines;
  - periodontal products;
  - therapeutic devices or appliances, including hypodermic needles, ostomy supplies, and durable medical equipment;

- any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order; and
- medicines/medications for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.

Compounded medications that contain one or more ingredients that are not FDA approved for use in the dosage form ordered are excluded from coverage.

As new drugs are developed or when current drugs receive FDA approval for new or alternative uses, the Medical Plan, upon knowledge of those new drugs, or reclassification of drugs, reserves the right to review the drug's, or the class of drugs, eligibility under the Medical Plan. As a result of the review, the Medical Plan reserves the right to exclude, discontinue or limit coverage of those drugs, or the class of drugs within a reasonable time following such review. Any benefit payments made for those drugs shall not invalidate the Medical Plan's right to make a determination at a later date.

To determine if a prescription drug is currently limited or excluded under the Medical Plan, call the CVS Caremark Customer Care team at (888) 293-5404.

Specialty Pharmacy Prescription Drugs

Complex conditions, such as anemia, multiple sclerosis, hepatitis C, rheumatoid arthritis, growth hormone deficiency, immune deficiency, cancer, hemophilia, and rare diseases may be treated with specialty medications. Specialty medications are typically injectable medications administered either by you or a health care professional, and they often require special handling, special administration, or intensive patient monitoring.

Prescriptions for specialty medications can only be filled for a 30-day supply; fills for more than 30 days will not be allowed. Also, prescriptions for specialty medications can only be filled at the On-Site Good Life Pharmacy or the CVS Specialty Pharmacy. They cannot be filled through the mail order services or at any retail pharmacy. (Note that not all specialty medications can be filled at the On-Site Good Life Pharmacy.)

The Medical Plan requires that certain specialty medications be handled through CVS Specialty Pharmacy, a specialty pharmacy of CVS Caremark. These specialty medications will not be covered through the medical plan coverage third party administrator. Please contact CVS Specialty Pharmacy at (866) 387-2573 for more information.

CVS Specialty Pharmacy provides the following services:

- 24 hours a day/7 days a week access to pharmacists who are trained in the handling and monitoring of specialty medications, their side effects, and the conditions they treat;
- Expedited delivery of specialty medications to your home or doctor's office;
- Access to some supplemental supplies, such as needles and syringes required to administer the medication, that may be included at no additional charge; and
- Scheduling of refills and coordination of services with home care providers, case managers, and doctors or other healthcare professionals.

Some medications may qualify for a third-party copay assistance card/program, which could lower your out-of-pocket costs. If copay assistance is used for a specialty medication, only the amount you pay will be applied to your Deductible and Out-of-Pocket Maximum. Any amount paid through the copay card/program for specialty medications will not be applied to your Deductible or Out-of-Pocket Maximum. Copay cards/programs cannot be used through the mail order pharmacy. Contact CVS Caremark for additional information.

A complete list of the medications subject to this special handling requirement is available by calling the telephone number on your prescription drug ID card. It is your responsibility to check this list before you have a prescription for a specialty medication filled.

If you use a specialty medication subject to this special handling requirement and do not obtain the medication through CVS Specialty Pharmacy, you may be responsible for the full cost of the medication without any cost sharing from the Plan. When you order a specialty medication subject to this special handling requirement and obtain the medication through CVS Specialty Pharmacy, the cost sharing with the Plan will be as set forth in the following Specialty Medications Schedule of Benefits chart.

CVS Specialty Pharmacy – Schedule of Benefits

Specialty Medications Preventive and Non-Preventive:	Your Cost
1 - 30-day supply	20% after Deductible

NOTE

Non-compliance will result in no benefit coverage. The only exception is that patients may fill some specialty medications at the Allstate Good Life Pharmacy in Northbrook, IL. Otherwise, CVS Specialty Pharmacy must be used.

Compounded medications that contain one or more ingredients that are not FDA approved for use in the dosage form ordered are excluded from coverage.

Clinical Interventions

In certain situations, CVS Caremark clinical staff will contact your prescribing Physician to inquire about a possible change in the drug being prescribed, the dosage being prescribed, possible interactions with other prescriptions previously dispensed to you, etc. These interventions are based on safety, drug effectiveness, and cost. Your prescription will not be changed unless your prescribing Physician approves the change. If you have a question regarding a changed prescription, contact your prescribing Physician or the CVS Caremark Customer Care team at (888) 293-5404.

NOTE

Any Copayment amounts and other Expenses that are the Employee's responsibility under the Prescription Drug Program are applied toward satisfying the Allstate Medical Savings Plan and Value Plan Deductible or Out-of-Pocket Maximum.

Allstate Medical Savings Plan and Allstate Medical Value Plan Exclusions may also apply to the Prescription Drug Program. Receipt of benefits under the Prescription Drug Program does not waive any of the Exclusions that apply to the medical option and will not affect payment of other benefits under either plan.

Restrictions may be placed on the quantity of certain drugs or medicines. Contact CVS Caremark at (888) 293-5404 for information on drug/medication limitations.

HEALTH CARE CLAIMS AND APPEAL PROCEDURES

In this section, you will find information about filing a claim or appealing the claim decision for your Medical Plan coverage, Prescription Drug Program, and the Mental Health and Substance Abuse Treatment Program.

Medical Services

For the Allstate Medical Savings and Value Plan coverage options under the Medical Plan, the responsibility for initial claims determinations and the full and fair review of denials and appeals (all levels) pursuant to Section 503 of ERISA has been delegated to the appropriate Third Party Administrator for such plan.

How to File a Claim

In-Network Claims

Usually, you do not need to file a claim for In-Network medical, prescription drug, or mental health and Substance Abuse benefits. Network providers are paid directly for your or your covered dependent(s)' covered health services. If an In-Network provider bills you or your covered dependent(s) for any covered health service, contact your Third Party Administrator. However, you are responsible for meeting the Deductible and for paying Copayments to an In-Network provider at the time of service, or when you receive a bill from the provider.

If you do need to file a claim for reimbursement of In-Network benefits, please contact your Third Party Administrator at the phone number listed on your Medical ID card for instructions.

Out-of-Network Claims

When you or your covered dependent(s) receive covered health services from an Out-of-Network provider, you are responsible for filing a claim. You must file the claim in a format that contains all of the information required, as described below. Claim forms can be obtained from your Third Party Administrator.

As soon as you or your dependents incur Out-of-Network medical Expenses, you and your Physician must complete a claim form and send it to the address shown on the claim form. In submitting your claim, you will be required to provide written proof acceptable to the Medical Plan regarding the occurrence, character, and extent of loss.

You should submit the claim within 15 months of the date the Expense was incurred, or be prepared to show that you submitted the claim as soon as reasonably possible. If an Out-of-Network provider submits a claim on your behalf, you will be held responsible for the timeliness of the submission.

This 15-month time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you or your covered dependent provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to you or your covered dependent. The Medical Plan will not reimburse third parties who have purchased benefits from or been assigned benefits by Physicians or other providers.

Claims submitted more than 15 months after the Expense was incurred are ineligible for payment and will be denied.

Required Information

When you file a claim requesting payment of benefits, you must provide all of the following information:

- Employee's name and address.
- The patient's name, age and relationship to the Employee.
- The member and Group number stated on your ID card.
- An itemized bill from your provider that includes the following:
  - Patient diagnosis
  - Date(s) of service
  - Procedure codes(s) and descriptions of service(s) rendered
  - Charge for each service rendered
  - Provider name, address, and Tax Identification Number
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

The information should be mailed to the address of your Third Party Administrator:

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

Blue Cross Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4412

Payment of Benefits

Your Third Party Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies your Third Party Administrator that your signature is on file, assigning benefits directly to that provider.
- You make a written request for the Out-of-Network Provider to be paid directly at the time you submit your claim.

In-Network benefits for covered medical, mental health, and Substance Abuse Expenses received from an In-Network Provider will be paid directly to that provider.

Subject to the Coordination of Benefits provision, all Medical Plan Out-of-Network benefits are payable to the assignee, if any. Benefit payments will be paid to you or an **Alternate Recipient,** or the Alternate Recipient's custodial parent or legal guardian, if a **Qualified Medical Child Support Order** has been approved by the Medical Plan. If benefits are payable after your death, the benefits may be paid to your estate or to any of the following of your surviving relatives: spouse, children, parents, or brothers and sisters.

Eligible Charge (Expense): (a) in the case of a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

(i) the Provider's billed charges, or;

(ii) the Claim Administrator non-contracting Eligible Charge (Expense). Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge (Expense) for Coordinated Home Care Program Covered Services will be 50% of the Non-Administrator Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge (Expenses) for Non-Administrator Providers will be 50% of the Non-Administrator Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize Claim processing rules and/or edits for processing Claims which may also alter the Eligible Charge (Expenses) for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge (Expense) will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Benefit Determinations

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after Medical Care has been received. If your claim is incomplete, the Third Party Administrator must notify you within 30 calendar days. You must then provide completed claim information to the Third Party Administrator within 45 days. If you do not provide the needed information within the 45-calendar-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the provision of the Medical Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving Medical Care. If your claim was a pre-service claim and was submitted properly with all needed information, you will receive written notice of the claim decision from your Third Party Administrator within 15 calendar days of receipt of the claim. If you filed a pre-service claim improperly, your Third Party Administrator will notify you of the improper filing and how to correct it within five calendar days after the pre-service claim was received. If additional information is needed to process the pre-service claim, your Third Party Administrator will notify you of the information needed within 15 calendar days after the claim was received, may request a one-time extension not longer than 15 calendar days, and may pend your claim until all information is received.

Once notified of the extension, you then have 45 calendar days to provide this information. If all of the needed information is received within the 45-calendar-day time frame, your Third Party Administrator will notify you of the determination within 15 calendar days after the information is received. If you do not provide the needed information within the 45-calendar-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the provision of the Medical Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent Care claims are those claims that require notification or approval prior to receiving Medical Care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations:

- Ø You will receive notice of the benefit determination in writing or electronically within 72 hours after your Third Party Administrator receives all necessary information, taking into account the seriousness of your condition.
- Ø Notice of denial may be oral with a written or electronic confirmation to follow within three calendar days.

If you filed an Urgent Care claim improperly, your Third Party Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, your Third Party Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- Ø Your Third Party Administrator's receipt of the requested information; or
- Ø The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the provision of the Medical Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Your Third Party Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Questions and Appeals

NOTE

This section provides you with information to help you with the following:

- Ø You have a question or concern about covered health services or your benefits.
- Ø You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Medical Plan and you wish to appeal such determination.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact your Third Party Administrator before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "How to File a Claim," you may appeal it as described below, without first informally contacting your Third Party Administrator. If you first informally contact your Third Party Administrator, and later wish to request a formal appeal in writing, you should contact your Third Party Administrator and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an Urgent Care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact your Third Party Administrator immediately.

The telephone number is shown on your ID card.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact your Third Party Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- Ø The patient's name and the identification number from the ID card
- Ø The date(s) of medical service(s)
- Ø The provider's name
- Ø The reason you believe the claim should be paid
- Ø Any documentation or other written information to support your request for claim payment

Your first appeal request must be submitted to your Third Party Administrator within 180 calendar days after you receive the claim denial. The information should be mailed to your Third Party Administrator:

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

Blue Cross Blue Shield of Illinois
Health Care Service Corporation
P.O. Box 2401
Chicago, IL 60690-1364

NOTE

Claims submitted more than 15 months after the Expense was incurred are ineligible for payment and will be denied.

Appeal Process

The Plan Administrator has appointed your Third Party Administrator, a named ERISA fiduciary under the plan, to (i) perform initial benefit determinations and payment, (ii) perform the fair and impartial review of first level appeals, (iii) perform the fair and impartial review of second level appeals and (iv) perform the fair and impartial review of Urgent Care appeals. As such, the Plan Administrator delegates to your Third Party Administrator the discretionary authority to (i) construe and interpret the terms of the Plan, (ii) to determine the validity of charges submitted to your Third Party Administrator under the Plan, and (iii) make final, binding determinations concerning the availability of Plan benefits.

A qualified individual who was not involved in the original claim denial decision will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. Your Third Party Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You must consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service claims, as defined in "How to File a Claim," the first-level appeal will be conducted and you will be notified by your Third Party Administrator of the decision within 15 calendar days from receipt of a request for appeal of a denied claim. The second-level appeal will be conducted and you will be notified by your medical provider of the decision within 15 calendar days from receipt of a request for review of the first-level appeal decision.
- For appeals of post-service claims, as defined in "How to File a Claim," the first-level appeal will be conducted and you will be notified by your medical provider of the decision within 30 calendar days from receipt of a request for appeal of a denied claim. The second-level appeal will be conducted and you will be notified by your medical provider of the decision within 30 calendar days from receipt of a request for review of the first-level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you disagree with the first-level appeal decision of your Third Party Administrator, you have the right to request a second-level appeal by your Third Party Administrator. Your second-level appeal request must be submitted within 60 calendar days from receipt of the first-level appeal decision. The second-level appeal request and pertinent information should be mailed to your Third Party Administrator:

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

Blue Cross Blue Shield of Illinois
Health Care Service Corporation
P.O. Box 2401
Chicago, IL 60690-1364

Please note that all decisions are based only on whether or not benefits are Eligible Expenses under the Medical Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call your Third Party Administrator as soon as possible.

- Your Third Party Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The Allstate Cafeteria Plan (at its Expense) has the right to have a Covered Person examined as often as reasonably necessary while a claim is pending in order to obtain needed information regarding the claim determination.

External Claim Review Process for Aetna and BCBSIL

Third Party Administrator: Aetna

"External Review" is a review of an adverse benefit determination or a final internal adverse benefit determination by an Independent **Review Organization**/External Review Organization (ERO).

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to the Plan's verification procedures, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any adverse benefit determination or any final internal adverse benefit determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the *Request for External Review Form* to Aetna within four (4) months from the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An adverse benefit determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent Review Organization refers the case for review to a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within five (5) business days following the date of receipt of the request for external review, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one (1) business day after completion of the preliminary review, Aetna must issue to you a notification in writing. M If the request is complete but not eligible for External Review; such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA (3272)). If the request for external review is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the four (4) months filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and (vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to the claimant, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow the claimant to request an expedited External Review at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but have not been discharged from a facility

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review of ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Third Party Administrator: BCBSIL

You have four (4) months to request an external review after receiving notice from BCBSIL of an adverse benefit determination or final internal adverse benefit determination.

BCBSIL will complete a preliminary review of the request within 5 business days, to determine whether you are eligible for external review. You will be notified within one business day after BCBSIL completes the preliminary review if the request is eligible or if further information or documents are needed.

BCBSIL will assign the matter to an independent Review Organization (IRO). The assigned IRO will be an independent, unbiased, randomly selected entity that receives no financial incentive based on the outcome of any review. The IRO is not bound by BCBSIL's adverse or final adverse benefit determination. The IRO will retain appropriate clinical and legal consultants to conduct the review. There will be no charge to you for the external review.

The IRO will issue a letter fully explaining its decision within 45 days after receipt of an eligible request for external review. This decision of the IRO is binding on the parties.

If your claim is not eligible for external review, BCBSIL will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration.

If the IRO reverses the adverse or final adverse benefit determination, BCBSIL will immediately provide coverage or payment for the claim.

Time Limits on Starting Lawsuits or Other Legal Action

No claimant (including Plan participants and their beneficiaries) or claimant's representative may file or commence any lawsuit or legal action (under §502 of ERISA or otherwise) to obtain any Medical Plan benefit under the Allstate Cafeteria Plan, without first having complied with, and exhausted all levels of appeal required by the Allstate Cafeteria Medical Plan, and in any event not more than one (1) year after the final appeal is denied by your Third Party Administrator.

Failure to follow the claim procedures of the Medical Plan, including timeframes and exhaustion of administrative remedies, shall result in a loss of benefits, if otherwise available.

Prescription Drug Services (CVS Caremark)

For the Prescription Drug services, the responsibility for initial claim determination and full and fair review of denials and appeals (all levels) pursuant to Section 503 of ERISA has been delegated to CVS Caremark, the Third Party Administrator for the program.

Claims submitted more than 15 months after the Expense was incurred are ineligible for payment and will be denied.

Claim Procedures

Your plan provides for reimbursement of prescriptions when you pay 100 percent of the prescription price at the time of purchase through a participating retail pharmacy. The claim will be processed based on your plan benefit. To request reimbursement you will send your claim to CVS Caremark Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196. You will be notified of the decision within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

If your claim does not provide sufficient information for the claim to be processed, you will be notified that more information is needed within 45 days of receipt of the claim. If your claim provides sufficient information to determine the last day that your plan allows you to submit the claim for reimbursement (i.e., plan's stale date), then you will be notified that more information is needed and you will have until that date to submit the missing information. If you do not submit the information by the required date, your claim is deemed denied and the appeal rights discussed below apply. If you do submit the information by the required date, you will be notified of the decision within 15 days after the information is received. If your claim is missing information, and without the information the claim's stale date cannot be determined, your claim will be denied and you have the right to appeal the decision as described below. Claims submitted more than 15 months after the Expense was incurred are ineligible for payment and will be denied.

If your claim is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please call CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If you are not satisfied with the decision on your claim or your claim is deemed denied, you have the right to appeal this decision. See below for appeal instructions.

Appeal

To appeal a denied claim or a claim that is deemed denied, you must submit your request within 180 days of receipt of notice of the decision. An appeal may be initiated by you or your authorized representative (such as your Physician). To initiate an appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied and
- any additional information that may be relevant to your appeal including missing information

This information should be mailed to CVS Caremark Appeals Department, MC109, P.O. Box 52084, Phoenix, AZ 85072-2084. A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please contact CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If you are not satisfied with the decision made on the appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your Physician). To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to CVS Caremark Appeals Department, MC109, P.O. Box 52084, Phoenix, AZ 85072-2084.

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes.

You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please contact CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you may have the right to an independent review by an external Review Organization if the case involves medical judgment or rescission. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below.

External Review Procedures

The right to an independent external review is only available for claims involving medical judgment or rescission. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed to: CVS Caremark Appeals Department, MC109, P.O. Box 52084, Phoenix, AZ 85072-2084.

Once you have submitted your external review request, your claim will be reviewed within five business days to determine if it is eligible to be forwarded to an independent Review Organization (IRO) and you will be notified within one business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan and CVS Caremark written notice of its decision.

If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a). If the IRO has determined that your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA section 502(a).

NOTE

Retail pharmacies do not exercise discretionary authority on behalf of the Medical Plan and, therefore, the pharmacy's refusal to fill the prescription without full payment by the participant is not considered a claim denial under the Medical Plan. You will be reimbursed the amount submitted less the negotiated discount less your applicable Copayment.

Claims submitted more than 15 months after the Expense was incurred are ineligible for payment and will be denied.

Appeal Procedures

The Plan Administrator has appointed CVS Caremark, a named ERISA fiduciary under the plan, to:

- perform initial benefit determinations and payment,
- perform the fair and impartial review of first level appeals,
- perform the fair and impartial review of second level appeals, and
- perform the fair and impartial review of Urgent Care appeals.

As such, the Plan Administrator delegates to CVS Caremark the discretionary authority to:

- construe and interpret the terms of the Plan,
- determine the validity of charges submitted to CVS Caremark under the Plan, and
- make final, binding determinations concerning the availability of Plan benefits.

A qualified individual who was not involved in the original claim denial decision will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. CVS Caremark may consult with, or seek the participation of, Prescription Drug experts as part of the appeal resolution process. You must consent to this referral and the sharing of pertinent Prescription Drug claim information. Upon request and free of charge, you have the right to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

For all claims other than member-submitted paper claims:

A pre-service claim is a request for coverage of a medication when your plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an Urgent Care claim, provided you have submitted sufficient information to decide your claim. A Post-Service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered "deemed" denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please contact CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Urgent Claims (Expedited Reviews)

An Urgent Care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving Urgent Care, you will be notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered "deemed" denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please contact CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered "deemed" denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your Physician). To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied and
- any additional information that may be relevant to your appeal

This information should be mailed to CVS Caremark Appeals Department, MC109, P.O. Box 52084, Phoenix, AZ 85072-2084. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim.

You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please contact CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your Physician). To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to CVS Caremark Appeals Department, MC109, P.O. Box 52084, Phoenix, AZ 85072-2084. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes.

You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please contact CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to an independent review by an external Review Organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

Urgent Appeal (Expedited Review)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your Physician (or other authorized representative) must contact CVS Caremark.

Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing.

In the case of an urgent appeal (for coverage involving Urgent Care), you will be notified of the benefit determination within 72 hours of receipt of the claim. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes.

You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please contact CVS Caremark. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination. The decision made on your urgent appeal is final and binding. In the Urgent Care situation, there is only one level of Appeal prior to an external review.

If your appeal is denied and you are not satisfied with the decision of the appeal (i.e., your "final adverse benefit determination") or any appeal denial notice (i.e., "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if your appeal is denied and you are not satisfied with the decision (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., your "adverse benefit determination" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to an independent review by an external Review Organization.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or you do not agree with the determination of the external Review Organization, you have the right to bring a civil action under ERISA section 502(a).

Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

External Review Procedures

The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed to: CVS Caremark Appeals Department, MC109, P.O. Box 52084, Phoenix, AZ 85072-2084.

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan and CVS Caremark written notice of its decision.

If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a). If the IRO has determined that your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA section 502(a).

Urgent External Review

Once you have submitted your urgent external review request, your claim will immediately be reviewed to determine if you are eligible for an urgent external review. An urgent situation is one where in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will immediately be reviewed to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan and CVS Caremark written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

Time Limits on Starting Lawsuits or Other Legal Action

No claimant (including Plan participants and their beneficiaries) or claimant's representative may file or commence any lawsuit or legal action (under §502 of ERISA or otherwise) to obtain any Medical Plan benefit under the Allstate Cafeteria Plan, without first having complied with, and exhausted all levels of appeal required by the Allstate Cafeteria Medical Plan, and in any event not more than one (1) year after the final appeal is denied by your Third Party Administrator.

Failure to follow the claim procedures of the Medical Plan, including timeframes and exhaustion of administrative remedies, shall result in a loss of benefits, if otherwise available.

Mental Health and Substance Abuse Treatment Services

For the Mental Health and Substance Abuse (MH/SA) Treatment services, the responsibility for initial claim determinations and full and fair review of denials and appeals (all levels) pursuant to Section 503 of ERISA has been delegated to the Third Party Administrator for the program.

Filing a Claim

In-Network Claims

Usually, you do not need to file a claim for In-Network mental health and Substance Abuse benefits. Network providers are paid directly for your or your covered dependent(s)' covered health services. If a Network provider bills you or your covered dependent(s) for any covered health service, contact your medical plan Third Party Administrator Member Services. However, you are responsible for meeting the annual Deductible and for paying Copayments to a Network provider at the time of service or when you receive a bill from the provider.

Out-of-Network Claims

When you or your covered dependent(s) receive covered health services from an Out-of-Network (or Out-of-Area) provider, you are responsible for filing a claim. You must file the claim in a format that contains all of the information required, as described below.

As soon as you or your dependents incur Out-of-Network mental health or Substance Abuse Expenses, you and your Physician must complete a claim form and send it to the address shown on the claim form. In submitting your claim, you will be required to provide written proof acceptable to your medical plan Third Party Administrator regarding the occurrence, character, and extent of loss.

You should submit the claim within 90 calendar days of the date the Expense was incurred or be prepared to show that you submitted the claim as soon as reasonably possible. If an Out-of-Network provider submits a claim on your behalf, you will be held responsible for the timeliness of the submission.

This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you or your covered dependent provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to you or your covered dependent. The Plan will not reimburse third parties who have purchased benefits from, or been assigned benefits by, Physicians or other providers.

Claims submitted more than 15 months after the Expense was incurred are ineligible for payment and will be denied.

Required Information

When you file a claim requesting payment of benefits, you must provide all of the following information:

- Employee's name and address.
- The patient's name, age and relationship to the Employee.
- The member and Group number.

- An itemized bill from your provider that includes the following:
  - Patient diagnosis
  - Date(s) of service
  - Procedure code(s) and descriptions of service(s) rendered
  - Charges for each service rendered
  - Provider name, address and Tax Identification Number
  - The date the Injury or Sickness began.

A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s). Claim forms can be obtained by contacting your medical plan Third Party Administrator Member Services. The completed claim form should be sent to:

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

BCBSIL
P.O. Box 805107
Chicago, IL 60680-4112

Payment of Benefits

The Third Party Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies the Third Party Administrator that your signature is on file, assigning benefits directly to that provider.
- You make a written request for the Out-of-Network provider to be paid directly at the time you submit your claim.
- In-Network benefits for covered mental health and Substance Abuse Expenses received from a Participating Provider will be paid directly to that provider.

Benefit Determinations

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after Medical Care has been received. If your post-service claim is denied, you will receive a written notice from your Third Party Administrator within 30 calendar days of receipt of the claim, as long as all needed information was provided with the claim. Your medical plan Third Party Administrator will notify you within this 30-calendar-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 calendar days, and pend your claim until all information is received.

Once notified of the extension, you then have 45 calendar days to provide this information. If all of the needed information is received within the 45-calendar-day time frame and the claim is denied, the Third Party Administrator will notify you of the denial within 15 calendar days after the information is received. If you do not provide the needed information within the 45-calendar-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Medical Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving Medical Care. If your claim was a pre-service claim and was submitted properly with all needed information, you will receive written notice of the claim decision from the Third Party Administrator within 15 calendar days of receipt of the claim. If you filed a pre-service claim improperly, the Third Party Administrator will notify you of the improper filing and how to correct it within five calendar days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Third Party Administrator will notify you of the information needed within 15 calendar days after the claim was received, may request a one time extension not longer than 15 calendar days, and pend your claim until all information is received.

Once notified of the extension, you then have 45 calendar days to provide this information. If all of the needed information is received within the 45-calendar-day time frame, the Third Party Administrator will notify you of the determination within 15 calendar days after the information is received. If you do not provide the needed information within the 45-calendar-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Medical Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent Care claims are those claims that require notification or approval prior to receiving Medical Care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations:

- Ø You will receive notice of the benefit determination in writing or electronically within 72 hours after the Third Party Administrator receives all necessary information, taking into account the seriousness of your condition.
- Ø Notice of denial may be oral with a written or electronic confirmation to follow within three calendar days.

If you filed an Urgent Care claim improperly, the Third Party Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Third Party Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- Ø the Third Party Administrator receipt of the requested information; or
- Ø The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Medical Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an Urgent Care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Third Party Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

MH/SA Questions and Appeals

To resolve a question or appeal, follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact your medical plan Third Party Administrator Member Services before requesting a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "How to File a Claim," you may appeal it as described below, without first informally contacting Member Services. If you first informally contact Member Services and later wish to request a formal appeal in writing, you should contact Member Services and request an appeal.

If you are appealing an Urgent Care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below, and contact Member Services immediately.

Member Services representatives are available to take your call 24 hours a day, seven days per week.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact your Third Party Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card
- The date(s) of medical service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any documentation or other written information to support your request for claim payment

Your first appeal request must be submitted to your Third Party Administrator within 180 calendar days after you receive the claim denial. The information should be mailed to:

Aetna – National External Review Unit
1100 Abernathy Road Ste 375
Atlanta, GA 30328

BCBSIL Claim Review Section
P.O. Box 2401
Chicago, IL 60690-1364

Appeal Process

A qualified individual who was not involved in the original claim denial decision will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Mental Health professional with appropriate expertise in the field who was not involved in the prior determination. Your Third Party Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process for first and second level appeals. You must consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, as defined in "How to File a Claim," the first-level appeal will be conducted and you will be notified by the Third Party Administrator of the decision within 15 calendar days from receipt of a request for appeal of a denied claim. If you request a second-level appeal it will be conducted and you will be notified by the Third Party Administrator of the decision within 15 calendar days from receipt of a request for review of the second-level appeal decision.
- For appeals of post-service claims as defined in "How to File a Claim," the first-level appeal will be conducted, and you will be notified by the Third Party Administrator of the decision within 30 calendar days from receipt of a request for appeal of a denied claim. The second-level appeal will be conducted and you will be notified by the Third Party Administrator of the decision within 30 calendar days from receipt of a request for review of the first-level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you disagree with the first-level appeal decision of the Third Party Administrator, you have the right to request a second-level appeal by the Third Party Administrator. Your second-level appeal request must be submitted within 60 calendar days from receipt of the first-level appeal decision. The second-level appeal request and pertinent information should be mailed to:

Aetna – National External Review Unit
1100 Abernathy Road Ste 375
Atlanta, GA 30328

BCBSIL Claim Review Section
P.O. Box 2401
Chicago, IL 60690-1364

Please note the decision is based only on whether or not Benefits are Eligible Expenses under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call Aetna or BCBSIL as soon as possible. The Third Party Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.
- For urgent claim appeals, we have delegated to the Third Party Administrator the exclusive right to interpret and administer provisions of the Plan. The Third Party Administrator's decisions are conclusive and binding.

External Appeal Process by an Independent Review Organization (IRO)

You or your appropriately designated representative may be eligible to request an external appeal conducted by an Independent Review Organization (IRO) certified by the Utilization Review Accreditation Commission (URAC). You may submit a claim for external review when you have exhausted the appeals provided within your benefit plan. If your claim is urgent, you may submit a claim for expedited external review before exhausting the appeals provided within your benefit plan.

To submit claims for external review, please send written request to your Third Party Administrator:

Aetna – National External Review Unit
1100 Abernathy Road Ste 375
Atlanta, GA 30328

BCBSIL Claim Review Section
P.O. Box 2401
Chicago, IL 60690-1364

If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by faxing your claim to Aetna at (860) 975-1526 and to BCBSIL at (217) 243-0044, Attention: Expedited External Review Request.

Please provide the following information in your external review claim:

Insurer Name, Member Name and ID #, Patient Name, Phone #, Mailing Address of the claimant and the Inquiry Number from the adverse determination letter received from the appeals provided within your benefit plan.

In accordance with federal and state laws, appeals of Substance Abuse or mental health treatment cannot be reviewed until an Authorization to Disclose Health Information Form (AFD) is completed and submitted to the Third Party Administrator. Please note that a request for an appeal is not considered complete until a written request for an appeal along with the (AFD) allowing your protected health information to be released to the IRO is received.

If you have any questions, including a request for a verbal interpretation of any part of your appeal process, or requests for alternative formats of written materials, please contact the Third Party Administrator Customer Services Department Monday through Friday as follows: Aetna (877) 848-5855 between 8 a.m. and 6 p.m. CST or BCBSIL (877) 557-3418 between 8 a.m. and 5 p.m. CST.

Time Limits on Starting Lawsuits or Other Legal Action

No claimant (including Plan participants and their beneficiaries) or claimant's representative may file or commence any lawsuit or legal action (under §502 of ERISA or otherwise) to obtain any Medical Plan benefit under the Allstate Cafeteria Plan, without first having complied with, and exhausted all levels of appeal required by the Allstate Cafeteria Medical Plan, and in any event not more than one (1) year after the final appeal is denied by your Third Party Administrator.

Failure to follow the claim procedures of the Medical Plan, including timeframes and exhaustion of administrative remedies, shall result in a loss of benefits, if otherwise available.

HMO COVERAGE

Health Maintenance Organization (HMO) options provide services through a select group of independent practicing Physicians, Hospitals, and other providers who are under contract with the Plan to provide services at a discounted rate. You may be eligible to enroll in an HMO if there is an Allstate-sponsored HMO offered in your home ZIP code area.

Employees residing in Hawaii are only eligible to enroll in HMO coverage under the Cafeteria Plan.

Please refer to your medical plan certificate of coverage for specific information regarding your plan's benefit provisions.

HMO Plan Service Areas

A plan's service area, which is a listing of all eligible ZIP codes, is determined by each plan. Service areas are based on adequate accessibility to providers and facilities within an area. For this reason, your home ZIP code determines your plan eligibility. In order to ensure appropriate access to care for plan participants, exceptions are not made to service area eligibility.

Selecting Your Primary Care Physician (PCP)

When you enroll in an HMO, you must select a Primary Care Physician (PCP) and Medical Group for yourself and your eligible dependents. Your PCP is a contracted doctor specializing in family or general practice, internal medicine, or pediatrics who has agreed to provide or arrange all necessary medical services. Your PCP is responsible for coordinating all of your health care needs.

If you initially seek care from your PCP and obtain care from other providers only as arranged by your PCP, you will have chosen In-Network benefits. To receive In-Network benefits for treatment from another Physician (i.e., specialist); your PCP must refer you to that Physician. You may be required to obtain a referral and the referral must specify the services to be rendered. Benefits will be limited to those specific services. An exception to this provision is care that is deemed to be "Emergency Care" by the plan. When you obtain care that is not arranged by your PCP, you will have chosen to go out of the plan's Network. Most HMO plans do not provide benefits for services received Out-of-Network, except for Emergency Care. PPO plans offer limited Out-of-Network benefits.

It is your responsibility to select the Physician or medical provider who meets your and/or your dependent's needs. Treatment decisions are made by you and/or your dependents in conjunction with your Physician or medical provider. Your Employer, the Allstate Cafeteria Plan, the Allstate Benefits Center, or the HMO are not responsible for treatment decisions, or for treatment that is not provided because the HMO does not cover the treatment in question, in whole or in part, and the Covered Person elects not to receive the treatment.

You may change your PCP within your chosen Medical Group by notifying your Medical Group directly. In order to change your Medical Group, you must notify your plan directly. The effective date of such a change may vary by plan. Certain other limitations may apply.

How to Obtain Information About Your Medical Plan

You may obtain the following information by contacting your plan's Member Services department at the telephone number on your ID card, or by accessing the plan's Internet website:

- the services provided by the plan (a summary of services may also be found in the Medical Plan Summary Sheet booklet provided as a supplement to this SPD)
- list of Participating Provider
- how to access services
- conditions under which services may be denied
- claim procedures
- procedures for review of denied claims

Eligible Expenses

Eligible Expenses for covered medical services are the medical services and supplies provided to you by your PCP and the providers whose services are arranged for you by your PCP, if those medical services and supplies are not excluded from coverage under your plan. Deductibles, Out-of-Pocket Maximums, maximum lifetime benefits, Copayments, and Coinsurance Levels that apply when you obtain covered medical services vary by plan. Refer to your Medical Plan Summary Sheet booklet, see your certificate of coverage, or contact the Member Services department at the telephone number on your ID card for details specific to your particular plan.

Prescription Drug Coverage

Generally, most plans provide a prescription drug benefit. In addition, your plan may include a mail-order prescription drug program. Please refer to the applicable section of the Medical Plan Summary Sheet booklet, see your certificate of coverage, or contact the Member Services department at the telephone number on your ID card for specific details regarding applicable Copayments and how to utilize your prescription drug benefit plan.

HMO Plan Claims

For any HMO plan under the Medical Plan, and all other benefit plans or coverages that provide benefits through insurance contracts, the powers, duties, and responsibilities described, including the responsibility for full and fair review of denials pursuant to Section 503 of ERISA, generally reside with the insurer, except that the Plan Administrator continues to have the sole and absolute discretion to determine eligibility under the terms of the Cafeteria Plan. The decisions of the Plan Administrator and his authorized delegates will be final and binding.

For questions related to specific benefit and claim provisions, please refer to your certificate of coverage or contact your plan's Member Services department.

In general, when you receive HMO covered services from an In-Network provider, the provider submits the claim to the plan and the plan makes appropriate payments to the provider. However, if you receive covered services from an Out-of-Network provider (such as Emergency or out-of-area Urgent Care) you must submit a claim for benefits. The claim must be submitted to the address on your Member ID card. HMOs do not cover Out-of-Network non-Emergency services.

Changes in Coverage

Rules for changing coverage under an HMO (i.e., as the result of a Qualified Change in Status) may be found in the *General Provisions* section of this SPD. If you cease to be enrolled in an HMO because of a change in your residence, or the HMO ceases operations or becomes insolvent, you may become eligible for coverage under the Allstate Medical Savings Plan, Allstate Medical Value Plan, or a different HMO plan, depending on the ZIP code of your primary residence. You may also make changes to your coverage during Annual Enrollment. Changes made during Annual Enrollment will be effective on January 1 following Annual Enrollment, provided you are still eligible for coverage.

Refer to your HMO certificate of coverage and the following HMO Medical Plan Summary Sheets. You may also call the Allstate Benefits Center at (888) 255-7772 for a list of the plans for which you may be eligible.

NOTE

Employees residing in Hawaii are only eligible to enroll in HMO coverage under the Cafeteria Plan.

The state of Georgia requires health plans to offer the option of nominating and accessing Out-of-Network providers. This is called "Consumer Choice Option." The option is available at an additional cost for each HMO offered in the state of Georgia. You may contact the HMO plan for more details.

HMO Summary Sheets

Refer to the following tables for details about your HMO's coverage and contact information:

- Kaiser Savings HMO – Northern California and Southern California
- Kaiser Value HMO – Northern California and Southern California
- Kaiser Savings HMO – Colorado
- Kaiser Value HMO – Colorado
- Kaiser Savings HMO – Georgia and Georgia (Consumer Choice)
- Kaiser Value HMO – Georgia and Georgia (Consumer Choice)
- Kaiser HMO – Hawaii
- Blue Advantage HMO – Illinois
- Kaiser Savings HMO – Mid Atlantic States – (District of Columbia, Maryland, Virginia)
- Kaiser Value HMO – Mid Atlantic States – (District of Columbia, Maryland, Virginia)
- Kaiser Foundation Health Plan of Washington Savings HMO
- Kaiser Foundation Health Plan of Washington Value HMO

Plan Type: HMO
Group: Actives/COBRA

Plan Name:	Kaiser Savings HMO – California
Group Number (Actives/COBRA): **2281, 2281**	***State/Region:*** **Northern and Southern California**
Benefit Provision:	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-800-464-4000 **Web site:** www.kp.org
Annual deductible	$2,000 Individual; $4,000 Family
Annual out-of-pocket maximum	$3,000 Individual; $6,000 Family
Ability to self-refer	**To OB/GYN:** Yes **To Specialist**: Contact Plan
Outpatient Care	
Office visits	**Primary Doctor:** 20% after deductible **Specialist:** 20% after deductible
Annual physical exam	100% covered
Pediatric/well-child exam	$0 copay per visit (23 months or younger)
Outpatient surgery	20% after deductible
Lab & x-ray	20% per encounter
Inpatient Hospital Care	
Hospital deductible	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable
Retail prescriptions	**Generic:** 20% after deductible up to $50 prescription maximum; 30 day supply **Formulary:** 20% after deductible up to $100 prescription maximum; 30 day supply; must be medically necessary; prescribed by a Plan physician and obtained at Plan pharmacies **Non formulary:** 20% after deductible up to $100 prescription maximum; 30 day supply; must be medically necessary; prescribed by a Plan physician and obtained at Plan pharmacies
Mail-order prescriptions	**Generic:** 20% after deductible up to $50 prescription maximum ; 100 day supply **Formulary:** 20% after deductible up to $100 prescription maximum ; 100 day supply; When medically necessary, prescribed by a Plan physician, and obtained through Plan mail-order **Non formulary:** 20% after deductible up to $100 prescription maximum ; 100 day supply; When medically necessary, prescribed by a Plan physician, and obtained through Plan mail-order
Oral contraceptives	Retail and mail-order available; 100% covered standard retail and mail-order copays apply
Specialty Drugs	**Generic:** 20% after deductible (retail) up to $250 prescription maximum/20% after deductible (mail-order) up to $250 prescription maximum per prescription when medically necessary, prescribed by a Plan physician, and obtained through Plan pharmacies/mail-order **Formulary:** 20% after deductible (retail) up to $250 prescription maximum /20% after deductible(mail-order) up to $250 prescription maximum per prescription when medically necessary, prescribed by a Plan physician, and obtained through Plan pharmacies/mail-order **Non formulary:** 20% after deductible (retail) up to $250 prescription maximum /20%(mail-order) up to $250 prescription maximum per prescription when medically necessary, prescribed by a Plan physician, and obtained through Plan pharmacies/mail-order
Family Planning/Maternity	
Pre/post-natal office visit	Prenatal: 100% covered; Post-Natal: 20% after deductible
Fertility services	80% covered for diagnosis and treatment of involuntary fertility when approved by a plan physician
Mental Health (MH) Services	
Outpatient treatment	20% after deductible
Inpatient treatment	20% after deductible is met
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible
Inpatient rehabilitation	20% after deductible
Other Services	
Emergency room	20% after deductible
Ambulance services	$150 after deductible
Noncustodial home health care	Check with Plan
Noncustodial skilled nursing care	Check with Plan
Hospice care	Check with Plan
Durable medical equipment	20% after deductible; must be deemed medically necessary and prescribed by a Plan physician; must be in accordance with DME formulary guidelines
Outpatient physical therapy	20% after deductible; must be medically necessary; preauthorization required by a Plan physician
Accidental injury to teeth	Not covered
Chiropractic services	Not covered
Routine vision exam	100% covered

Plan Type: HMO
Group: Actives/COBRA

Plan Name:	Kaiser Value HMO – California
Group Number (Actives/COBRA): **2281, 2281**	***State/Region:*** **Northern and Southern California**
Benefit Provision:	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-800-464-4000 **Web site:** www.kp.org
Annual deductible	$3,000 Individual; $6,000 Family
Annual out-of-pocket maximum	$4,500 Individual; $9,000 Family
Ability to self-refer	**To OB/GYN:** Yes **To Specialist**: Contact Plan
Outpatient Care	
Office visits	**Primary Doctor:** 20% after deductible **Specialist:** 20% after deductible
Annual physical exam	100% covered
Pediatric/well-child exam	$0 copay per visit (23 months or younger)
Outpatient surgery	20% after deductible
Lab & x-ray	20% per encounter
Inpatient Hospital Care	
Hospital deductible	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable
Retail prescriptions	**Generic:** 20% after deductible up to $50 prescription maximum; 30 day supply **Formulary:** 20% after deductible up to $100 prescription maximum; 30 day supply; must be medically necessary; prescribed by a Plan physician and obtained at Plan pharmacies **Non formulary:** 20% after deductible up to $100 prescription maximum; 30 day supply; must be medically necessary; prescribed by a Plan physician and obtained at Plan pharmacies
Mail-order prescriptions	**Generic:** 20% after deductible up to $50 prescription maximum ; 100 day supply **Formulary:** 20% after deductible up to $100 prescription maximum ; 100 day supply; When medically necessary, prescribed by a Plan physician, and obtained through Plan mail-order **Non formulary:** 20% after deductible up to $100 prescription maximum ; 100 day supply; When medically necessary, prescribed by a Plan physician, and obtained through Plan mail-order
Oral contraceptives	Retail and mail-order available; 100% covered standard retail and mail-order copays apply
Specialty Drugs	**Generic:** 20% after deductible (retail) up to $250 prescription maximum/20% after deductible (mail-order) up to $250 prescription maximum per prescription when medically necessary, prescribed by a Plan physician, and obtained through Plan pharmacies/mail-order **Formulary:** 20% after deductible (retail) up to $250 prescription maximum /20% after deductible(mail-order) up to $250 prescription maximum per prescription when medically necessary, prescribed by a Plan physician, and obtained through Plan pharmacies/mail-order **Non formulary:** 20% after deductible (retail) up to $250 prescription maximum /20%(mail-order) up to $250 prescription maximum per prescription when medically necessary, prescribed by a Plan physician, and obtained through Plan pharmacies/mail-order
Family Planning/Maternity	
Pre/post-natal office visit	Prenatal: 100% covered; Post-Natal: 20% after deductible
Fertility services	80% covered for diagnosis and treatment of involuntary fertility when approved by a plan physician
Mental Health (MH) Services	
Outpatient treatment	20% after deductible
Inpatient treatment	20% after deductible is met
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible
Inpatient rehabilitation	20% after deductible
Other Services	
Emergency room	20% after deductible
Ambulance services	$150 after deductible
Noncustodial home health care	Check with Plan
Noncustodial skilled nursing care	Check with Plan
Hospice care	Check with Plan
Durable medical equipment	20% after deductible; must be deemed medically necessary and prescribed by a Plan physician; must be in accordance with DME formulary guidelines
Outpatient physical therapy	20% after deductible; must be medically necessary; preauthorization required by a Plan physician
Accidental injury to teeth	Not covered
Chiropractic services	Not covered
Routine vision exam	100% covered

Plan Type: HMO
Group: Actives/COBRA

Plan Name:	Kaiser Savings HMO - Colorado
Group Number (Actives/COBRA): 1071, 1071	**State: Colorado**
Benefit Provision	**Your Schedule of Benefits**
Background Information	
Member services	**Phone:** 1-800-632-9700; 1-303-338-3800 **Web site**: www.kaiserpermanente.org
Annual deductible	$2,000 Individual; $4,000 Family
Annual out-of-pocket maximum	$3,000 Individual; $6,000 Family
Ability to self-refer	To OB/GYN: Yes **To Specialist**: Yes
Outpatient Care	
Office visits	**Primary Doctor:** 20% after deductible **Specialist:** 20% after deductible
Annual physical exam	$0 copay
Pediatric/well-child exam	$0 copay
Outpatient surgery	20% after deductible
Lab & x-ray	20% after deductible
Inpatient Hospital Care	
Hospital deductible/copay	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable
Retail prescriptions	**Generic:** 20% after deductible; 30 day supply **Formulary:** 20% after deductible; 30 day supply **Non formulary:** Not covered
Mail-order prescriptions	**Generic:** 20% after deductible; 90 day supply **Formulary**: 20% after deductible; 90 day supply **Non formulary:** Not covered
Oral contraceptives	Covered
Specialty Drugs	**Generic:** 20% after deductible; 30 day retail (2× mail-order) **Formulary:** 20% after deductible; 30 day retail (2× mail-order) **Non formulary:** Not covered
Family Planning/Maternity	
Pre/post-natal office visit	20% after deductible
Fertility services	50% covered; limitations apply; check with Plan for details
Mental Health (MH) Services	
Outpatient treatment	20% after deductible
Inpatient treatment	20% after deductible
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible
Inpatient rehabilitation	20% after deductible
Other Services	
Emergency room	20% after deductible
Ambulance services	20% after deductible; $500 max per trip
Noncustodial home health care	20% after deductible
Noncustodial skilled nursing care	20% after deductible – limited to 100 days per calendar year
Hospice care	20% after deductible
Durable medical equipment	200% after deductible
Outpatient physical therapy	20% after deductible; limited to 20 visits per calendar year
Accidental injury to teeth	Not covered
Chiropractic services	Not covered
Routine vision exam	20% after deductible

Plan Type: HMO
Group: Actives/COBRA

Plan Name:	Kaiser Value HMO - Colorado
Group Number (Actives/COBRA): **1071, 1071**	***State:*** **Colorado**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-800-632-9700; 1-303-338-3800 **Web site:** www.kaiserpermanente.org
Annual deductible	$3,000 Individual; $6,000 Family
Annual out-of-pocket maximum	$4,500 Individual; $9,000 Family
Ability to self-refer	**To OB/GYN:** Yes **To Specialist:** Yes
Outpatient Care	
Office visits	**Primary Doctor:** 20% after deductible **Specialist:** 20% after deductible
Annual physical exam	$0 copay
Pediatric/well-child exam	$0 copay
Outpatient surgery	20% after deductible
Lab & x-ray	**20% after deductible**
Inpatient Hospital Care	
Hospital deductible/copay	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable
Retail prescriptions	**Generic:** 20% after deductible; 30 day supply **Formulary:** 20% after deductible; 30 day supply **Non formulary:** Not covered
Mail-order prescriptions	**Generic:** 20% after deductible; 90 day supply **Formulary:** 20% after deductible; 90 day supply **Non formulary:** Not covered
Oral contraceptives	Covered
Specialty Drugs	**Generic:** 20% after deductible; 30 day retail (2× mail-order) **Formulary:** 20% after deductible; 30 day retail (2× mail-order) **Non formulary:** Not covered
Family Planning/Maternity	
Pre/post-natal office visit	20% after deductible
Fertility services	50% covered; limitations apply; check with Plan for details
Mental Health (MH) Services	
Outpatient treatment	20% after deductible
Inpatient treatment	20% after deductible
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible
Inpatient rehabilitation	20% after deductible
Other Services	
Emergency room	20% after deductible
Ambulance services	20% after deductible; $500 max per trip
Noncustodial home health care	20% after deductible
Noncustodial skilled nursing care	20% after deductible – limited to 100 days per calendar year
Hospice care	20% after deductible
Durable medical equipment	200% after deductible
Outpatient physical therapy	20% after deductible; limited to 20 visits per calendar year
Accidental injury to teeth	Not covered
Chiropractic services	Not covered
Routine vision exam	20% after deductible

Plan Type: HMO
Group: Actives/COBRA

Plan Name:	Kaiser Savings HMO - Mid Atlantic States
Group Number (Actives/COBRA): **8008, 8008**	***State:*** **District of Columbia, Maryland, Virginia**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-800-777-7902; 1-301-468-6000 **Web site:** www.kaiserpermanente.org
Annual deductible	$2,000 Individual; $4,000 Family
Annual out-of-pocket maximum	$3,000 Individual; $6,000 Family
Ability to self-refer	**To OB/GYN:** Yes **To Specialist:** No
Outpatient Care	
Office visits	**Primary Doctor:** 20% Coinsurance **Specialist:** 20% Coinsurance
Annual physical exam	100% covered
Pediatric/well-child exam	100% covered
Outpatient surgery	20% after deductible
Lab & x-ray	**Lab** & **X-ray:** 20% after deductible
Inpatient Hospital Care	
Hospital deductible/copay	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable
Retail prescriptions	**Retail 30 day supply: Generic** $5 copay for Kaiser Permanente Pharmacy; $10 copay for Community Pharmacy. **Formulary/Non-Formulary** $10 copay for Kaiser Permanente Pharmacy; $20 Community Pharmacy. **Specialty Drug:** Kaiser Permanente Pharmacy 20% Coinsurance w/$250 Max after Deductible is met. Community Pharmacy 30% Coinsurance w/$250 Max after Deductible is met. Must be deemed medically necessary by member's physician; otherwise member pays entire cost
Mail-order prescriptions	**Maintenance medications 90 day Supply: Generic** $10 copay; **Formulary/Non-Formulary** $20 copay available through a Kaiser Pharmacy
Oral contraceptives	100% covered (retail and mail-order)
Family Planning/Maternity	
Pre/post-natal office visit	$0 copay per prenatal visit and initial post natal visit
Fertility services	50% covered; of allowable charges of the average wholesale price
Mental Health (MH) Services	
Outpatient treatment	20% after deductible individual and group unlimited visits
Inpatient treatment	20% after deductible
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible individual and group unlimited visits
Inpatient rehabilitation	20% after deductible
Other Services	
Emergency room	20% after deductible
Ambulance services	20% after deductible
Noncustodial home health care	Check with Plan
Noncustodial skilled nursing care	Check with Plan
Hospice care	Check with Plan
Durable medical equipment	20% after deductible
Outpatient physical therapy	20% after deductible ; limited to 90 days per incident
Accidental injury to teeth	Not covered
Chiropractic services	20% after deductible ; limited to 20 visits per year
Routine vision exam	20% after deductible for optometry and ophthalmology

Plan Type: HMO
Group: Actives/COBRA

Plan Name:	**Kaiser Value HMO - Mid Atlantic States**
Group Number (Actives/COBRA): **8008, 8008**	***State:*** **District of Columbia, Maryland, Virginia**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-800-777-7902; 1-301-468-6000 **Web site:** www.kaiserpermanente.org
Annual deductible	$3,000 Individual; $6,000 Family
Annual out-of-pocket maximum	$4,500 Individual; $9,000 Family
Ability to self-refer	**To OB/GYN:** Yes **To Specialist:** No
Outpatient Care	
Office visits	**Primary Doctor:** 20% Coinsurance **Specialist:** 20% Coinsurance
Annual physical exam	100% covered
Pediatric/well-child exam	100% covered
Outpatient surgery	20% after deductible
Lab & x-ray	**Lab** & **X-ray:** 20% after deductible
Inpatient Hospital Care	
Hospital deductible/copay	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable
Retail prescriptions	**Retail 30 day supply: Generic**: $5 copay for Kaiser Permanente Pharmacy; $10 copay for Community Pharmacy. **Formulary/Non-Formulary:** $10 copay for Kaiser Permanente Pharmacy; $20 Community Pharmacy. **Specialty Drug:** Kaiser Permanente Pharmacy 20% Coinsurance w/$250 Max after Deductible is met. Community Pharmacy 30% Coinsurance w/$250 Max after Deductible is met. Must be deemed medically necessary by member's physician; otherwise member pays entire cost
Mail-order prescriptions	**Preventive:** Maintenance medications 90 day supply**: Generic** $10 copay; **Formulary/Non-Formulary** $20 copay available through Kaiser Pharmacy mail order **Non-Preventive** 90 day Supply: **Generic, Formulary and Non formulary**: 20% Coinsurance at Kaiser Permanente Pharmacy (maintenance medications only at 2× copay mail-order) must be deemed medically necessary
Oral contraceptives	100% covered (retail and mail-order)
Family Planning/Maternity	
Pre/post-natal office visit	$0 copay per prenatal visit and initial post natal visit
Fertility services	50% covered; of allowable charges of the average wholesale price
Mental Health (MH) Services	
Outpatient treatment	20% after deductible individual and group unlimited visits
Inpatient treatment	20% after deductible
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible individual and group unlimited visits
Inpatient rehabilitation	20% after deductible
Other Services	
Emergency room	20% after deductible
Ambulance services	20% after deductible
Noncustodial home health care	Check with Plan
Noncustodial skilled nursing care	Check with Plan
Hospice care	Check with Plan
Durable medical equipment	20% after deductible
Outpatient physical therapy	20% after deductible ; limited to 90 days per incident
Accidental injury to teeth	Not covered
Chiropractic services	20% after deductible ; limited to 20 visits per year
Routine vision exam	20% after deductible for optometry and ophthalmology

Plan Type: HMO
Group: Actives/COBRA

Plan Name—	Kaiser Savings HMO – Georgia and Georgia (Consumer Choice)
Group Number (Actives/COBRA): **8110, 8110**	***State:*** **Georgia**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-888-865-5813; 1-404-261-2590 **Web site:** www.kaiserpermanente.org
Annual deductible	$2,000 Individual; $4,000 Family
Annual out-of-pocket maximum	$3,000 Individual; $6,000 Family
Ability to self-refer	**To OB/GYN:** Yes **To Specialist:** No; members may self-refer to OB/GYN, Dermatology, Vision and Mental Health/Substance Abuse
Outpatient Care	
Office visits	20% after deductible per visit
Annual physical exam	100% covered
Pediatric/well-child exam	100% covered; well-child visits through age 5
Outpatient surgery	20% after deductible per visit
Lab & x-ray	20% after deductible
Inpatient Hospital Care	
Hospital deductible/copay	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Rx deductible same as plan deductible
Retail prescriptions (Generic & Brand)	$5 copay preventive & 20% coinsurance after deductible non-preventive at Kaiser Permanente & Network Pharmacies. Network Pharmacies limited to a one-time fill per medication
Mail-order prescriptions (Generic & Brand)	$10 copay preventive & 20% coinsurance after deductible non-preventive through Kaiser Permanente Pharmacies only
Oral contraceptives	100% covered (retail and mail-order)
Specialty Drugs	20% Coinsurance after deductible (max $250) Kaiser Permanente Pharmacies & Network Pharmacies. Network Pharmacies limited to a one-time fill per medication
Family Planning/Maternity	
Pre/post-natal office visit	100% covered for routine care
Fertility services	Not covered
Mental Health (MH) Services	
Outpatient treatment	20% after deductible; unlimited visits
Inpatient treatment	20% after deductible, unlimited days per year
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible; unlimited visits
Inpatient rehabilitation	20% after deductible, unlimited days per year
Other Services	
Emergency room	20% after deductible per visit
Ambulance services	20% after deductible per trip
Noncustodial home health care	20% after deductible, up to 120 visits per year. Private duty nursing not covered.
Noncustodial skilled nursing care	20% after deductible, up to 100 days per calendar year
Hospice care	20% after deductible
Durable medical equipment	20% after deductible
Outpatient physical therapy	20% after deductible (up to 20 visits per year; PT/OT combined)
Accidental injury to teeth	Accidental injury to sound, natural teeth covered at 50%; limited to $500 per accident
Chiropractic services	Not covered
Routine vision exam	20% after deductible

Plan Type: HMO
Group: Actives/COBRA

Plan Name—	Kaiser Value HMO - Georgia and Georgia (Consumer Choice)
Group Number (Actives/COBRA): **8110, 8110**	***State:*** **Georgia**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-888-865-5813; 1-404-261-2590 **Web site:** www.kaiserpermanente.org
Annual deductible	$3,000 Individual; $6,000 Family
Annual out-of-pocket maximum	$4,500 Individual; $9,000 Family
Ability to self-refer	**To OB/GYN:** Yes **To Specialist:** No; members may self-refer to OB/GYN, Dermatology, Vision and Mental Health/Substance Abuse
Outpatient Care	
Office visits	20% after deductible per visit
Annual physical exam	100% covered
Pediatric/well-child exam	100% covered; well-child visits through age 5
Outpatient surgery	20% after deductible per visit
Lab & x-ray	20% after deductible
Inpatient Hospital Care	
Hospital deductible/copay	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	20% after deductible
Prescription Drugs	
Annual Rx deductible/maximum	Rx deductible same as plan deductible
Retail prescriptions (Generic & Brand)	$5 copay preventive & 20% coinsurance after deductible non-preventive at Kaiser Permanente & Network Pharmacies. Network Pharmacies limited to a one-time fill per medication
Mail-order prescriptions (Generic & Brand)	$10 copay preventive & 20% coinsurance after deductible non-preventive through Kaiser Permanente Pharmacies only
Oral contraceptives	100% covered (retail and mail-order)
Specialty Drugs	20% Coinsurance after deductible (max $250) Kaiser Permanente Pharmacies & Network Pharmacies. Network Pharmacies limited to a one-time fill per medication
Family Planning/Maternity	
Pre/post-natal office visit	100% covered for routine care
Fertility services	Not covered
Mental Health (MH) Services	
Outpatient treatment	20% after deductible; unlimited visits
Inpatient treatment	20% after deductible, unlimited days per year
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after deductible; unlimited visits
Inpatient rehabilitation	20% after deductible, unlimited days per year
Other Services	
Emergency room	20% after deductible per visit
Ambulance services	20% after deductible per trip
Noncustodial home health care	20% after deductible, up to 120 visits per year. Private duty nursing not covered.
Noncustodial skilled nursing care	20% after deductible, up to 100 days per calendar year
Hospice care	20% after deductible
Durable medical equipment	20% after deductible
Outpatient physical therapy	20% after deductible (up to 20 visits per year; PT/OT combined)

Plan Type: HMO
Group: Actives/COBRA

Plan Name—	Kaiser Permanente of Hawaii	
Group Number (Actives/COBRA): **8110, 8110**		***State:*** **Hawaii**
Benefit Provision	***Your Schedule of Benefits***	
Background Information		
Member services	**Phone:** 1-800-966-5955; 1-808-432-5955 Oahu **Web site:** www.kaiserpermanente.org	
Annual deductible	$0 Individual; $0 Family	
Annual out-of-pocket maximum	$1,500 Individual; $4,500 Family	
Ability to self-refer	**To OB/GYN:** Yes **To Specialist:** No	
Outpatient Care		
Office visits	**Primary Doctor:** $15 copay **Specialist:** $15 copay	
Annual physical exam	100% covered	
Pediatric/well-child exam	100% covered	
Outpatient surgery	$15 copay	
Lab & x-ray	**Lab** & **X-ray:** $15 copay	
Inpatient Hospital Care		
Hospital deductible/copay	$50 copay per day	
Room & board (semi-private)	$50 per day: 100% covered after hospital copay	
Lab & x–ray	100% covered	
Surgery–surgeon	100% covered	
Prescription Drugs		
Annual Rx deductible/maximum	Not applicable/Check with Plan	
Retail prescriptions	**Generic:** $3 copay generic maintenance**;** $10 copay generic; 30 day supply; must use Kaiser Permanente pharmacy **Formulary:** $35 copay; 30 day supply; must use Kaiser Permanente pharmacy **Non formulary:** Not covered	
Mail-order prescriptions	**Generic:** $6 copay generic maintenance**;** $20 generic copay; 90 day supply; must use Kaiser Permanente mail-order pharmacy **Formulary:** $70 copay; 90 day supply; must use Kaiser Permanente mail-order pharmacy **Non formulary:** Not covered	
Oral contraceptives	100% covered (retail and mail-order)	
Specialty Drugs	**Generic:** $200 copay per prescription; 30 day supply; must use Kaiser Permanente pharmacy **Formulary:** $200 copay per prescription; 30 day supply; must use Kaiser Permanente pharmacy **Non formulary:** Not covered	
Family Planning/Maternity		
Pre/post-natal office visit	$15 copay initial visit only	
Fertility services	$15 copay for office visit; $15 per department per day for lab, imaging, and testing services; $10 per generic and $35 per brand name for prescription drugs	
Mental Health (MH) Services		
Outpatient treatment	$15 copay	
Inpatient treatment	$50 copay per day	
Substance Abuse (SA) Services		
Outpatient rehabilitation	$15 copay	
Inpatient rehabilitation	$50 copay per day	
Other Services		
Emergency room	$25 copay in area per visit	
Ambulance services	20% covered	
Noncustodial home health care	No Charge, physician visit covered at PCP copay	
Noncustodial skilled nursing care	No Charge, limited to 120 days per accumulation period	
Hospice care	No Charge, includes two 90 day periods followed by unlimited 60 day periods	
Durable medical equipment	20% covered	
Outpatient physical therapy	$15 copay; limited by certain clinical criteria and physician determination	
Accidental injury to teeth	Not covered	
Chiropractic services	Not covered	
Routine vision exam	$15 copay; exam for eyeglasses; limited to one exam per year	

Plan Type: HMO
Group: Actives/COBRA

Plan Name—	**Blue Advantage (Illinois)**
Group Number (Actives/COBRA): **B63003 section 0100**	***State:*** **Illinois**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-800-892-2803 **Web site:** www.bcbsil.com
Annual deductible	$1,500 Individual; $3,000 Family
Annual out-of-pocket maximum	Medical: $3,000 Individual; $6,000 Family;
Ability to self-refer	**To OB/GYN:** Yes **To Specialist:** No
Outpatient Care	
Office visits	**Primary Doctor:** $25 copay **Specialist:** $40 copay
Annual physical exam	100% covered
Pediatric/well-child exam	100% covered
Outpatient surgery	20% after deductible
Lab & x-ray	**Lab** & **X-ray:** 100% covered
Inpatient Hospital Care	
Hospital deductible/copay	20% after deductible
Room & board (semi-private)	20% after deductible
Lab & x–ray	20% after deductible
Surgery–surgeon	Hospital facility charges 20% after annual deductible; Professional fee from Surgeon 100% covered.
Prescription Drugs	
Annual Rx deductible/maximum	RX subject to overall medical deductible and out-of-pocket maximum
Retail prescriptions	**After annual deductible, Generic:** $5 copay **Formulary:** 20% coinsurance; $200 maximum **Non formulary:** 20% coinsurance; $200 maximum
Mail-order prescriptions	**After annual deductible, Generic:** $10 copay **Formulary:** 20% coinsurance; $400 maximum **Non formulary:** 20% coinsurance; $400 maximum
Oral contraceptives	**Select Oral Contraceptives available at 100%. Contact Plan for detail.** **After annual deductible, Retail Generic:** $5 copay **Formulary:** 20% coinsurance; $200 maximum **Non formulary:** 20% coinsurance; $200 maximum **After annual deductible Mail-order: Generic**: $10 copay **Formulary:** 20% coinsurance; $400 maximum **Non formulary:** 20% coinsurance;$400 maximum
Specialty Drugs	**After annual deductible, Generic:** $5 copay; 90 day supply benefit not available for Specialty Drugs **Formulary:** 20% coinsurance; $200 maximum; 90 day supply benefit not available for Specialty Drugs **Non formulary:** 20% coinsurance; $200 maximum; 90 day supply benefit not available for Specialty Drugs
Family Planning/Maternity	
Pre/post-natal office visit	$25 copay initial visit only; 100% thereafter
Fertility services	$40 copay; PCP referral required; limitations apply; check with Plan for details
Mental Health (MH) Services	
Outpatient treatment	$25 copay per visit
Inpatient treatment	20% after deductible
Substance Abuse (SA) Services	
Outpatient rehabilitation	$25 copay per visit
Inpatient rehabilitation	20% after deductible
Other Services	
Emergency room	20% after deductible
Ambulance services	20% after deductible
Noncustodial home health care	20% after deductible
Noncustodial skilled nursing care	20% after deductible
Hospice care	20% after deductible
Durable medical equipment	100% covered
Outpatient physical therapy	$25 copay; limited to 60 visits per year; combined with occupational and speech therapies
Accidental injury to teeth	Applicable copays apply for dental services required as a result of accidental injury to Sound Natural Teeth
Chiropractic services	$40 copay, PCP referral required; chiropractic services are available through Alternative medicine Integration of Illinois Medical Group #381 (PCP copay would apply); discount available through Blue Extras
Routine vision exam	100% covered limited to one exam every 12 months

Plan Type: HMO
Group: Actives/COBRA

Plan Name—	Kaiser Foundation Heath Plan of Washington Savings HMO
Group Number (Actives/COBRA): **Active 0158100 individual, 1645600 family; Retiree 0264700 individual, 1645900 family**	***State:*** **Washington**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-888-901-4636; 1-206-901-4636 **Web site:** www.ghc.org
Annual deductible	$2,000 individual, $4,000 family Aggregate
Annual out-of-pocket maximum	$3,500 Individual; $7,000 Family Aggregate
Ability to self-refer	**To OB/GYN:** Yes T**o Specialist:** Yes
Outpatient Care	
Office visits	**Primary Doctor:** 20% after Deductible **Specialist:** 20% after Deductible; PCP referral required
Annual physical exam	100% covered
100% covered	100% covered
Outpatient surgery	20% after Deductible
Lab & x-ray	**Lab** & **X-ray:** Deductible and coinsurance apply
Inpatient Hospital Care	
Hospital deductible/copay	20% after Deductible
Room & board (semi-private)	20% after Deductible
Lab & x–ray	20% after Deductible
Surgery–surgeon	20% after Deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable/Check with Plan
Retail prescriptions	**Generic:** 20% after Deductible; formulary applies **Formulary:** 20% after Deductible; formulary applies **Non formulary:** Not covered
Mail-order prescriptions	**Generic:** 20% after Deductible **Formulary:** 20% after Deductible **Non formulary:** Not covered
Oral contraceptives	100% covered (retail and mail-order)
Specialty Drugs	**Generic:** 20% after Deductible; formulary applies **Formulary:** 20% after Deductible formulary applies **Non formulary:** Not covered
Family Planning/Maternity	
Pre/post-natal office visit	20% after Deductible
Fertility services	Not covered
Mental Health (MH) Services	
Outpatient treatment	20% after Deductible
Inpatient treatment	Deductible & coinsurance apply
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after Deductible
Inpatient rehabilitation	Deductible & coinsurance apply
Other Services	
Emergency room	Deductible & Coinsurance apply
Ambulance services	Deductible & Coinsurance apply
Noncustodial home health care	Check with Plan
Noncustodial skilled nursing care	Check with Plan
Hospice care	Check with Plan
Durable medical equipment	50% Coinsurance, Deductible applies
Outpatient physical therapy	20% after Deductible; limited to 45 visits per year; combined physical, occupational and speech therapies
Accidental injury to teeth	Not covered
Chiropractic services	20% after Deductible; limited to 10 visits per year
Routine vision exam	20% after Deductible; limited to one exam every 12 months

Plan Type: HMO
Group: Actives/COBRA

Plan Name—	Kaiser Foundation Health Plan of Washington Value HMO
Group Number (Actives/COBRA): **Active: 1645700 individual, 1645800 family; Retiree 1646000 individual, 1646100 family**	***State:*** **Washington**
Benefit Provision	***Your Schedule of Benefits***
Background Information	
Member services	**Phone:** 1-888-901-4636; 1-206-901-4636 **Web site:** www.ghc.org
Annual deductible	$2,750 individual, $5,500 Family Embedded
Annual out-of-pocket maximum	$4,500 Individual; $9,000 Family Embedded
Ability to self-refer	**To OB/GYN:** Yes T**o Specialist:** Yes
Outpatient Care	
Office visits	**Primary Doctor:** 20% after Deductible **Specialist:** 20% after Deductible; PCP referral required
Annual physical exam	100% covered
100% covered	100% covered
Outpatient surgery	20% after Deductible
Lab & x-ray	**Lab** & **X-ray:** Deductible and coinsurance apply
Inpatient Hospital Care	
Hospital deductible/copay	20% after Deductible
Room & board (semi-private)	20% after Deductible
Lab & x–ray	20% after Deductible
Surgery–surgeon	20% after Deductible
Prescription Drugs	
Annual Rx deductible/maximum	Not applicable/Check with Plan
Retail prescriptions	**Generic:** 20% after Deductible; formulary applies **Formulary:** 20% after Deductible; formulary applies **Non formulary:** Not covered
Mail-order prescriptions	**Generic:** 20% after Deductible **Formulary:** 20% after Deductible **Non formulary:** Not covered
Oral contraceptives	100% covered (retail and mail-order)
Specialty Drugs	**Generic:** 20% after Deductible; formulary applies **Formulary:** 20% after Deductible formulary applies **Non formulary:** Not covered
Family Planning/Maternity	
Pre/post-natal office visit	20% after Deductible
Fertility services	Not covered
Mental Health (MH) Services	
Outpatient treatment	20% after Deductible
Inpatient treatment	Deductible & coinsurance apply
Substance Abuse (SA) Services	
Outpatient rehabilitation	20% after Deductible
Inpatient rehabilitation	Deductible & coinsurance apply
Other Services	
Emergency room	Deductible & Coinsurance apply
Ambulance services	Deductible & Coinsurance apply
Noncustodial home health care	Check with Plan
Noncustodial skilled nursing care	Check with Plan
Hospice care	Check with Plan
Durable medical equipment	50% Coinsurance, Deductible applies
Outpatient physical therapy	20% after Deductible; limited to 45 visits per year; combined physical, occupational and speech therapies
Accidental injury to teeth	Not covered
Chiropractic services	20% after Deductible; limited to 10 visits per year
Routine vision exam	20% after Deductible; limited to one exam every 12 months