Select Path

Choose a better path – an employer benefit plan that combines a classic level-funded nationwide network plan design with a cutting-edge tool to help you save on health care costs.

Allstate BENEFITS

ABGH_1048

quality health care benefits
with cutting-edge cost control

Offer your employees a nationwide network plan with an integrated savings tool to cut down your health care costs.

Select Path, a level-funded nationwide network plan, uses an integrated Smart Match Scheduler, powered by Amino, that members use to select providers and schedule preplanned services. This customer-driven tool incentivizes your employees to save money and lowers your overall plan costs.

Select Path Offers:

Access to the nationwide Aetna Signature Administrators® (ASA) PPO network.

Navigation to lower-cost, high-quality network providers.

Savings for your members and your health care costs without sacrificing quality.

Seamless administration and concierge customer service with trusted third-party administrator, Allied Benefit Systems, LLC.

Select Path requires members to schedule most preplanned services through the Smart Match Scheduler, and obtain services from a provider available through the Smart Match Scheduler. In the event that a member's preferred provider is not available with the scheduler, the member will need to seek out a new provider for their services. If members do not schedule services through the Smart Match Scheduler or use the provider/facility available through the Smart Match Scheduler, they will incur a penalty.

Savings With a Search

Using the Smart Match Scheduler to locate and schedule with participating providers ensures maximum savings for you and your plan members.

Here's How it Works

Your members will access the Smart Match Scheduler through the Allied member portal.

Members use the mobile-friendly website to select and schedule services with Smart Match Providers who are high-quality, lower-cost ASA providers.

Preplanned procedures such as the ones listed below require members to book appointments through the Smart Match Scheduler.

Failure to do so will result in penalties*:

- Outpatient Service Penalty: $500
- Inpatient Service Penalty: $1,000

In the event that a member's preferred provider is not available with the scheduler, the member will need to seek out a new provider for their services to avoid penalties.

Examples of services that require selecting a provider and scheduling through the Smart Match Scheduler:

1. Cardiac and Vascular Services including but not limited to:
   - Non-emergency bypass surgery
   - Heart valve repair or replacement
   - Pacemaker implantation
   - Carotid endarterectomies
   - Endovascular revascularization
   - Cardiac catheterizations
   - Percutaneous coronary interventions
2. Diagnostic Radiology Services, including but not limited to:
   - MRIs
   - CT scans
   - CTA scans
   - PET scans
   - CMR scans
   - Myocardial imaging
   - Heart infarct imaging
3. Joint Surgeries and Procedures, including:
   - Surgeries or procedures for the hips, knees, ankles, or shoulders
4. Spinal Surgeries and Procedures, including:
   - Spinal fusion
   - Cervical, lumbar, and thoracic services

Penalties are not applicable to preplanned cancer treatment, mental health, or pregnancy services. You do not need to use the Smart Match Scheduler in emergency situations.

For complete details please refer to the plan documents. | * Penalties applied will not exceed the allowed amount on the claim.

When members use the tool for all services, they're sure to save more on care and reduce the plan costs.

plan designs

choose from our flexible plan design options

All employer-established health benefit plans meet the standards set by the Affordable Care Act. Select Path is available as a PPO or Network-Only plan.

Stop-loss options

Aggregate Deductible	Based on total expected claims, calculated based on the census of your group and other factors such as number of members, age, gender, etc.
Specific Deductible[1]	• $6,500 • $10,000 • $15,000 • $20,000 • $25,000 • $30,000 • $40,000 • $50,000 • $100,000

Group-member plan options

Deductible Options[1] *With the PPO option, family deductible is two times the individual. Out-of-network deductible is two times the in-network deductible.*	• $500 • $1,000 • $1,500[2] • $2,000[2] • $2,500[2] • $2,750 • $2,800[2] • $3,000[2] • $3,500[2] • $5,000[2] • $5,750[3] • $6,250[3] • $6,600[4] • $7,150[4] • $7,900[4] • $8,550[4]
Coinsurance Options	• 100% • 90% / 10% • 80% / 20% • 70% / 30% • 50% / 50%[5]
Out-of-Pocket Maximums[1]	$1,000 to $8,550 and $1,000 to $7,900 in CO (these include deductible, coinsurance, and copay amounts)
Office Visits *(primary care physician / specialist / urgent care)*	• $20 / $35 / $75 • $35 / $50 / $75 • $40 / $60 / $75 • $25 / ded. and coins. / $75 • $35 / ded. and coins. / $75 • $40 / ded. and coins. / $75 • $50 / ded. and coins. / $75 • $50 / $75 / $100 • $60 / $100 / $100 • Ded. and coins.
Hospital and Surgery Charges *Preplanned procedures require members to book appointments through the Smart Match Scheduler. Failure to do so may result in penalties.*	Subject to deductible and coinsurance
Diagnostic X-ray and Lab Benefit	• Subject to deductible and coinsurance • 100% first-dollar benefit • $500 first-dollar benefit, followed by deductible and coinsurance

OUT-OF-NETWORK BENEFITS NOT AVAILABLE WITH NETWORK-ONLY PLANS.
PRODUCT AVAILABILITY VARIES BY STATE.

Group-member plan options

Outpatient Physical Medicine / Chiropractic Care	Subject to deductible and coinsurance, limited to 30 visits per plan year
Subacute Rehab & Nursing Facility	Subject to deductible and coinsurance, limited to 31 days per plan year
Home Health Care	Subject to deductible and coinsurance, limited to 30 visits per plan year
Emergency Room Visit *Note: Copay waived if admitted*	• Subject to deductible and coinsurance • $250, $350, or $500 access fee, followed by deductible and coinsurance • $250, $350, or $500 copay, no deductible or coinsurance (not allowed on HSA plan types)
Mental/Behavioral Health and Substance Abuse	**Outpatient, groups 50 and under:** • In-network: Subject to deductible and 50% coinsurance. Limited to 40 visits per plan year. • Out-of-network: Subject to deductible and 30% coinsurance. Limited to 40 visits per plan year.* **Outpatient, groups over 50:** • Follows plan copay, deductible, and coinsurance options chosen. **Inpatient, groups 50 and under:** • In-network: Subject to deductible and 50% coinsurance. Limited to 30 days per plan year. • Out-of-network: Subject to deductible and 30% coinsurance. Limited to 30 days per plan year.* **Inpatient, groups over 50:** • Follows plan deductible and coinsurance options chosen.
Prescription Drugs *(generic / preferred / non-preferred)*	**Copay options:** *(additional options available)* • $15 / $45 / $60 • $20 / $50 / $75 • $0 / $35 / $50 • $5 / $65 / $100 • $20 / $65 / $100 • Ded. then $20 / $50 / $753 **Non-copay options:** • Subject to deductible and coinsurance[6] • 50% / 50% coinsurance option
Infertility Treatments	**Groups with 50 total employees and under:** Not covered **Groups with more than 50 total employees:** Covered up to a maximum of $10,000 per plan year
Accident Medical Expense (Optional Benefit)	• $500 • $1,000

* OUT-OF-NETWORK BENEFITS NOT AVAILABLE WITH NETWORK-ONLY PLANS.
PRODUCT AVAILABILITY VARIES BY STATE.

THE FOOTNOTES BELOW APPLY TO PAGES 4 AND 5 OF THE BROCHURE.

1 Availability varies by state.
2 Health Savings Account (HSA)-compatible options.
3 Available with HSA plans only.
4 Not available with $6,500 specific deductible.
5 Not available with all networks.
6 When you select this option, there is a 20% increase in the insured's coinsurance responsibility when non-preferred prescription drugs are purchased. Applies to the following coinsurance options: 90% / 10%, 80% / 20%, 70% / 30%.
Refer to your Summary Plan Description for full benefit details.

Select Path is a Self-Funded Plan

That means you get all of the transparency, plan options, and ease-of-management of our Self-Funded Program.

ALLIED No-Hassle Plan Administration

We work with a trusted third-party administrator to manage your plan. Allied Benefit Systems, LLC has over 30 years of experience in benefit management and administration services. Allied's team takes care of your group's claims payments, accounting, customer service needs, and more. This allows you to focus on your business – not your benefits!

With our Self-Funded Program, you may receive money back from your claims account in years when claims are lower than planned.*

* See Plan Details and Exclusions

Unlike fully-insured plans, your single monthly payment is split among the program's three components so you know exactly where your dollars are going.

Plan administration • Dedicated member services team. • Manages claims payments. • Provides reporting to help manage costs.	**Stop-loss insurance** • Protects your finances from higher-than-expected claims. • Helps you limit your business's financial exposure.	**Employer claims account** • Account used to pay employees' claims. • Stop-loss advances money to your claims account if claims exceed the balance in any given month.

Give your benefit plan a boost with these features

Adding these features can help you save more on costs and provide members with a more robust package.

TELADOC®

Teladoc® is a cost-saving service that helps drive medical expenses down.
Members can receive treatment anytime, anywhere, whether they're at work, home, or traveling abroad.
Teladoc doctors can give treatment for many common, non-emergency conditions.

Consultations at no additional cost to members.

Vitality®

You can add the unique wellness program through **Vitality®** to your benefit plan to help keep your employees healthier, while enhancing and protecting their lives. When you do healthy right, you save big on your business's health care costs.

plan details and exclusions

Services that require the use of the Smart Match Scheduler include:

1. Cardiac and Vascular Services including but not limited to:
    - Non-emergency bypass surgery
    - Heart valve repair or replacement
    - Pacemaker implantation
    - Carotid endarterectomies
    - Endovascular revascularization
    - Cardiac catheterizations
    - Percutaneous coronary interventions
2. Diagnostic Radiology Services, including but not limited to:
    - MRIs
    - CT scans
    - CTA scans
    - PET scans
    - CMR scans
    - Myocardial imaging
    - Heart infarct imaging
3. Joint Surgeries and Procedures, including surgeries or procedures for the hips, knees, ankles or shoulders.
4. Spinal Surgeries and Procedures, including spinal fusion and cervical, lumbar, and thoracic services.

Failure to use the Smart Match Scheduler will result in penalties. Penalties are not applicable to elective services for cancer treatment, mental health, or pregnancy services. You do not need to use the Smart Match Scheduler in emergency situations.

For complete details please refer to the plan documents.

Out-of-network services (out-of-network terms and provisions do not apply to Network-Only option)

If a covered person seeks non-emergency care at a doctor or hospital that is not part of your network, he or she will not receive network discounts and may incur additional expenses. This applies to prescriptions that are filled by an out-of-network provider as well.

For instance, copays are not accepted by doctors and hospitals that are not part of your network, and the covered charges will be handled as any other out-of-network service — subject to the:

- Maximum allowable amount — the most the plan pays for covered services. The covered person will be responsible for any balance in excess of this amount.
- Out-of-network deductible — two times the in-network deductible.
- Out-of-network coinsurance — typically an additional 30% of charges.
- Out-of-network, out-of-pocket maximum — three times the in-network out-of-pocket maximum (except for 100% coinsurance plans)

Emergency care benefit

In emergency situations, covered charges will be handled as network services, no matter where services are performed. All charges are subject to the maximum allowable amount.

Emergency care benefit for Network-Only plan

Covered charges will be handled as network services, no matter where the services are performed, subject to any applicable Maximum Allowable Amounts. When the facility is out-of-network, the plan will cover the member's transfer to an in-network facility once the member is stabilized. All follow-up visits after the condition has stabilized will be treated as nonemergency treatment and services under the plan.

Affiliated provider services

As long as a covered person uses hospitals and admitting physicians that are part of your network, his/her covered charges will be handled as network services even when affiliated physicians and other health care providers (e.g., radiologists, anesthesiologists, pathologists or surgeons) are not part of your network. All charges are subject to the maximum allowable amount.

Family deductible accumulations

Individual/Family

Covered expenses for each family member accumulate toward his or her individual deductible and benefits begin:

- For the family member — once his or her individual deductible is met.
- For all family members — once the combined amounts accumulated toward two or more individual deductibles reach the amount of the family deductible.

Utilization review

When inpatient treatment is needed, the covered person is responsible for calling the 800 number on the card to receive authorization. If authorization is not received, a penalty could be applied. No benefits are paid for transplants that are not authorized. Authorization is not a guarantee of coverage.

Out-of-pocket maximums

The family out-of-pocket maximum is the total dollar amount of covered charges that must be paid by you and your covered dependents before we will consider any out-of-pocket maximum for all covered persons under the same family plan to be satisfied.

The individual out-of-pocket maximum is the dollar amount of covered charges that must be paid by each covered person before any out-of-pocket maximum is satisfied for that covered person.

Employment waiting period

The employment waiting or affiliation period is the number of consecutive days an employee must be working before he/she is eligible to be covered. The following choices are available: 0, 30, 60 or 90 days.

New hires

For groups with a 0-, 30- or 60-day employment waiting period, new eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:

- First day of the billing month following the date of full-time

plan details and exclusions

employment, when the enrollment request is received within 31 days of this date.

For groups with a 90-day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date:

- The 90th day following the date of full-time employment, when the enrollment request is received within 31 days of the expiration of the employment waiting period.

Deductible credit

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the prior group plan during the same calendar year, except when the deductible credit is waived. No credit is given for past policy-year deductibles. The deductible credit option can be waived.

Summary of exclusions

The health benefit plan templates do not provide benefits for:

- NGBS Network-Only plans, any charges that are provided or performed by a Health Care Practitioner, facility, or supplier that is not identified for the Health Care Provider Network as a Participating Provider, Participating Pharmacy, Specialty Pharmacy Provider, or Designated Transplant Provider. This exclusion does not apply to PPO plans that cover charges for treatment provided or performed by either Participating Providers (In-network) or Non-Participating Providers (Out-of-network).
- Treatment not listed in the Summary Plan Description.
- Services by a medical provider who is an immediate family member or who resides with a covered person.
- Charges for services, supplies or drugs provided by or through any employer of a Covered Person or of a Covered Person's family member.
- Treatment reimbursable by Medicare, Workers' Compensation, automobile carriers or expenses for which other coverage is available.
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or routine vision care and foot care unless part of the diabetic treatment.
- Charges for custodial care, private nursing, telemedicine or phone consultations with the exception of Teladoc® services if purchased as part of your plan.
- Charges for diagnosis and treatment of infertility except for groups of 51 or more.
- Charges for surrogate pregnancy or sterilization reversal.
- Charges for cosmetic services, including chemical peels, plastic surgery and medications.
- Charges for umbilical cord storage, genetic testing, counseling and services.
- Treatment of "quality of life" or "lifestyle" concerns including but not limited to obesity, hair loss, restoration or promotion of sexual function, cognitive enhancement and educational testing or training.
- Over-the-counter drugs, (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs not approved by the FDA, drugs obtained from sources outside the United States, and the difference in cost between a generic and brand name drug when the generic is available.
- Complications of an excluded service.
- Charges in excess of any stated benefit maximum.
- Treatment of an illness or injury caused by acts of war, felony, or influence of an illegal substance.
- Dental care not related to a dental injury.
- Non-surgical treatment for TMJ or CMJ other than that described in the contract, or any related surgical treatment that is not pre-authorized.
- Any correction of malocclusion, protrusion, hypoplasia or hyperplasia of the jaws.
- Charges for cranial orthotic devices, except following cranial surgery.
- Charges for medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section.
- Charges for devices or supplies, except as described under a Prescription Order.
- Charges for prophylactic treatment.
- Charges related to health care practitioner-assisted suicide.
- Charges for growth hormone stimulation treatment to promote or delay growth.
- Charges for treatment of behavioral health or substance abuse, except as otherwise covered in the Behavioral Health and Substance Abuse provision in the Medical Benefits section.
- Charges for testing and treatment related to the diagnosis of behavioral conduct or developmental problems; charges for applied behavioral analysis.
- Charges for alternative medicine, including acupuncture and naturopathic medicine.
- Charges for chelation therapy.
- Charges for experimental or investigational services.

This brochure provides summary information for the health benefit plan templates. Please refer to the summary plan description for a complete listing of the benefits, terms and exclusions. In the event that there are discrepancies with the information in this brochure, the terms and conditions of the Summary Plan Description and other plan documents will govern.

For more information, or to apply for coverage, contact your insurance agent.

about Allstate Benefits

Allstate Benefits is a leading provider of employee benefit solutions in the U.S. and Canada, protecting more than 8 million individuals with top-rated supplemental and self-funded insurance products. Allstate Benefits is proud to be part of The Allstate Corporation (NYSE: ALL), a Fortune 100 company and the nation's largest publicly held personal lines insurer. Allstate Benefits helps deliver the Good Hands® promise every day with the name that many know and trust. Learn more at www.allstatebenefits.com.

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Select Path is available in: AR, AZ, CO*, GA, IA, ID, IL, IN, KS, KY, LA, MI, MN, MO, NE, NJ, NV, OH, OK, PA, SD, TX, VA, WV, and WY
Network-Only option is not available in: ID and SD

For use for July 1, 2021, and later effective dates.
* In Colorado, the program is available for October 1, 2021, and later effective dates.

The Allstate Benefits Self-Funded Program provides tools for employers owning small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by: Integon National Insurance Company in CO, CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered. National Health Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation are rated "A+" (Superior) by A.M. Best.

Contact me for more information:

Allstate BENEFITS