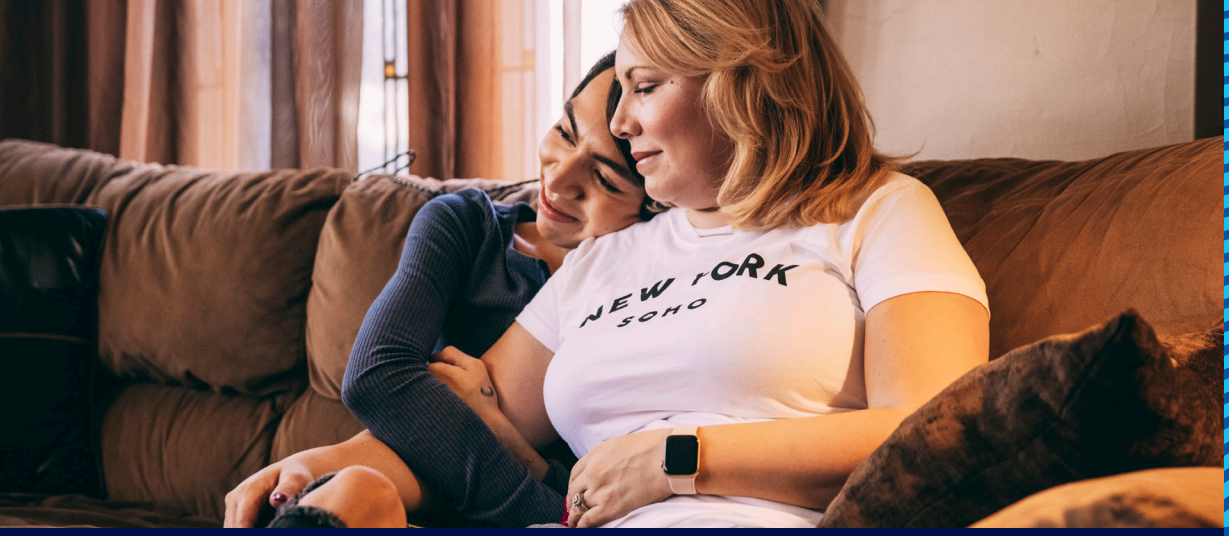
Allstate
HEALTH SOLUTIONS

COLORADO

Allstate Health Access

Fixed-benefit policies that offer an easy, affordable way to pay for everyday health care.

allstatehealth.com



life is full of what ifs...

But when it comes to health care, questions like, “What if I get sick or injured?” and “What if I have unexpected costs?” can leave us wondering if we have the right amount of coverage.

Allstate Health Access is fixed-benefit insurance that helps you cover the “what ifs” of everyday health care. Policies give you an affordable and predictable way to pay for things like checkups, prescriptions, lab tests and more. You choose the set dollar amount up front, and we’ll pay covered expenses for that policy year. And there are no deductibles or copays. You simply cover anything above the dollar amount you choose.

Allstate Health Access is most effective when used in combination with a major medical policy. But it can also serve as minimum coverage when major medical is not an affordable option. So you’ll get coverage at a cost that works for you.

Notice: This policy does not meet the definition of Minimum Essential Coverage under the Affordable Care Act.

health care without the hassle

Benefits in every policy

Predictable, set payments	You know exactly what your policy will pay for office visits, lab tests, hospitalization and more.
Short waiting periods[1]	Immediate benefits for injury and sickness; 90 days for preventative care.
Rx reimbursement	Prescription drug coverage and reimbursement is included in most policies.
Flexibility and renewability	Apply anytime; policies auto-renew and some benefits increase each year.
No lifetime maximum	The maximum benefit amount is paid every year you own your policy, for life.

Access to First Health Network

Access to 5,300 hospitals, 100,000 ancillary facilities, and 695,000 doctors and health care providers, with discounts for covered services from network providers.

Find a First Health provider at: www.firsthealthlbp.com

[1] No waiting period for injury and sickness benefits. The waiting period for preventive care services is 90 days from effective date.

pick the right policy for you

	Value	Fundamentals	Enhanced	Guaranteed issue
Inpatient hospitalization				
Hospital admission	$500; 3 per year	$750; 5 per year	$1,000; 10 per year	$500; 1 per year
Confinement (sickness)[2]	$1,000; $1,250; $1,500; per day	$2,000; $2,500; $3,000; per day	$3,000; $3,750; $4,500; per day	$1,000; $1,250; $1,500; per day; 90 days
Confinement (injury)[2]	$2,000; $2,500; $3,000; per day	$4,000; $5,000; $6,000; per day	$6,000; $7,500; $9,000; per day	$2,000; $2,500; $3,000; per day; 90 days
ICU (sickness)	$2,000 per day; 60 days	$3,000 per day; 60 days	$4,000 per day; 60 days	$2,000 per day; 60 days
ICU (injury)	$4,000 per day; 60 days	$5,000 per day; 60 days	$6,000 per day; 60 days	$4,000 per day; 60 days
Health care practitioner visit	$50 per visit; 2 per year	$75 per visit; 4 per year	$75 per visit; 10 per year	$50 per visit; 1 per year
Surgery				
Surgeon (tier 1)	$5,000 per surgery	$6,000 per surgery	$7,000 per surgery	$5,000 per surgery
Surgeon (tier 2 inpatient & outpatient)	$1,000 per surgery	$2,000 per surgery	$3,000 per surgery	$1,000 per surgery
Assistant surgeon (tier 1)	N/A	$3,000 per surgery; 3 per year	$3,500 per surgery; 4 per year	N/A
Assistant Surgeon (tier 2 inpatient and outpatient)	N/A	$1,000 per surgery; 3 per year	$1,500 per surgery; 4 per year	N/A
Anesthesia (tier 1)	$500 per surgery; 2 per year	$1,000 per surgery; 3 per year	$1,500 per surgery; 4 per year	N/A
Anesthesia (tier 2 inpatient and outpatient)	$250 per surgery; 2 per year	$500 per surgery; 3 per year	$750 per surgery; 4 per year	N/A
Outpatient surgical facility	N/A	$500 per surgery; 3 per year	$750 per surgery; 4 per year	N/A

NOTE: The different benefit levels shown in this brochure are for informational purposes. Policy holders will only receive the benefits that are written, or printed, in the policy they select and is issued to them.

[2] This benefit increases in your second and third consecutive year with the policy. The first number is your year-one benefit amount; the second number is your year-two benefit amount; and the third number is your year-three benefit amount. After year three, this benefit then stays at that amount for all future years.

	Value	Fundamentals	Enhanced	Guaranteed issue
Outpatient and drugs				
Office visit[3]	$75 per visit; 2; 3; 4; per year	$75 per visit; 4; 5; 6; per year	$100 per visit; 4; 5; 6; per year	$75 per visit; 2 per year
Preventive care office visit	N/A	N/A	$100 per visit; 2 per year	N/A
Urgent care visit	$100 per visit; 2 per year	$100 per visit; 3 per year	$200 per visit; 4 per year	N/A
Outpatient prescription drugs	N/A	$15 reimbursement per fills; 50 fills	$25 reimbursement per fills; 50 fills	N/A
Laboratory services				
Radiology	$200 per test; 2 per year	$250 per test; 2 per year	$300 per test; 2 per year	$200 per test; 1 per year
Laboratory	$75 per test; 2 tests per day, 3 per year	$75 per test; 2 tests per day, 4 per year	$75 per test; 2 tests per day, 5 per year	$75 per test; 1 per year
Emergency services				
Ambulance (ground)	$500 per trip; 1 per year	$750 per trip; 1 per year	$1,000 per trip; 1 per year	$500 per trip; 1 per year
Ambulance (air)	$1,000 per trip; 1 per year	$1,500 per trip; 1 per year	$2,000 per trip; 1 per year	$1,000 per trip; 1 per year
Emergency room	$100 per visit; 1 per year	$250 per visit; 2 per year	$250 per visit; 3 per year	N/A
Transitional care				
Skilled nursing facility	N/A	N/A	$100 per day; 50 days	N/A
Home health care	N/A	N/A	$100 per day; 50 days	N/A
Hospice care	N/A	N/A	$100 per day; 50 days	N/A

NOTE: The different benefit levels shown in this brochure are for informational purposes. Policy holders will only receive the benefits that are written, or printed, in the policy they select and is issued to them.

[3] This benefit increases in your second and third consecutive year with the policy. The first number is your year-one benefit amount; the second number is your year-two benefit amount; and the third number is your year-three benefit amount. After year three, this benefit then stays at that amount for all future years.

policies, continued

	Fundamentals+	Enhanced+
Inpatient hospitalization		
Hospital admission	$750; 3 per year	$1,000; 3 per year
Confinement (sickness)[4]	$2,000; $2,500; $3,000; per day	$3,000; $3,750; $4,500; per day
Confinement (injury)[4]	$4,000; $5,000; $6,000; per day	$6,000; $7,500; $9,000; per day
ICU (sickness)	$3,000 per day; 60 days	$3,000 per day; 60 days
ICU (injury)	$5,000 per day; 60 days	$5,000 per day; 60 days
Health care practitioner visit	$75 per visit; 10 per year	$75 per visit; 10 per year
Surgery and observation unit		
Surgeon (tier 1)	$8,000 per surgery	$10,000 per surgery
Surgeon (tier 2)	$4,000 per surgery	$5,000 per surgery
Surgeon (outpatient)	$3,000 per surgery; 3 per year	$5,000 per surgery; 4 per year
Assistant surgeon (tier 1)	$3,500 per surgery; 4 per year	$5,000 per surgery; 4 per year
Assistant surgeon (tier 2)	$1,500 per surgery; 4 per year	$2,500 per surgery; 4 per year
Assistant surgeon (outpatient)	$2,000 per surgery; 3 per year	$2,500 per surgery; 4 per year
Anesthesia (tier 1)	$2,000 per surgery; 3 per year	$2,500 per surgery; 4 per year
Anesthesia (tier 2)	$750 per surgery; 3 per year	$1,000 per surgery; 4 per year
Anesthesia (outpatient)	$750 per surgery; 3 per year	$1,000 per surgery; 4 per year
Outpatient surgical facility	$500 per surgery; 3 per year	$750 per surgery; 4 per year
Observation unit	$1,000 per day; 1 per year	$1,500 per day; 2 per year

NOTE: The different benefit levels shown in this brochure are for informational purposes. Policy holders will only receive the benefits that are written, or printed, in the policy they select and is issued to them.

[4] This benefit increases in your second and third consecutive year with the policy. The first number is your year-one benefit amount; the second number is your year-two benefit amount; and the third number is your year-three benefit amount. After year three, this benefit then stays at that amount for all future years.

	Fundamentals+	Enhanced+
Outpatient and drugs		
Office visit[5]	$125 per visit; 6; 7; 8; per year	$150 per visit; 7; 8; 9; per year
Preventive care office visit	$125 per visit; 1 per year	$150 per visit; 2 per year
Urgent care visit	$100 per visit; 5 per year	$100 per visit; 8 per year
Outpatient prescription drugs	$15 reimbursement per fills; 50 fills	$15 reimbursement per fills; 50 fills
Laboratory services		
Radiology	$200 per test; 3 per year	$300 per test; 5 per year
Laboratory	$50 per test; 7 tests per year	$50 per test; 10 tests per year
Emergency services		
Ambulance (ground)	$750 per trip; 1 per year	$1,500 per trip; 1 per year
Ambulance (air)	$1,500 per trip; 1 per year	$2,500 per trip; 1 per year
Emergency room	$500 per visit; 2 per year	$500 per visit; 3 per year

NOTE: The different benefit levels shown in this brochure are for informational purposes. Policy holders will only receive the benefits that are written, or printed, in the policy they select and is issued to them.

[5] This benefit increases in your second and third consecutive year with the policy. The first number is your year-one benefit amount; the second number is your year-two benefit amount; and the third number is your year-three benefit amount. After year three, this benefit then stays at that amount for all future years.

frequently asked questions

Is this policy an Affordable Care Act (ACA) policy?

No, this policy is not an ACA-compliant policy. Allstate Health Access is a limited medical policy that pays set-dollar amounts when a member receives particular services, no matter what the provider charges. Members are responsible for any remaining costs not covered by the policy benefits. Limited medical policies are not major medical insurance and do not meet the standards set by the ACA.

Do I need to complete an application to qualify for coverage?

Yes. To obtain an Allstate Health Access policy, you must complete a short application which includes questions regarding your health. Your answers will determine whether or not you are eligible for the coverage.

Do your policies have network requirements?

With your Allstate Health Access policy, you have access to First Health Network providers that may offer you a discount on services, saving you money up front. There are no penalties for seeing a doctor that is not in the network. The policy pays the same dollar amount no matter which provider you see. You are responsible for all remaning costs.

How do I find network providers?

Your new policy information packet and ID cards will include this link to help you find providers in your network: www.firsthealthlbp.com

Does this policy cover Pre-Existing Conditions?

No, this policy does not cover treatment for pre-existing conditions in the first 12 months of coverage.

See the Limitations & Exclusions page for more information about Pre-Existing Conditions.

What are first-dollar benefits?

“First-dollar” benefits are benefits paid without any deductibles or copays to satisfy first. Please note that this pays a set fixed-benefit so any costs that exceed the benefit amount are the customer’s responsibility. If you choose a policy that includes prescription benefits you must first purchase the prescription then file a claim before reimbursement benefits begin (Fundamentals, Enhanced, Fundamentals Plus, and Enhanced Plus levels only).

Is there a waiting period?

Yes, there is a 90-day waiting period for preventive services. There is no waiting period for other services.

If I have other health insurance that covers an expense, will I still get benefits from my Allstate Health Access insurance policy?

Yes, you will receive your fixed-benefit amount for your covered service. You get paid regardless if other coverage has also paid for the same benefit.

What if I want more coverage?

We have smart solutions that can help. Add more levels of cost protection with our supplemental accident and critical illness policies. They help you get affordable coverage for the things in life you can’t see coming.

Ask your agent for more information.

limitations and exclusions

This insurance policy provides benefits only for Covered Services identified in the Benefits section.

We will not pay benefits for claims resulting from, or relating to, any of the following:

- Sickness and Injury resulting directly or indirectly from a Pre-Existing Condition or a complication resulting therefrom for the first 12 months following the Covered Person's Effective Date.
- Pre-Existing Condition means a Sickness, Injury, or condition, including any related or resulting complications:
- For which medical advice, consultation, diagnosis, care, or treatment (includes receipt of services, supplies, or diagnostic tests) was received or recommended from a provider or prescription drugs were prescribed during the 1 years period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
- That produced signs or symptoms during the 1 year period immediately prior to the Covered Person's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following:

- The signs or symptoms reasonably should have allowed or would have allowed a medical provider to diagnose the condition; or
- The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek medical advice, consultation, diagnosis, care, or treatment.
- A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.
- Treatment, services, or supplies received before the Effective Date or after this Policy terminates in accordance with the Termination provision.
- Treatment, services, or supplies not specifically listed as a Covered Services in the Benefits section.
- Complications of non-covered treatment, services, or supplies.
- Treatment, services, or supplies that are Experimental or Investigational Services.
- Treatment, services, or supplies provided while participating in a clinical trial.
- Charges for preventive services except as otherwise covered in the Benefits section.
- Prophylactic services, including prophylactic surgery or other procedures performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
- Suicide or attempted suicide, Health Care Practitioner assisted suicide, or intentionally self-inflicted injury.
- War or any act of war; participation in the military service of any country.
- A Covered Person's voluntary attempt to commit, participation in, or commission of a felony, whether or not charged.
- Charges for routine eye exams, eyeglasses, and contact lenses.
- Eye surgery for cataracts, nearsightedness, farsightedness, or astigmatism.
- Charges for routine hearing exams.
- Cochlear implant, auditory prosthesis or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.
- Snoring, sleep disorders, the treatment or prevention for hair loss, change in skin pigmentation, or cognitive enhancement.
- Gastric bypass, surgery for weight control, obesity or morbid obesity, including but not limited to any type of gastric bypass or other weight loss surgery, suction lipectomy.
- Custodial Care, respite care, rest care, supportive care, homemaker services, personal comfort or convenience of the Covered Person, the Covered Person's family, a Health Care Practitioner or a provider.
- Cosmetic Services, including but not limited to cosmetic or plastic surgery, except for Reconstructive Surgery.
- Capsular contraction, augmentation or reduction mammoplasty, except for Reconstructive Surgery.
- Mental Illness or Substance Abuse.

An injury sustained while participating in, instructing, demonstrating, guiding or accompanying others in any hazardous activity, whether or not compensation is received including, but not limited to:

- Parachute jumping.
- Hang-gliding.
- Bungee jumping.
- Rodeo activities.
- Racing any motorized vehicle or conveyance.
- Rock or mountain climbing.
- Skydiving.
- Parkour.

limitations and exclusions

An injury sustained while participating in, instructing, demonstrating, guiding or accompanying others in any hazardous occupation or other activity for which compensation is received including, but not limited to:

- Racing any non-motorized vehicle or conveyance.
- Professional or semi-professional contact sports.
- Injury sustained while participating in any inter-collegiate sport, contest or competition for any such sport, contest or competition.
- Treatment, services, or supplies received outside of the United States or its possessions or Canada. Drugs or medications obtained from pharmacy provider sources outside the United States.
- Treatment, services, or supplies resulting from or related to chronic pain disorders.
- Foot conditions including, but not limited to, flat foot conditions, bunion, corns.

Reproductive or contraceptive treatment, services, or supplies including, but not limited to:

- Pregnancy, except for Complications of Pregnancy.
- Childbirth.
- Fetal reduction surgery.
- Infertility diagnosis and treatment.
- Cryopreservation of sperm or eggs.
- Surrogate pregnancy.
- Umbilical cord stem cell or other blood component harvest.
- Sterilization, drugs or devices used directly or indirectly to promote or prevent conception.
- Abortion.

Treatment, services, or supplies, regardless of underlying causes, including, but not limited to:

- Sex transformation.
- Gender dysphoric disorder.
- Gender reassignment.
- Sexual function, dysfunction or inadequacy.
- Dental treatment, services, or supplies.
- Orthodontic treatment, services or supplies, including, but not limited to, dental braces and dental appliances.
- Care for supporting structures of the teeth.
- Temporomandibular or craniomandibular joint dysfunction.
- Maxillary or mandibular hypoplasia.
- Malocclusion or mandibular protrusion or recession.
- Maxillary or mandibular hyperplasia.
- Sclerotherapy or other treatment, services, or supplies resulting from or related to varicose veins or spider veins
- Growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
- Allergies (including allergy testing, allergy shots, and allergy immunotherapy), except for Emergency treatment of allergic reactions.
- Services provided by or through any employer of a Covered Person or the employer of a Covered Person's Immediate Family member.
- Services provided by or through any Covered Person's Immediate Family member or any entity in which a Covered Person or their Immediate Family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity.
- End stage kidney or end stage renal disease.
- Treatment, services, or supplies related to transplants and organ donation.
- Congenital conditions, except when provided to a newborn or newly adopted child who is a Covered Person.

Products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:

- Herbal or homeopathic medicines or products.
- Minerals and vitamins.
- Health and beauty aids.
- Batteries.
- Appetite suppressants.
- Dietary or nutritional substances or dietary supplements.
- Nutraceuticals.
- Tube feeding formulas and infant formulas.
- Medical foods.
- Devices or supplies including, but not limited to, support garments, bandages and non-medical items regardless of intended use.
- (Outpatient prescription drugs only prints for Value and GI plans) Outpatient prescription drugs.

Guaranteed Renewable except for stated reasons: This Policy is guaranteed renewable until attainment of age 65 years except for stated reasons. This Policy automatically renews except as stated in the Effective Date and Termination Date provision section.

limitations and exclusions

Termination date

termination Coverage ends at 11:59 P.M. Standard Time the earliest of:

- The date a Covered Person becomes eligible for Medicare.
- The date the benefits paid for a Covered Person reaches the Policy Maximum Benefit amount, as shown in the Benefit Schedule. (This exclusion only prints for the GI plan)
- The date a Covered Person's coverage is rescinded pursuant to the Rescission provision below.
- The date a Covered Person, or anyone acting on a Covered Person's behalf, knowingly files a fraudulent claim.
- The date this Policy lapses for nonpayment of premium (including any applicable fees) pursuant to the Grace Period provision.
- The date requested by You for termination and agreed upon by Us.
- For a covered Dependent, the last date after which premium is paid following the date they no longer meet the Dependent definition.
- The last day of the month in which a Covered Person reaches age 65.
- The date of a Covered Person's death.
- The date all insurancy policies with the same form number are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides. We will give you advance notice, as required by state law, of the termination of Your coverage.
- The date We terminate or non-renew hospital confinement and other fixed indemnity insurance coverage in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.

A Dependent can become the Policyholder by making a request to Us within 30 days from the date the Policyholder's coverage terminates and paying the required premium in the event the Policyholder's coverage terminates due to:

- The Policyholder reaches age 65.
- The Policyholder's death.

Rescission

We may rescind coverage for a Covered Person or all Covered Persons if We determine that there was fraud or intentional misrepresentation of a material fact that caused Us to issue this coverage when coverage would not have otherwise been issued. Rescission causes coverage to be terminated back to the Effective Date as if the coverage were never issued.

Rescission will result in denial of claims. If rescission occurs We will refund premiums received less any claims We have paid for the person(s) whose coverage is rescinded. If We have paid claims in excess of the amount of premium We received, We have the right to obtain a refund.

Age Limitation

If You or Your spouse or Domestic Partner are age 65, or have a dependent child over age 25 on the Effective Date, Our sole liability will be for the return of premiums paid for that person less any claims We have paid and their coverage will be void.

Hospital

A facility that provides acute care or subacute medical care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility and must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or The Centers for Medicare and Medicaid Services (CMS) to provide acute care or Subacute Medical Care.
2. Be staffed by an on duty physician 24 hours per day.
3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
4. Maintain daily medical records that document all services provided for each patient.
5. Provide immediate access to appropriate in-house laboratory and imaging services.
6. Not primarily provide care for Mental Illnesses or Substance Abuse although these services may be provided in a distinct section of the same physical facility.

limitations and exclusions

A special ward, floor or other accommodation used primarily for Custodial Care, convalescent, skilled nursing or rehabilitation purposes is not considered a Hospital. A special ward, floor, or other accommodation that satisfies the definition of Skilled Nursing Facility is not considered a Hospital.

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This document provides summary information. For a complete listing of benefits, exclusions and limitations, please refer to the Insurance policy. In the event there are discrepancies with the information in this document, the terms and conditions of the coverage documents will govern.

FORM: NHIC HI 2019 IND POL CO

Allstate®
HEALTH SOLUTIONS

about

The Allstate Corporation (NYSE: ALL) is one of the largest publicly held personal lines insurers in the United States. As part of the Allstate Corporation, Allstate Health Solutions is focused on providing supplemental and short-term coverage options to individuals and associations. Allstate Health Solutions is the marketing name for products underwritten by National Health Insurance Company, Integon National Insurance Company, Integon Indemnity Corporation and American Heritage Life Insurance Company. These four companies, together, are authorized to provide health insurance in all 50 states and the District of Columbia. Each underwriting company is responsible for its respective products. National Health Insurance Company underwrites policies in AL, AR, AZ, CO, DC, DE, FL, GA, IA, IL, KY, LA, ME, MI, MO, MS, NC, NE, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WV, and WY.

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Allstate Health Access policies are fixed-benefit medical policies that help pay for out-of-pocket costs for covered services.

For use in: CO