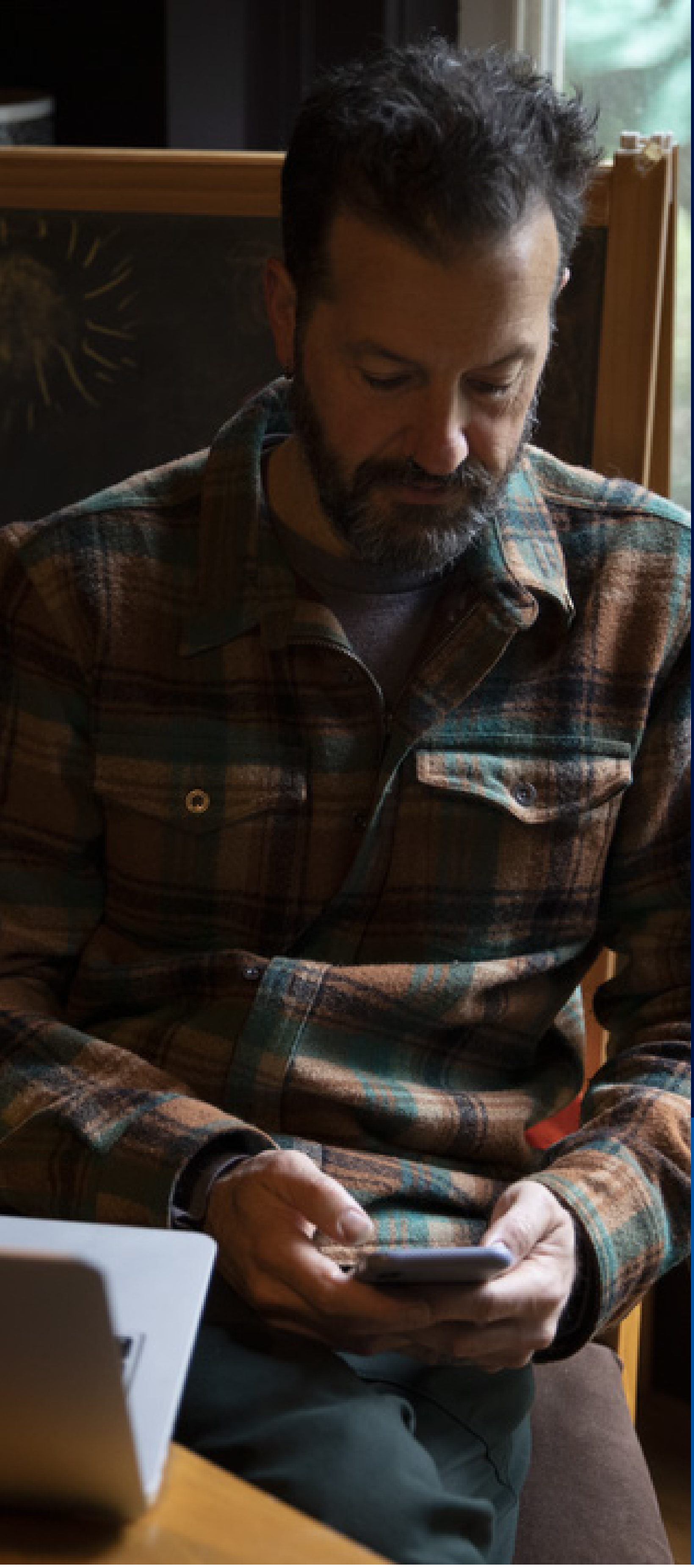


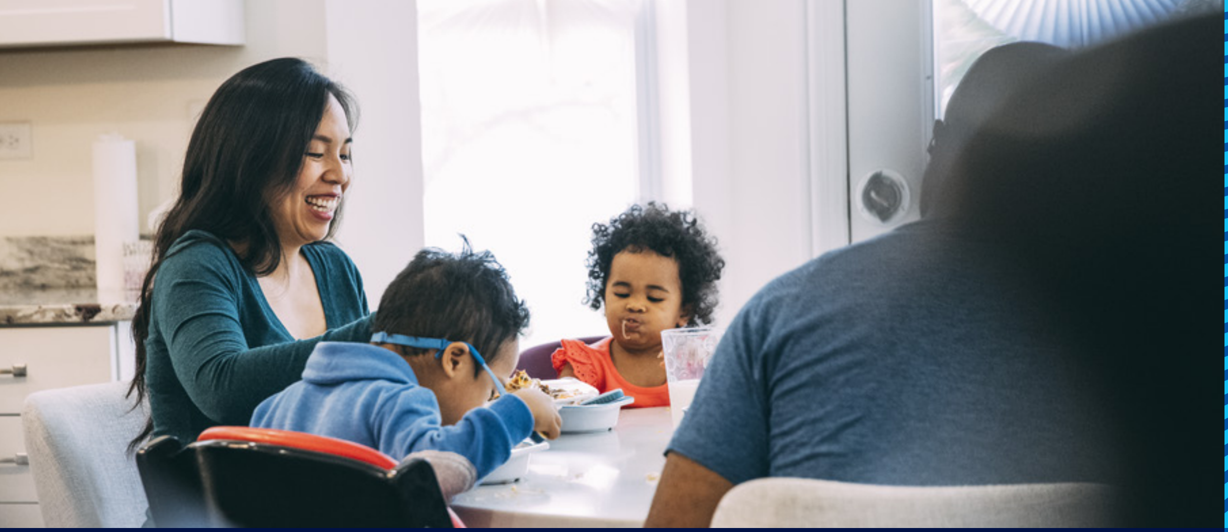
Allstate
HEALTH SOLUTIONS

WISCONSIN

short term medical insurance

Coverage you need for the time you need it.

PPO Network provided by Aetna®



short term plans that are never short on benefits

Allstate Health Solutions understands that how you live and work is constantly changing. That's why short term medical insurance gives you flexibility to choose the amount of coverage you need, for the amount of time you need it.

With options that include national networks, such as Aetna, you can customize a plan that protects you from everyday health care costs, and unexpected health emergencies.

Whether you're between jobs, waiting for open enrollment or aging out of a family plan — short term medical insurance has a plan to fit your needs and budget. Get coverage today, so your health, and wealth, are protected tomorrow.

features of short term medical

Flexible coverage periods

Your choice of plan length, from 30 days up to 18 months[1], for both individuals and families.

Immediate protection

When you sign up for a plan[2], coverage kicks in as soon as the next day. So you'll get peace of mind knowing you're protected.

Tax savings

Plans that are compatible with a Health Savings Account are available, helping you maximize every dollar you spend on eligible expenses.

In-person office visits

All plans come with office visit benefits. And you choose the copay option that is right for you.

No urgent care deductibles

After a $50 access fee, the deductible is waived and any additional costs are subject to coinsurance.

Rx benefits and discounts

Choose the prescription savings option that fits you best - discount and copay options available.

Access to Aetna

Choose from more than 690,000 primary care doctors and specialists across 5,700 hospitals in the Aetna Open Choice® PPO Network.[3]

Find a provider at: myallstatehealthsolutions.com/aetnaopenchoiceppo

[1] Plan durations vary by state. Short Term Medical continuous coverage options and availability vary by state. See page 7 for more details. [2] Eligibility for sickness benefits after 7 days. The 7 day wait on sickness benefits is waived if the application date is more than 7 days from effective date. [3] Provider count source: https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.htm

Short Term Medical plans do not cover pre-existing conditions. They are not Minimum Essential Coverage under the Affordable Care Act.

pick the right plan for you

	Essentials PPO plan	Enhanced PPO plan			Copay Enhanced PPO plan	
Deductibles[4]	**$5,000; $10,000; $25,000**	**$2,500; $5,000**	**$2,500; $5,000; $7,500**	**$2,500; $5,000; $10,000; $25,000**	**$2,000; $4,000**	**$6,000; $8,000**
Coinsurance % paid by you	40%	50%	20%	0%	25%	0%
Coinsurance out-of-pocket Per member	$7,500	$5,000	$5,000	$0	$7,500	$0
Coverage period maximum	**$250,000**	**$1,000,000**			**$5,000,000**	
Office visits Including preventive visits	Applies to deductible and coinsurance	Applies to deductible and coinsurance			Copay:[5] $40 PCP; $60 Specialist	
					Up to 6 months: Single: 1 total Family: 3 total	**Over 6 months:** Single: 2 total Family: 4 total
Pharmacy[6]	Not applicable	Not applicable			• $10 Copay on generic drugs • Maximum benefit of $3,000	
Outpatient services[7]	• Applies to deductible and coinsurance • $15,000 Limit *(Some restrictions apply)*[8]	• Applies to deductible and coinsurance • Some limit restrictions apply, see footnote for details[8]			• Applies to deductible and coinsurance • Some limit restrictions apply, see footnote for details[8]	
Preventive screenings[9]	• First-dollar coverage for child immunizations; deductible and coinsurance are waived • Applies to deductible and coinsurance	• First-dollar coverage for child immunizations; deductible and coinsurance are waived • Applies to deductible and coinsurance			• First-dollar coverage for child immunizations; deductible and coinsurance are waived • Adult immunizations are subject to deductible and coinsurance • Applies to deductible and coinsurance	

Benefits in every plan	
Emergency room visit	Applies to deductible and coinsurance. $250 access fee, waived if admitted[10].
Diagnostic, x-ray and lab	Applies to deductible and coinsurance.
Inpatient services	Includes hospital stays. Applies to deductible and coinsurance.

Out-of-network deductibles and coinsurances are double their in-network amounts. Coinsurance percentages are the same for out-of-network services.

[4] The family deductible is capped at 3x the individual deductible. For families with more than 3 members, all covered expenses accumulate towards the family deductible, but no individual member will pay more than their individual deductible. [5] Additional office visits apply to deductible and coinsurance. Copays are not applicable to out-of-network services. [6] No waiting period applies. [7] Includes services such as surgeon, anesthesia, office visits, preventive services, urgent care, diagnostics and lab. [8] A $5,000 benefit limit applies to outpatient treatment of a joint, neck, spine, or connective tissue including tendons, ligaments, and cartilage (exclusions may apply, see exclusion list). There is also a 30-visit limit for physical therapy, occupational therapy, speech therapy, cardiac and pulmonary rehabilitation. [9] For a general breakdown of covered screenings, see page 5. [10] Access fees do not apply to HSA compatible plans.

preventive screening benefits

STM preventive benefit[11]	STM PPO (non-copay)	STM PPO (copay)
Routine preventive exam (An office visit which includes routine preventive exams for adults and children.)	Deductible and coinsurance	Non-specialist office visit copay
Breast cancer screening (including 3D mammography) (Annually)	Deductible and coinsurance	Deductible and coinsurance
Prostate cancer screening (Includes one prostate specific antigen test and one digital rectal examination.)	Deductible and coinsurance	Deductible and coinsurance
Colorectal cancer examinations and laboratory tests (As specified in current American Cancer Society guidelines for colorectal cancer screening. Colorectal cancer screening includes a fecal blood test performed annually, a flexible sigmoidoscopy performed every five years, or a colonoscopy performed every 10 years.)	Deductible and coinsurance	Deductible and coinsurance
Cervical cancer screening (with HPV screening) (Annually with Pap smear.)	Deductible and coinsurance	Deductible and coinsurance
Chlamydia screening	No coverage	Deductible and coinsurance
Cholesterol abnormalities screening	No coverage	Deductible and coinsurance
Gonorrhea screening	No coverage	Deductible and coinsurance
Hepatitis B screening	No coverage	Deductible and coinsurance
Hepatitis C screening	No coverage	Deductible and coinsurance
HIV screening	No coverage	Deductible and coinsurance
Diabetes screening	No coverage	Deductible and coinsurance
Osteoporosis screening (For postmenopausal women under age 65.)	No coverage	Deductible and coinsurance
Syphilis screening	No coverage	Deductible and coinsurance
Tuberculosis screening	No coverage	Deductible and coinsurance
Adult immunizations: • COVID-19 • Influenza • Meningococcal meningitis • Hepatitis A and B vaccine • DTaP-IPV-Hib-HepB (diphtheria, tetanus toxoids, acellular pertussis vaccine, poliovirus vaccine, haemophilus influenza type B, and hepatitis B) • HPV vaccine • MMR (measles, mumps and rubella virus vaccine) • MMRV (measles, mumps and rubella virus and varicella) • IPV (poliovirus vaccine, inactivated) • Varicella virus (chickenpox) vaccine • Zoster (shingles) vaccine for a covered person age 60 or older	No coverage	Deductible and coinsurance
Child immunizations: • From birth through 18 years of age as recommended by the United States Preventative Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention on the date the service is incurred.	First dollar benefits	First dollar benefits

[11] This is a generic list of preventive services. For benefits specific to your state, ask your agent for more information.

add benefits with optional services from Recuro Health

For more information on Recuro Health, scan the QR code below:

Recuro Health prescription benefit[12]

Recuro's prescription benefit includes $0 copay for chronic conditions and urgent care medications. It is accepted at over 65,000 retail pharmacy locations across the U.S.

- Prescription benefit card
- Medication delivery
- Extensive list of prescriptions
- National pharmacy network
- Easy-to-use member portal

Learn more at: recurohealth.com/prescription-benefit/

Recuro Health virtual care[12]

Access to virtual urgent care that provides unlimited 24/7 access with $0 copay for you and your family, ensuring that you get quality care when you need it, all from the convenience of your mobile device or computer.

Learn more at: recurohealth.com/offering-primarycare/

Recuro Health virtual behavioral health

Recuro Health virtual behavioral health services features a $0 copay and combines comprehensive care with the comfort and convenience of home. It treats a variety of conditions, including ADHD, anxiety, depression, PTSD, bipolar disorder, sleep disorders, and more. Most health visits are available within 48 hours[13], giving you flexibility in getting the care you need when you need it. Virtual behavioral health services include:

- Psychiatry[14]
- Therapy and counseling
- Depression screening
- Risk scoring
- Primary care coordination

Learn more at: recurohealth.com/offering-behavioralhealth/

[12] The Recuro Health virtual care and prescription benefit are optional benefits, and not insurance. The prescription benefit has a $50 maximum benefit per prescription fill. Recuro does not accept child only policies. [13] Subject to provider listed availability. [14] Psychiatry requires copay of $260 for initial visit and $140 on follow up visit. These copays are separate from insurance and do not accumulate towards any out-of-pocket costs.

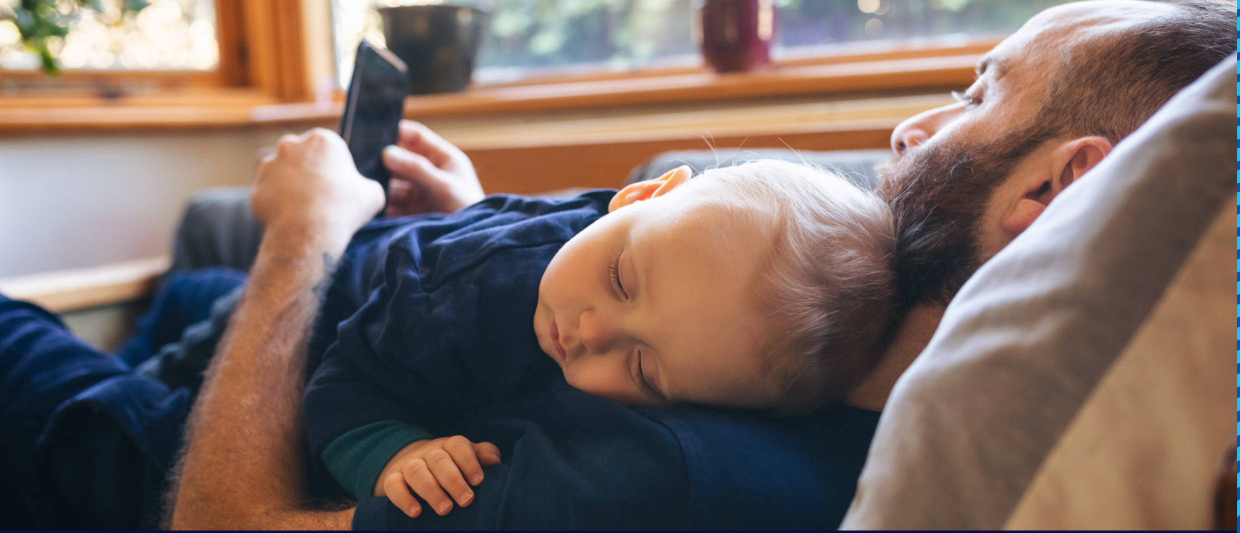
extending your coverage

Plan purchase options

Purchase multiple plans with one application. And renewable options[15] let you extend coverage for up to 18 months.

	Renewable option
Pre-existing conditions are covered after the first 12 months of coverage.	yes
Deductible/coinsurance resets with each new policy term.	yes
Coverage period maximum resets each new policy term.	no
Guaranteed rate option available	no
Rates determined at the time of purchase and may vary by plan.	no
Coverage	an additional 6 months of coverage

[15] All plan options must be selected at the time of purchase. Not available for Guaranteed Issue Plans. Maximum allowable policy period is 364 days.



HSA Compatible options

HSA Compatible plans help you maximize your health care dollars by giving you extra tax savings. All four plan designs meet the Internal Revenue Service rules and regulations for high-deductible health plans (HDHPs) and qualify as a health savings account (HSA) compatible plan. This means you can pay deductibles, coinsurance, and other qualified health expenses with tax-deductible dollars that you save in a special HSA account, giving you significant savings.

If you have already established an HSA account at your financial institution, you can continue to deposit money into this account and use it to pay for qualified health care expenses with your Short Term Medical HSA Compatible plan. If you do not yet have an HSA account, contact your bank or financial institution. They can help you open one.

Our plans offer:

- Coverage for doctor visits and hospital stays.
- Preventive care for both adults and children with first-dollar coverage.
- Emergency room and urgent care visits with no access fees.
- Flexible coverage periods. Your choice of plan length[16], from one to three years, both for individuals and families.
- Immediate protection. When you sign up for a plan[17], coverage kicks in as soon as the next day. You'll get peace of mind, knowing you're protected.
- Access to Aetna. Choose from more than 850,000 primary care doctors and specialists across 6,900 hospitals in the Aetna Open Choice® PPO Network.[18]

[16] Plan durations vary by state. Short Term Medical continuous coverage options and availability vary by state. [17] Eligibility for sickness benefits after seven days. The seven-day wait on sickness benefits is waived if the application date is more than seven days from effective date. [18] Provider count source: https://healthdepotassociation.com/benefits/aetna-open-choice-ppo-network.

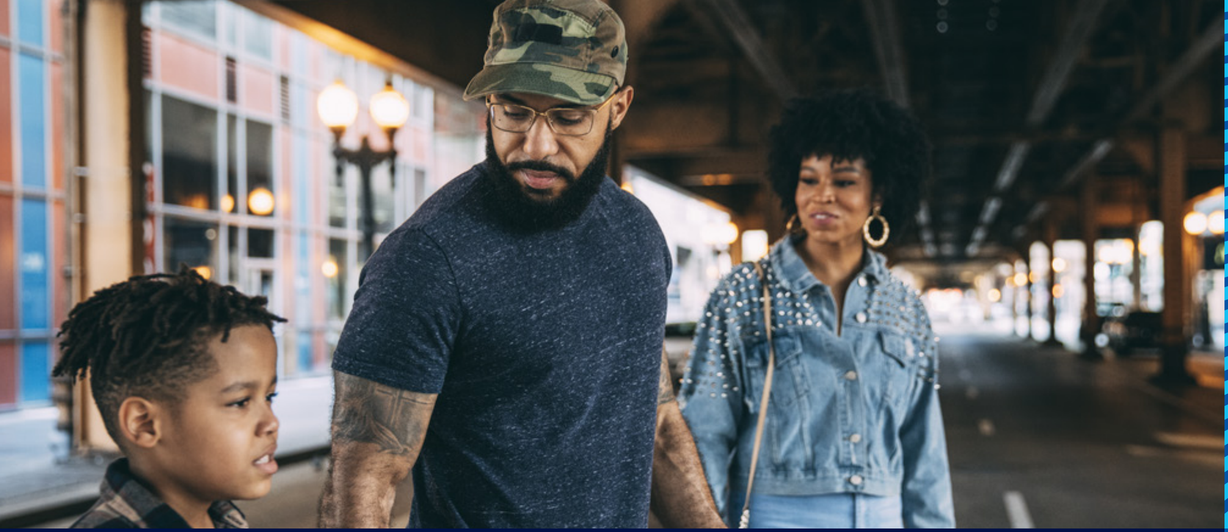
Short Term Medical plans do not cover pre-existing conditions. They are not Minimum Essential Coverage under the Affordable Care Act.

HSA plan designs

	HSA Compatible Plan options[19]			
Deductibles[20]	**$6,000**	**$6,000**	**$6,000**	**$7,500**
Coinsurance % paid by you	30%	10%	0%	0%
Coinsurance out-of-pocket x2 for family	$1,500	$1,500	$0	$0
Coverage period maximum	**$1,000,000**			

Additional benefits					
Adult screening *Applies to deductible and coinsurance*	**Emergency room visit** *Applies to deductible and coinsurance*	**Urgent care** *Applies to deductible and coinsurance*	**Diagnostic and lab** *Applies to deductible and coinsurance*	**Inpatient services** *Deductible and coinsurance; Not to exceed the average for a semi-private room; $150 per day; maximum of 30 days per benefit period.*	**Outpatient services[22]** Applies to deductible and coinsurance; Some restrictions apply. See footnote for details[23]
Office visits *Deductible and coinsurance.*	**Preventive care[21]** (child and adult) *First dollar benefit*	**Organ transplant** *Deductible and coinsurance, up to $100,000*	**Joint and neck** *Deductible and coinsurance, up to $5,000*		

[19] HSA options are available for 12-month and renewal plans only. [20] The family deductible is capped at 2x the individual deductible. For families with more than two members, all covered expenses accumulate toward the family deductible, but no individual member will pay more than their individual deductible. [21] For a general breakdown of covered screenings, see page 5. [22] Includes services such as surgeon, anesthesia, office visits, preventive services, urgent care, diagnostics and lab. [23] A $5,000 benefit limit applies to outpatient treatment of joint, neck, spine or connective tissue, including tendons, ligaments and cartilage (exclusions may apply. See exclusion list). There is also a 30-visit limit for physical therapy, occupational therapy, speech therapy, cardiac and pulmonary rehabilitation.



consider a guaranteed alternative

Our Guaranteed Issue PPO[24] plan is a great alternative to our Essentials, Enhanced, or Copay Enhanced plans. You are guaranteed eligibility and there is no health questionnaire to fill out.

Just pick the option that works best for you and you're all set. And with many of the same benefits as other PPO plan options, you can't go wrong.

	Guaranteed Issue PPO	
Deductibles[25]	**$3,500**	**$5,000**
Coinsurance % paid by you	**20%**	**10%**
Coinsurance out-of-pocket Per member	**$6,500**	**$5,000**
Coverage period maximum	**$100,000**	**$100,000**

Other benefits in Guaranteed Issue PPO				
Office visits (including preventive) *Applies to deductible and coinsurance*	**Emergency room visit** $250 access fee; waived if admitted *Applies to deductible and coinsurance*	**Inpatient services** Includes hospital stays *Applies to deductible and coinsurance*	**Urgent care** $50 access fee. Deductible waived. Remaining cost subject to coinsurance.	**Outpatient services** Includes services such as surgeon, anesthesia, office visits, preventive services, urgent care, diagnostics and lab. *Applies to deductible and coinsurance*
Child immunizations First dollar benefit	**Diagnostic and lab** *Applies to deductible and coinsurance*	**Preventive screening[26]** *Applies to deductible and coinsurance*	**Outpatient services** No limit	

Out-of-network deductibles and coinsurances are double their in-network amounts. Coinsurance percentages are the same for out-of-network services.

[24] Short Term Medical plans do not cover costs associated with pre-existing conditions. [25] The family deductible is capped at 3x the individual deductible. For families with more than 3 members, all covered expenses accumulate towards the family deductible, but no individual member will pay more than their individual deductible. [26] For a general breakdown of covered screenings, see page 5.

add an extra layer of protection

No one plans for things like chronic illness, accidents or hospital stays. But you can add a supplemental coverage plan to protect yourself from out-of-pocket costs. Plans are affordable, and help you keep more money in your pocket when you have unexpected medical bills.

How supplemental coverage works

Let's say you chose a Short Term Medical policy with a $5,000 deductible. Then, you need emergency care, and have a $12,900 medical bill. You would typically pay $5,000 out-of-pocket, or whatever remains on your deductible.

But if you have a supplemental plan with a $250 deductible, your plan would pay $4,750. Or, 98% of your medical plan's deductible. Either way, you're only paying $250 out-of-pocket.

Affordable plans for:

- **Accidental injuries**
- **Critical illness**
- **Cancer and heart/stroke**
- **Hospital stays**

limitations and exclusions

Pre-existing condition exclusion

- This Plan does not cover any charges related to Policy benefits resulting directly or indirectly from a Pre-Existing Condition or a complication resulting therefrom.

Pre-existing condition means:

  » A condition for which medical advice, diagnosis, care, or treatment was received or recommended during the 1 year period immediately prior to the Covered Person's Effective Date.

  » A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.

Organ transplant or marrow reconstitution

Both organ transplant and marrow reconstitution services are covered under the plan pursuant to applicable terms and limitations. Benefits are subject to deductible and coinsurance.

- Maximum benefit of $100,000 per policy.
- Donor expense maximum benefit of $10,000 per policy.

Additional charges not covered by this policy

Unless set forth as a benefit in the benefits section, this policy does not cover charges for:

Treatment, services or supplies that are: 1) received before the effective date or after the termination date; 2) provided at no cost to the covered person; 3) not specifically listed in the benefits section; 4) are in excess of the maximum allowable amount or maximum benefit stated.

- Complications resulting or related to treatment, services or supplies that are not covered.
- Treatment, services or supplies that are: 1) experimental or investigational services; 2) preventive; 3) prophylactic; 4) not medically necessary; 5) received in a clinical trial; 6) for the personal comfort or convenience of the covered person, the covered person's family, a health care practitioner or a provider; 7) incurred outside of the United States or its possessions or Canada.
- Suicide or attempted suicide, health care practitioner assisted suicide, and intentionally self-inflicted injury; war or any act of war or participation in the military service of any country.
- Treatment, services or supplies paid by Medicare or any other government law or program except Medicaid (Medi-Cal in California), motor vehicle insurance, no fault insurance or worker's compensation insurance.
- Treatment, services or supplies incurred while a covered person is committing or participating in a felony.
- An Injury resulting from or related to a covered person being under the influence of illegal narcotics, non-prescribed controlled substances, or alcohol (such that the covered person is intoxicated per state law).
- Eyeglasses, contact lenses, eye exams, eye refraction, eye surgery, vision therapy.
- Artificial hearing devices, batteries, cochlear implants, auditory prostheses or other mechanical or surgical means of enhancing, creating or restoring auditory comprehension.
- Smoking cessation; snoring; sleep disorders; treatment of hair loss; change in skin pigmentation; cognitive enhancement.
- Gastric bypass surgery.
- Weight reduction or weight control programs or treatment, surgery for weight control, obesity or morbid obesity, suction lipectomy, physical fitness programs, exercise equipment, exercise therapy, health club or gym membership fees, nutritional and dietary counseling.
- Family and/or marriage counseling; hypnotherapy; custodial care, respite care; rest care; supportive care; homemaker services; private duty nursing services rendered during hospital confinement; standby health care practitioners; hospice care.
- Adjustments; manipulations; acupuncture; rolfing; cupping therapy; massage; biofeedback; neurotherapy; electrical stimulation; aversion therapy; non-medical items; self-care or self-help programs; stress management; aromatherapy; meditation or relaxation therapy; naturopathic medicine; homeopathic medicine; acne.

limitations and exclusions

- Cosmetic services, capsular contraction, augmentation or reduction mammoplasty, except reconstructive surgery.
- Sales tax or gross receipt tax; provider administrative expenses; missed appointments; non-medical items.
- Learning disorders or disabilities or developmental delays; educational services; wilderness therapy programs; or, education-based residential treatment programs.
- Mental illness or substance abuse; applied behavior therapy or applied behavior analysis, except as covered in the autism spectrum disorder (ASD) benefit.
- 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 or non-motorized vehicle or conveyance, rock or mountain climbing, skydiving or parkour.
- Any hazardous occupation or other activity for which compensation is received including, but not limited to: skiing, horse riding, or racing any non-motorized vehicle or conveyance.
- An injury sustained while participating in any inter-collegiate sport or professional or semi-professional contact sports.
- Chronic pain disorders.
- Surgery for: ear tubes, tonsils, adenoids, hernia, sinuses, or deviated septum.
- Joint replacement, unless related to an Injury.
- End stage kidney or end stage renal disease.
- Foot conditions.
- Cranial orthotic devices.
- Genetic testing, genetic counseling or reproductive treatment; growth hormone therapy; allergies and allergy testing.
- Pregnancy, except for complications of pregnancy; including but not limited to: childbirth; fetal reduction surgery; routine well baby care, including hospital nursery charges at birth; abortion; 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; and sexual treatment regardless of underlying causes.
- Treatment, services or supplies resulting from or related to any congenital condition, except when provided to a newborn or adopted child added who is a covered dependent.
- Except as otherwise covered in the Temporomandibular Disorders benefits, dental treatment, orthodontic treatment, or care for supporting structures of the teeth.
- Sclerotherapy, varicose veins or spider veins.
- Herbal or homeopathic medicines or products; minerals; vitamins; appetite suppressants; dietary or nutritional substances or dietary supplements; nutraceuticals; tube feeding formulas and infant formulas; medical foods.
- Over-the-counter products or drugs; Inpatient drugs prescribed for treatment of a sickness or an injury that is not covered; outpatient prescription drugs, except as otherwise covered.
- Treatment, services or supplies 1) provided by or through any employer of a covered person or the employer of a covered person's immediate family member; or 2) provided by the 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.

Prescription drug exclusions and limitations

If you purchase the Copay Enhanced PPO plan with prescription drug coverage, then in addition to the exclusions and limitations listed in the policy, we will not pay outpatient prescription drug benefits for:

- Drugs that are:
  - » Not on our drug list, received at a non-participating pharmacy, or covered under the plan.
  - » Prescribed for treatment of a sickness or Injury that is not covered under the plan.
  - » Dispensed in excess of the supply limits provision.
  - » Taken to prevent the transmission of disease during activities such as intercourse, sharing of needles, or direct or indirect exchange of bodily fluids.
  - » Obtained from pharmacy provider sources online outside the United States.
  - » Designed or used to diagnose, treat, alter, impact, or differentiate genetic make-up or genetic predisposition.

limitations and exclusions

- Diagnostic kits and products, blood or blood products.
- Duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates.
- Bulk powder/chemical drugs and drugs containing, or made of, bulk powder/chemicals.
- Compounded medications made up of two or more active parts or ingredients.
- Combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients
- Amounts above the contracted rate for a participating pharmacy.
- DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a covered person under the age of 8.
- Postage, handling and shipping charges for any drugs.
- Injectable outpatient prescription drugs.
- Any administrative charge for drugs.

Short Term Medical is nonrenewable

This short term medical plan is nonrenewable. Termination of this plan is not considered a qualifying life event for the purposes of enrolling in an ACA-compliant major medical plan.

If you choose to purchase a new subsequent short term medical plan, you must submit a new application. Any sickness or condition developed during under a previous plan will be considered a pre-existing condition, regardless of whether the sickness or condition was covered under your previous plan, and will not be covered by subsequent short term medical plans. Re-application may not be available in all states.

If you purchased a Renewability rider at the time you initially enrolled in your short term medical plan, then your plan will be renewable up to 18 months so long as you maintain compliance with the plan provisions.

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.

For a full list of limitations and exclusions go to: allstatehealth.com/claims-help.php

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, and Integon Indemnity Corporation. These three 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 products in WI.

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