

Cancer Insurance (GVCP3)

Group Voluntary Cancer from Allstate Benefits

See attached Important Information About Coverage.

Offered to the employees of: **Jasper County**

BENEFIT AMOUNTS

	PLAN 1	PLAN 2
HOSPITAL AND RELATED BENEFITS		
Continuous Hospital Confinement (daily)	\$200	\$300
Government or Charity Hospital (daily)	\$200	\$300
Private Duty Nursing Services (daily)	\$200	\$300
Extended Care Facility (daily)	\$200	\$300
At Home Nursing (daily)	\$200	\$300
Hospice Care Center (daily) or Hospice Care Team (per visit)	\$200 \$200	\$300 \$300
RADIATION/CHEMOTHERAPY AND RELATED BENEFITS		
Radiation/Chemotherapy for Cancer ¹ (every 12 months)	\$10,000	\$15,000
Blood, Plasma, and Platelets ¹ (every 12 months)	\$10,000	\$15,000
Medical Imaging ¹	\$500	\$750
Hematological Drugs ¹	\$200	\$300
SURGERY AND RELATED BENEFITS		
Surgery ²	\$3,000	\$4,500
Anesthesia (% of surgery)	25%	25%
Ambulatory Surgical Center (daily)	\$500	\$750
Second Opinion	\$400	\$600
Bone Marrow or Stem Cell Transplant		
1. Autologous	\$1,000	\$1,500
2. Non-autologous (cancer or specified disease treatment)	\$2,500	\$3,750
3. Non-autologous (Leukemia)	\$5,000	\$7,500
MISCELLANEOUS BENEFITS		
Inpatient Drugs and Medicine (daily)	\$25	\$25
Physician's Attendance (daily)	\$50	\$50
Ambulance (per confinement)	\$100	\$100
Non-Local Transportation ¹ (per trip or mile)	Coach Fare or \$0.40/Mile	Coach Fare or \$0.40/Mile
Outpatient Lodging	\$50	\$50
Family Member Lodging (daily) and Transportation ¹ (per trip or mile)	\$50 Coach Fare or \$0.40/Mile	\$50 Coach Fare or \$0.40/Mile
Physical or Speech Therapy (daily)	\$50	\$50
New or Experimental Treatment ³ (every 12 months)	\$5,000	\$5,000
Prosthesis ³	\$2,000	\$2,000
Hair Prosthesis (every 2 years)	\$25	\$25
Nonsurgical External Breast Prosthesis ¹	\$50	\$50
Anti-Nausea Benefit ¹	\$200	\$200
Waiver of Premium (Employee only)	Yes	Yes
ADDITIONAL BENEFITS		
Cancer Initial Diagnosis (one-time benefit)	\$1,000	\$3,000
Wellness Benefit	\$50	\$50

¹Pays actual cost up to amount listed. ²Pays actual charges up to amount listed in certificate Schedule of Surgical Procedures. Amount paid depends on surgery. ³Pays actual charges up to amount listed.

PLAN 1 PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Bi-Weekly	\$9.64	\$14.76	\$13.66	\$18.76
Monthly	\$20.88	\$31.96	\$29.58	\$40.64

PLAN 2 PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Bi-Weekly	\$14.58	\$22.30	\$20.82	\$28.56
Monthly	\$31.56	\$48.32	\$45.11	\$61.86

EE = Employee; EE + SP = Employee + Spouse; EE + CH = Employee + Child(ren); F = Family



For use in enrollments situated in: GA. This rate insert is part of forms ABJ31043-Flyer and ABJ30590 and is not to be used on its own.

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