



Group Voluntary Cancer from Allstate Benefits

See attached Important Information About Coverage.

JM Smith Corporation

Offered to the employees of:

BENEFIT AMOUNTS

HOSPITAL AND RELATED BENEFITS

Continuous Hospital Confinement (daily)
 Government or Charity Hospital (daily)
 Private Duty Nursing Services (daily)
 Extended Care Facility (daily)
 At Home Nursing (daily)
 Hospice Care Center (daily) or
 Hospice Care Team (per visit)

	PLAN 1	PLAN 2	PLAN 3
Continuous Hospital Confinement (daily)	\$100	\$200	\$300
Government or Charity Hospital (daily)	\$100	\$200	\$300
Private Duty Nursing Services (daily)	\$100	\$200	\$300
Extended Care Facility (daily)	\$100	\$200	\$300
At Home Nursing (daily)	\$100	\$200	\$300
Hospice Care Center (daily) or Hospice Care Team (per visit)	\$100	\$200	\$300

RADIATION/CHEMOTHERAPY AND RELATED BENEFITS

Radiation/Chemotherapy for Cancer* (every 12 months)
 Blood, Plasma, and Platelets* (every 12 months)
 Medical Imaging*
 Hematological Drugs*

	PLAN 1	PLAN 2	PLAN 3
Radiation/Chemotherapy for Cancer* (every 12 months)	\$5,000	\$10,000	\$15,000
Blood, Plasma, and Platelets* (every 12 months)	\$5,000	\$10,000	\$15,000
Medical Imaging*	\$250	\$500	\$750
Hematological Drugs*	\$100	\$200	\$300

SURGERY AND RELATED BENEFITS

Surgery**
 Anesthesia (% of surgery)
 Ambulatory Surgical Center (daily)
 Second Opinion
 Bone Marrow or Stem Cell Transplant
 1. Autologous
 2. Non-autologous (cancer or specified disease treatment)
 3. Non-autologous (Leukemia)

	PLAN 1	PLAN 2	PLAN 3
Surgery**	\$1,500	\$3,000	\$4,500
Anesthesia (% of surgery)	25%	25%	25%
Ambulatory Surgical Center (daily)	\$250	\$500	\$750
Second Opinion	\$200	\$400	\$600
Bone Marrow or Stem Cell Transplant			
1. Autologous	\$500	\$1,000	\$1,500
2. Non-autologous (cancer or specified disease treatment)	\$1,250	\$2,500	\$3,750
3. Non-autologous (Leukemia)	\$2,500	\$5,000	\$7,500

MISCELLANEOUS BENEFITS

Inpatient Drugs and Medicine (daily)
 Physician's Attendance (daily)
 Ambulance (per confinement)
 Non-Local Transportation* (per trip or mile)
 Outpatient Lodging
 Family Member Lodging (daily)
 and Transportation* (per trip or mile)
 Physical or Speech Therapy (daily)
 New or Experimental Treatment*** (every 12 months)
 Prosthesis***
 Hair Prosthesis (every 2 years)
 Nonsurgical External Breast Prosthesis*
 Anti-Nausea Benefit*
 Waiver of Premium (Employee only)

	PLAN 1	PLAN 2	PLAN 3
Inpatient Drugs and Medicine (daily)	\$25	\$25	\$25
Physician's Attendance (daily)	\$50	\$50	\$50
Ambulance (per confinement)	\$100	\$100	\$100
Non-Local Transportation* (per trip or mile)	Coach Fare or \$0.40/Mile	Coach Fare or \$0.40/Mile	Coach Fare or \$0.40/Mile
Outpatient Lodging	\$50	\$50	\$50
Family Member Lodging (daily) and Transportation* (per trip or mile)	\$50	\$50	\$50
	Coach Fare or \$0.40/Mile	Coach Fare or \$0.40/Mile	Coach Fare or \$0.40/Mile
Physical or Speech Therapy (daily)	\$50	\$50	\$50
New or Experimental Treatment*** (every 12 months)	\$5,000	\$5,000	\$5,000
Prosthesis***	\$2,000	\$2,000	\$2,000
Hair Prosthesis (every 2 years)	\$25	\$25	\$25
Nonsurgical External Breast Prosthesis*	\$50	\$50	\$50
Anti-Nausea Benefit*	\$200	\$200	\$200
Waiver of Premium (Employee only)	Yes	Yes	Yes

ADDITIONAL BENEFITS

Cancer Initial Diagnosis (one-time benefit)
 Wellness Benefit

	PLAN 1	PLAN 2	PLAN 3
Cancer Initial Diagnosis (one-time benefit)	\$4,000	\$6,000	\$8,000
Wellness Benefit	\$100	\$100	\$100

For Internal Home Office use only

3Hosp; 6Rad; 3Surg; 1Misc; 8Init; OICU; 4Well; 0Prog

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

***Pays actual charges up to amount listed.

PREMIUMS PLAN 1

MODE	EE	EE + SP	EE + CH	F
Semi-Monthly	\$8.26	\$13.10	\$11.38	\$16.21

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

PREMIUMS PLAN 2

MODE	EE	EE + SP	EE + CH	F
Semi-Monthly	\$13.60	\$21.29	\$19.15	\$26.82

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

PREMIUMS PLAN 3

MODE	EE	EE + SP	EE + CH	F
Semi-Monthly	\$18.94	\$29.47	\$26.91	\$37.43

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



For use in enrollments situated in: SC. This rate insert is part of the approved flyer for JM Smith and form ABJ30590-1; it is not to be used on its own.

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