
 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at <https://www.myallsavers.com/MyAllSavers/Plan> or by calling 1-800-291-2634. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-291-2634 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,000 /Individual <u>Network</u> \$2,000 /Family <u>Network</u> Not Covered/Individual Out-of-Network Not Covered/Family Out-of-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.  If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$3,500 individual / \$7,000 family; for <u>out-of-network providers</u> Not covered individual / Not covered family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.  If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.myallsavers.com">www.myallsavers.com</a> or call 1-800-291-2634 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit <u>Deductible</u> does not apply.	Not covered	<u>Out-of-network providers</u> are not covered.
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Physician: 20% <u>coinsurance</u> Facility: 20% <u>coinsurance</u>	Physician: Not covered Facility: Not covered	<u>Out-of-network providers</u> are not covered. Sleep studies require a <u>Prior Authorization</u> or benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	Physician: 20% <u>coinsurance</u> Facility: 20% <u>coinsurance</u>	Physician: Not covered Facility: Not covered	<u>Out-of-network providers</u> are not covered. <u>Prior Authorization</u> is required. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service.

\* For more information about limitations and exceptions, see the plan or policy document at [www.myallsavers.com](http://www.myallsavers.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.myallsavers.com">www.myallsavers.com</a>	Tier 1 drugs	\$15 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply. \$38 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply.	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail prescription). If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> maybe applied. Certain drugs may have a <u>prior authorization</u> requirement. <u>Out-of-network pharmacies</u> are not covered.
	Tier 2 drugs	\$35 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply. \$88 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply.	Not covered	
	Tier 3 drugs	\$75 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply. \$188 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply.	Not covered	
	Tier 4 drugs	\$250 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply. \$625 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> are not covered. <u>Prior Authorization</u> is required. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: \$60 <u>copay</u> /visit <u>Deductible</u> does not apply. Surgeon: 20% <u>coinsurance</u>	Physician: Not covered Surgeon: Not covered	
<b>If you need immediate medical attention</b>	<u>Emergency room services</u>	Physician: 20% <u>coinsurance</u> Facility: \$300 <u>copay</u> /visit and 20% <u>coinsurance</u>	Physician: 20% <u>coinsurance</u> * Facility: \$300 <u>copay</u> /visit and 20% <u>coinsurance</u> *	<u>*Out-of-network emergency services</u> are covered at the <u>Network</u> benefit level.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> *	
	<u>Urgent care</u>	Physician: \$100 <u>copay</u> /visit <u>Deductible</u> does not apply. Facility: \$100 <u>copay</u> /visit <u>Deductible</u> does not apply.	Physician: Not covered Facility: Not covered	<u>Out-of-network providers</u> are not covered. One <u>copay</u> is applied per <u>network urgent care</u> visit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> are not covered. <u>Prior Authorization</u> is required. If you don't get <u>Prior Authorization</u> , benefits could be
	Physician/surgeon fees	Physician: \$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	Physician: Not covered Surgeon: Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.myallsavers.com](http://www.myallsavers.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Surgeon: 20% <u>coinsurance</u>		reduced by 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: \$60 <u>copay/visit</u> <u>Deductible</u> does not apply. Facility: 20% <u>coinsurance</u> for other outpatient services	Physician: Not covered Facility: Not covered	None
	Inpatient services	Physician: \$60 <u>copay/visit</u> <u>Deductible</u> does not apply. Facility: 20% <u>coinsurance</u>	Physician: Not covered Facility: Not covered	<u>Out-of-network providers</u> are not covered. <u>Prior Authorization</u> is required for inpatient services. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	Primary Care Visit: \$30 <u>copay/visit</u> <u>Deductible</u> does not apply.  Specialist Visit: \$60 <u>copay/visit</u> <u>Deductible</u> does not apply.	Not covered	<u>Out-of-network providers</u> are not covered. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Prior Authorization</u> is required for inpatient services. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	30 visits/year. <u>Prior Authorization</u> is required. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service. <u>Out-of-network providers</u> are not covered.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	30 combined visits/year for <u>rehabilitation</u> and <u>habilitation</u> services. Includes physical
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.myallsavers.com](http://www.myallsavers.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	60 visits/year. <u>Prior Authorization</u> is required. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> are not covered. <u>Prior Authorization</u> is required if greater than \$1000. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	<u>Out-of-network providers</u> are not covered. <u>Prior Authorization</u> is required. If you don't get <u>Prior Authorization</u> , benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

#### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or <u>plan</u> documents for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (adult)</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the United States</li> <li>• Out-of-network pharmacies</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (adult)</li> <li>• Routine foot care, and</li> <li>• Weight-loss programs</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [www.myallsavers.com](http://www.myallsavers.com).

**Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)**

- Acupuncture
- Chiropractic care, and
- Hearing aids

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Other options to continue coverage are available to you too, including individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: All Savers at 1-800-291-2634, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-291-2634.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-2634.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-291-2634.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-291-2634.

----- *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* -----

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$3,110</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,490</b>