
 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>? | \$2,500 /Individual <u>Network</u> \$5,000 /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 <u>your deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| 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> \$7,900 individual /\$15,800 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</u> charges, 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 www.myallsavers.com 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</u> charge 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> . |
|--|-----|--|

 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</u> office or clinic | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit <u>Deductible</u> does not apply. | Not covered | Under age 19 - <u>Network</u> visits are covered at No Charge. <u>Out-of-network providers</u> are not covered. |
| | <u>Specialist</u> visit | \$75 <u>copay</u> /visit <u>Deductible</u> does not apply. | Not covered | <u>Out-of-network providers</u> are 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.

| 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myallsavers.com | 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 90-day supply for retail and mail order pharmacies. One retail <u>copay</u> applies per 30-day retail 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> may be applied. Certain drugs may have a <u>prior authorization</u> requirement. <u>Out-of-network pharmacies</u> are not covered. |
| | Tier 2 drugs | \$50 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply. \$125 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply. | Not covered | |
| | Tier 3 drugs | \$150 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply. \$375 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply. | Not covered | |
| | Tier 4 drugs | \$300 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply. \$750 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply. | Not covered | |
| If you have outpatient surgery | 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: \$75 <u>copay</u> /visit <u>Deductible</u> does not apply. Surgeon: 20% <u>coinsurance</u> | Physician: Not covered Surgeon: Not covered | |
| If you need immediate medical attention | <u>Emergency room services</u> | ER Physician: 20% <u>coinsurance</u> Facility: \$300 <u>copay</u> /visit and 20% <u>coinsurance</u> | ER 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> | <u>Urgent Care</u> Physician: \$50 <u>copay</u> /visit <u>Deductible</u> does not apply. Facility: \$50 <u>copay</u> /visit <u>Deductible</u> does not apply. | <u>Urgent Care</u> Physician: Not covered Facility: Not covered | <u>Out-of-network providers</u> are not covered. One <u>copay</u> is applied between the physician charge and the facility charge for <u>urgent care</u> visits. Lab, x-rays or diagnostic testing are not included in the <u>urgent care copay</u> |

* For more information about limitations and exceptions, see the plan or policy document at 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) | |
| | | | | and are subject to the applicable benefit for these services. |
| If you have a hospital stay | 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 reduced by 50% of the total cost of the service. |
| | Physician/surgeon fees | Physician: \$75 <u>copay</u> /visit <u>Deductible</u> does not apply. Surgeon: 20% <u>coinsurance</u> | Physician: Not covered Surgeon: Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Physician: \$75 <u>copay</u> /visit <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: \$75 <u>copay</u> /visit <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: \$25 <u>copay</u> /visit <u>Deductible</u> does not apply. Specialist Visit: \$75 <u>copay</u> /visit <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 | <u>Home health care</u> | 20% <u>coinsurance</u> | Not covered | 30 visits/year. <u>Prior Authorization</u> |

* For more information about limitations and exceptions, see the plan or policy document at 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) | |
| recovering or have other special health needs | | | | 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 therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy. |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | Not covered | |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | Not covered | |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | Not covered | |
| | <u>Hospice services</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>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>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 | |

* For more information about limitations and exceptions, see the plan or policy document at www.myallsavers.com.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan documents for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Out-of-network pharmacies
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- Weight-loss programs

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
- 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. 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 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 on how 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.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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, kwijigo holne' 1-800-291-2634

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

* For more information about limitations and exceptions, see the plan or policy document at www.myallsavers.com.

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 \$2,500
- Specialist copayment \$75
- 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)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,500 |
| <u>Copayments</u> | \$50 |
| <u>Coinsurance</u> | \$1,700 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Peg would pay is | \$4,270 |

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

- The plan's overall deductible \$2,500
- Specialist copayment \$75
- 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)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$90 |
| <u>Copayments</u> | \$800 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$910 |

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

- The plan's overall deductible \$2,500
- Specialist copayment \$75
- 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)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,800 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,300 |