



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://www.myallsavers.com/MyAllSavers/Plan> or by calling 1-800-291-2634.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	Individual network: Family network: Individual out-of-network: Family out-of-network: Deductibles are per calendar year. Premiums, co-payments, co-insurance, and preventive services don't count toward the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?		
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Individual network: Family network: Individual out-of-network: Family out-of-network:	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u>?	Yes. To find a provider in the network, see www.myallsavers.com or call 1-800-291-2634.	If you use a network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network provider for some services. Plans use the term network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you visit a health care <u>provider’s</u> office or clinic	Primary care visit to treat an injury or illness	co-pay	deductible, and co-insurance	--- none ---
	Specialist visit	co-pay	deductible, and co-insurance	
	Other practitioner office visit	co-pay	deductible, and co-insurance	
	Preventive care/screening/immunization	No charge	deductible, and co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	deductible, and co-insurance	--- none ---
	Imaging (CT/PET scans, MRIs)	deductible, and co-insurance	deductible, and co-insurance	

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Plan : All Savers Alternate Funding
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: –
Coverage for: | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myallsavers.com	Tier 1 drugs	pharmacy deductible, and Tier 1 retail co-pay per prescription, or mail-order co-pay per prescription	Out-of-network pharmacies are not covered	Retail prescriptions: 30-day supply
	Tier 2 drugs	pharmacy deductible, and Tier 2 retail co-pay per prescription, or mail-order co-pay per prescription	Out-of-network pharmacies are not covered	Mail-order prescriptions: 31- to 90-day supply
	Tier 3 drugs	pharmacy deductible, and Tier 3 retail co-pay per prescription, or mail-order co-pay per prescription	Out-of-network pharmacies are not covered	If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable co-pay and/or co-ins may be applied.
	Tier 4 drugs	pharmacy deductible, and Tier 4 retail co-pay per prescription Mail-order co-pay per prescription	Out-of-network pharmacies are not covered	Out-of-network pharmacies are not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	deductible, and co-insurance	deductible, and co-insurance	--- none ---
	Physician/surgeon fees	deductible, and co-insurance	deductible, and co-insurance	

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Plan

: All Savers Alternate Funding

Coverage Period: —

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for:

Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you need immediate medical attention	Emergency room services	co-pay	co-pay*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	deductible, and co-insurance	deductible, and co-insurance*	
	Urgent care	co-pay	deductible, and co-insurance	--- none ---
If you have a hospital stay	Facility fee (e.g., hospital room)	deductible, and co-insurance	deductible, and co-insurance	--- none ---
	Physician/surgeon fee	Physician: co-pay per visit Surgeon: deductible, and co-insurance	deductible, and co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Physician: co-pay per visit Facility: deductible, and co-insurance	deductible, and co-insurance	--- none ---
	Mental/Behavioral health inpatient services	Physician: co-pay per visit Facility: deductible, and co-insurance	deductible, and co-insurance	
	Substance use disorder outpatient services	Physician: co-pay per visit Facility: deductible, and co-insurance	deductible, and co-insurance	
	Substance use disorder inpatient services	Physician: co-pay per visit Facility: deductible, and co-insurance	deductible, and co-insurance	
If you are pregnant	Prenatal and postnatal care	co-pay	deductible, and co-insurance	--- none ---
	Delivery and all inpatient services	deductible, and co-insurance	deductible, and co-insurance	

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you need help recovering or have other special health needs	Home health care	deductible, and co-insurance	deductible, and co-insurance	30 visit limit/calendar year
	Rehabilitation services	deductible, and co-insurance	deductible, and co-insurance	visit limit/calendar year
	Habilitation services	deductible, and co-insurance	deductible, and co-insurance	Combined with Rehab limit
	Skilled nursing care	deductible, and co-insurance	deductible, and co-insurance	visit limit/calendar year
	Durable medical equipment	deductible, and co-insurance	deductible, and co-insurance	--- none ---
	Hospice service	deductible, and co-insurance	deductible, and co-insurance	--- none ---
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--- none ---
	Glasses	Not covered	Not covered	--- none ---
	Dental check-up	Not covered	Not covered	--- none ---

Excluded Services & Other Covered Services:

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

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

- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-291-2634. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays
- Patient pays

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays
- Patient pays

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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