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 deductible?	$5,000 /Individual Network $10,000 /Family Network $10,000 /Individual Out-of-Network $20,000 /Family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $8,150 individual / $16,300 family; for out-of-network providers $16,300 individual / $32,600 family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	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.
Will you pay less if you use a network provider?	Yes. See www.myallsavers.com or call 1-800-291-2634 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply.	50% coinsurance	None
	Specialist visit	$75 copay/visit Deductible does not apply.	50% coinsurance	
	Preventive care/screening/ immunizations	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Physician: 20% coinsurance Facility: 20% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	Sleep studies require a Prior Authorization or benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	Physician: 20% coinsurance Facility: 20% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.

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	$10 retail copay, deductible does not apply. $25 mail-order copay, deductible does not apply. $ 10 specialty copay, deductible does not apply.	$10 retail copay, deductible does not apply. $25 mail-order copay, deductible does not apply. $ 10 specialty copay, deductible does not apply.	Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay 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 copay and/or coinsurance may be applied. Certain drugs may have a prior authorization requirement. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.
	Tier 2 drugs	$35 retail copay, deductible does not apply. $88 mail-order copay, deductible does not apply. $ 35 specialty copay, deductible does not apply.	$35 retail copay, deductible does not apply. $88 mail-order copay, deductible does not apply. $ 35 specialty copay, deductible does not apply.	
	Tier 3 drugs	$75 retail copay, deductible does not apply. $188 mail-order copay, deductible does not apply. $ 75 specialty copay, deductible does not apply.	$75 retail copay, deductible does not apply. $188 mail-order copay, deductible does not apply. $ 75 specialty copay, deductible does not apply.	
	Tier 4 drugs	$250 retail copay, deductible does not apply. $625 mail-order copay, deductible does not apply. $ 500specialty copay, deductible does not apply.	$250 retail copay, deductible does not apply. $625 mail-order copay, deductible does not apply. $ 500specialty copay, deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: $75 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	
If you need immediate medical attention	Emergency room services	ER Physician: 20% coinsurance Facility: $300 copay/visit and 20% coinsurance	ER Physician: 20% coinsurance* Facility: $300 copay/visit and 20% coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	One copay is applied between the physician charge and the

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)	
	Urgent care	Urgent Care Physician: $50 copay/visit Deductible does not apply. Facility: $50 copay/visit Deductible does not apply.	Urgent Care Physician: 50% coinsurance Facility: 50% coinsurance	facility charge for urgent care visits. Lab, x-rays or diagnostic testing are not included in the urgent care copay and are subject to the applicable benefit for these services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: $75 coinsurance Surgeon: 20% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 20% coinsurance for other outpatient services	Physician: 50% coinsurance Facility: 50% coinsurance or other outpatient services	None
	Inpatient services	Physician: 20% coinsurance Facility: 20% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	Primary Care Visit: $25 copay/visit Deductible does not apply. Specialist Visit: $75 copay/visit Deductible does not apply.	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	30 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost

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)	
				of the service.
	Rehabilitation services	20% coinsurance	50% coinsurance	30 combined visits/year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	60 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior Authorization is required if greater than $1000. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	20% coinsurance	50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, 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 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
- 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, kwiijigo 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	$5,000
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:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,770

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

The plan's overall deductible	$5,000
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:

Cost Sharing	
Deductibles	$300
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,400

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

The plan's overall deductible	$5,000
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:

Cost Sharing	
Deductibles	$2,600
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,700

The plan would be responsible for the other costs of these EXAMPLE covered services.