



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.mylsavers.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?                             | \$500 /Individual Network<br>\$1,000 /Family Network<br>\$1,000 /Individual Out-of-Network<br>\$2,000 /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 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                   |
| 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 \$3,000 individual / \$6,000 family; for out-of-network providers \$6,000 individual / \$12,000 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 <a href="https://www.mylsavers.com">www.mylsavers.com</a> 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                                   | No.                                                                                                                          | You can see the specialist you choose without a referral.                                                                                                                                                                                                                                                                                                                                                                                                            |

| <div>  All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies. </div> |                                                        |                                                                                                                                                                  |                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                                                                                                                                                                                                  | Services You May Need                                  | What You Will Pay                                                                                                                                                |                                                                                                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                       |                                                        | Network Provider<br>(You will pay the least)                                                                                                                     | Out-of-Network Provider<br>(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       | \$30 <u>copay/visit</u><br><u>Deductible</u> does not apply.                                                                                                     | 50% <u>coinsurance</u>                                                                                                                                           | None                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                       | <u>Specialist</u> visit                                | \$30 <u>copay/visit</u><br><u>Deductible</u> does not apply.                                                                                                     | 50% <u>coinsurance</u>                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                       | <u>Preventive</u> care/ <u>screening</u> /immunization | No charge                                                                                                                                                        | 50% <u>coinsurance</u>                                                                                                                                           | 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 plan will pay for.                                                                                                                                                                                                                                                    |
| If you have a test                                                                                                                                                                                                                                    | <u>Diagnostic test</u> (x-ray, blood work)             | Physician: No charge<br>Facility: No charge                                                                                                                      | Physician: 50% <u>coinsurance</u><br>Facility: 50% <u>coinsurance</u>                                                                                            | 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><br>Facility: 20% <u>coinsurance</u>                                                                                            | Physician: 50% <u>coinsurance</u><br>Facility: 50% <u>coinsurance</u>                                                                                            | <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 you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.mysallsaunders.com">www.mysallsaunders.com</a>                                                   | Tier 1 drugs                                           | \$10 retail <u>copay/prescription</u> , or <u>Deductible</u> does not apply.<br>\$25 mail-order <u>copay/ prescription</u><br><u>Deductible</u> does not apply.  | \$10 retail <u>copay/prescription</u> , or <u>Deductible</u> does not apply.<br>\$25 mail-order <u>copay/ prescription</u><br><u>Deductible</u> does not apply.  | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail prescription).<br>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.<br>Certain drugs may have a <u>prior authorization</u> requirement.<br>If you use an <u>out-of-network pharmacy</u> (including a mail order |
|                                                                                                                                                                                                                                                       | Tier 2 drugs                                           | \$35 retail <u>copay/prescription</u> , or <u>Deductible</u> does not apply.<br>\$88 mail-order <u>copay/ prescription</u><br><u>Deductible</u> does not apply.  | \$35 retail <u>copay/prescription</u> , or <u>Deductible</u> does not apply.<br>\$88 mail-order <u>copay/ prescription</u><br><u>Deductible</u> does not apply.  |                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                       | Tier 3 drugs                                           | \$60 retail <u>copay/prescription</u> , or <u>Deductible</u> does not apply.<br>\$150 mail-order <u>copay/ prescription</u><br><u>Deductible</u> does not apply. | \$60 retail <u>copay/prescription</u> , or <u>Deductible</u> does not apply.<br>\$150 mail-order <u>copay/ prescription</u><br><u>Deductible</u> does not apply. |                                                                                                                                                                                                                                                                                                                                                                                                                                       |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                                                                                                                               |                                                                                                                                                                 | Limitations, Exceptions, & Other Important Information                                                                                    |
|---------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Network Provider<br>(You will pay the least)                                                                                                                    | Out-of-Network Provider<br>(You will pay the most)                                                                                                              |                                                                                                                                           |
| If you have outpatient surgery                                            | Tier 4 drugs                                   | \$200 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply.<br>\$500 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply. | \$200 retail <u>copay</u> /prescription, or <u>Deductible</u> does not apply.<br>\$500 mail-order <u>copay</u> / prescription <u>Deductible</u> does not apply. | pharmacy), you may be responsible for any amount over the <u>allowed amount</u> .                                                         |
|                                                                           | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                          | 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: \$30 <u>copay</u> /visit<br><u>Deductible</u> does not apply.<br>Surgeon: 20% <u>coinsurance</u>                                                     | Physician: 50% <u>coinsurance</u><br>Surgeon: 20% <u>coinsurance</u>                                                                                            |                                                                                                                                           |
| If you need immediate medical attention                                   | <u>Emergency room services</u>                 | Physician: 20% <u>coinsurance</u><br>Facility: \$300 <u>copay</u> /visit and 20% <u>coinsurance</u>                                                             | Physician: 20% <u>coinsurance</u> *<br>Facility: \$300 <u>copay</u> /visit and 20% <u>coinsurance</u> *                                                         | *Out-of-network emergency services are covered at the Network benefit level.                                                              |
|                                                                           | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                                                                                                                          | 50% <u>coinsurance</u> *                                                                                                                                        |                                                                                                                                           |
|                                                                           | <u>Urgent care</u>                             | Physician: \$100 <u>copay</u> /visit<br><u>Deductible</u> does not apply.<br>Facility: \$100 <u>copay</u> /visit<br><u>Deductible</u> does not apply.           | Physician: 50% <u>coinsurance</u><br>Facility: 50% <u>coinsurance</u>                                                                                           | One <u>copay</u> is applied per network urgent care visit.                                                                                |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                          | 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: \$30 <u>copay</u> /visit<br><u>Deductible</u> does not apply.<br>Surgeon: 20% <u>coinsurance</u>                                                     | Physician: 50% <u>coinsurance</u><br>Surgeon: 50% <u>coinsurance</u>                                                                                            |                                                                                                                                           |
|                                                                           | Outpatient services                            | Physician: \$30 <u>copay</u> /visit<br><u>Deductible</u> does not apply.<br>Facility: 20% <u>coinsurance</u> for other outpatient services                      | Physician: 50% <u>coinsurance</u><br>Facility: 50% <u>coinsurance</u> for other outpatient services                                                             |                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Inpatient services                             | Physician: \$30 <u>copay</u> /visit<br><u>Deductible</u> does not apply.<br>Facility: 20% <u>coinsurance</u>                                                    | Physician: 50% <u>coinsurance</u><br>Facility: 50% <u>coinsurance</u>                                                                                           | Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service. |
|                                                                           | Office visits                                  | Primary Care Visit: \$30 <u>copay</u> /visit<br><u>Deductible</u> does not apply.<br>Specialist Visit: \$30 <u>copay</u> /visit                                 | Primary Care Visit: 50% <u>coinsurance</u><br>Specialist Visit: 50% <u>coinsurance</u>                                                                          | Cost sharing does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply.      |

\* 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                             |
| If you need help recovering or have other special health needs |                                           | <u>Deductible</u> does not 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>                       | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                             |
|                                                                | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                       | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                             |
|                                                                | <u>Home health care</u>                   | 20% <u>coinsurance</u>                       | 50% <u>coinsurance</u>                             | 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>Rehabilitation services</u>            | 20% <u>coinsurance</u>                       | 50% <u>coinsurance</u>                             | 30 combined visits/year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-rehabilitation therapy, cochlear implant aural therapy, and cognitive rehabilitation therapy. |
|                                                                | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                       | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                             |
|                                                                | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                       | 50% <u>coinsurance</u>                             | 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>                       | 50% <u>coinsurance</u>                             | <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.                                                                                                                             |

| Common Medical Event                   | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                   |
|----------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                          |
|                                        | <u>Hospice services</u>    | 20% <u>coinsurance</u>                       | 50% <u>coinsurance</u>                             | <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 plan 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>Private-duty nursing</li> <li>Routine eye care (adult)</li> <li>Routine foot care, and</li> <li>Weight-loss programs</li> </ul> |
| Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)                      |                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Chiropractic care, and</li> </ul>                                                             | <ul style="list-style-type: none"> <li>Hearing aids</li> </ul>                                                                                                                                                                                                      |

**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.

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



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): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-291-2634.

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*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\$500
- Specialist copayment\$30
- Hospital (facility) coinsurance20%
- Other coinsurance20%

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              | \$12,800 |
| In this example, Peg would pay: |          |
| Cost Sharing                    |          |
| Deductibles                     | \$500    |
| Copayments                      | \$100    |
| Coinsurance                     | \$2,000  |
| What isn't covered              |          |
| Limits or exclusions            | \$10     |
| The total Peg would pay is      | \$2,610  |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible\$500
- Specialist copayment\$30
- Hospital (facility) coinsurance20%
- Other coinsurance20%

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              | \$7,400 |
| In this example, Joe would pay: |         |
| Cost Sharing                    |         |
| Deductibles                     | \$0     |
| Copayments                      | \$1,000 |
| Coinsurance                     | \$0     |
| What isn't covered              |         |
| Limits or exclusions            | \$20    |
| The total Joe would pay is      | \$1,020 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible\$500
- Specialist copayment\$30
- Hospital (facility) coinsurance20%
- Other coinsurance20%

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              | \$1,900 |
| In this example, Mia would pay: |         |
| Cost Sharing                    |         |
| Deductibles                     | \$500   |
| Copayments                      | \$400   |
| Coinsurance                     | \$200   |
| What isn't covered              |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$1,100 |

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