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 www.myallsavers.com or by calling 1-800-291-2634. For 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?	$2,000 /Individual Network $4,000 /Family Network Not Covered /Individual Out-of-Network Not Covered /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. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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 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 $4,000 individual / $8,000 family For out-of-network providers: Not Covered individual / Not Covered family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-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.

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	Not covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. Under age 19 – Network visits are covered at No Charge.
	Specialist visit	$75 copay/visit, deductible does not apply	Not covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not covered	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: 0% coinsurance Facility: 0% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	Physician: 0% coinsurance Facility: 0% coinsurance	Not covered	None
If you need drugs to treat your illness or condition	Tier 1 drugs	Retail: $10 copay, deductible does not apply Mail-Order: $25 copay, deductible does not apply Specialty: $10 copay, deductible does not apply	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 90 day supply. Mail-Order: Up to a 90 day supply. Specialty: Up to a 31 day supply. One retail copay applies per 31-day retail prescription. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.
	Tier 2 drugs	Retail: $35 copay, deductible does not apply Mail-Order: $88 copay, deductible does not apply Specialty: $150 copay, deductible does not apply	Not covered	

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)	
More information about **prescription drug coverage** is available at www.myallsavers.com	Tier 3 drugs	Retail: $75 copay, deductible does not apply Mail-Order: $188 copay, deductible does not apply Specialty: $350 copay, deductible does not apply	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 copay and/or coinsurance may be applied. Certain drugs may have a preauthorization requirement. Out-of-network pharmacies are not covered.
	Tier 4 drugs	Retail: $250 copay, deductible does not apply Mail-Order: $625 copay, deductible does not apply Specialty: $500 copay, deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	None
	Physician/surgeon fees	Physician: $75 copay/visit, deductible does not apply Surgeon: 0% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	ER Physician: 0% coinsurance Facility: $300 copay/visit and 0% coinsurance	ER Physician: 0% coinsurance* Facility: $300 copay/visit and 0% coinsurance*	*Out-of-Network emergency services are covered at the network benefit level.
	Emergency medical transportation	0% coinsurance	0% coinsurance*	
	Urgent Care	Urgent Care Physician: $50 copay/visit,* deductible does not apply Facility: $50 copay/visit*, deductible does not apply	Not covered	*One copay is applied between the physician charge and the facility charge for urgent care visits. If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	None
	Physician/surgeon fees	Physician: 0% coinsurance Surgeon: 0% coinsurance	Not covered	

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 mental health behavioral health, or substance abuse services.	Outpatient services	Physician: $75 copay/visit deductible does not apply Facility: 0% coinsurance for other outpatient services	Not covered	Network partial hospitalization/intensive outpatient treatment: 0% coinsurance, after deductible
	Inpatient services	Physician: 0% coinsurance Facility: 0% coinsurance	Not covered	None
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	Not covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	Not covered	
	Childbirth/delivery facility services	0% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Limited to 30 visits per year.
	Rehabilitation services	0% coinsurance	Not covered	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	0% coinsurance	Not covered	

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)	
	Skilled nursing care	0% coinsurance	Not covered	Limited to 60 days per year, combined with Inpatient Rehabilitation and Residential Treatment.
	Durable medical equipment	0% coinsurance	Not covered	None
	Hospice service	0% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Bariatric surgery	• Cosmetic surgery	• Non-emergency care when traveling outside the United States	• Weight-loss programs
• Children's eye exam	• Dental care (adult)	• Private-duty nursing	
• Children's dental check-up	• Infertility Treatments	• Routine eye care (adult)	
• Children's glasses	• Long-term care	• Routine foot care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture – 10 visits/year	• Chiropractic Care – 20 visits/year	• Hearing aids – Limited to $5,000 in Allowed Amounts every 36 months

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. Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia State Corporation Commission at 877-310-6560 or email bureauofinsurance@scc.virginia.gov.

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** $2,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 100%
- **Other coinsurance** 100%

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	$2,000
Copayments	$10
Coinsurance	$90
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,160

Managing Joe's type 2 Diabetes

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

- **The plan's overall deductible:** $2,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 100%
- **Other coinsurance** 100%

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:** $2,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 100%
- **Other coinsurance** 100%

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	$2,000
Copayments	$100
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,110

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