**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?** | $5,000 / Individual Network<br>$10,000 / Family Network<br>$10,000 / Individual Out-of-Network<br>$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. 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 $6,900 individual / $13,800 family; For out-of-network providers $20,000 individual / $40,000 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, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services. | 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 and 0% coinsurance | 50% coinsurance | None |
| | Specialist visit | $75 copay/visit and 0% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/ immunization | 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: 0% coinsurance<br>Facility: 0% coinsurance | Physician: 50% coinsurance<br>Facility: 50% coinsurance | Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount. |
| | Imaging (CT/PET scans, MRIs) | Physician: 0% coinsurance<br>Facility: 0% coinsurance | Physician: 50% coinsurance<br>Facility: 50% coinsurance | Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 50% coinsurance | Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount. |
| | Physician/surgeon fees | Physician: $75 copay/visit and 0% coinsurance<br>Surgeon: 0% coinsurance | Physician: 50% coinsurance<br>Surgeon: 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | ER Physician: 0% coinsurance<br>Facility: $300 copay/visit and 0% coinsurance | ER Physician: 0% coinsurance*<br>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 and 0% coinsurance*<br>Facility: $50 copay/visit and 0% coinsurance* | Urgent Care Physician: 50% coinsurance<br>Facility: 50% coinsurance | *One copay is applied between the physician charge and the facility charge for urgent care visits.<br>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 | 50% coinsurance | Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount. |
| | Physician/surgeon fees | Physician: 0% coinsurance<br>Surgeon: 0% coinsurance | Physician: 50% coinsurance<br>Surgeon: 50% coinsurance | |

| 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 and 0% coinsurance<br>Facility: 0% coinsurance for other outpatient services | Physician: 50% coinsurance<br>Facility: 50% coinsurance for other outpatient services | Network partial hospitalization/intensive outpatient treatment: 0% coinsurance, after deductible |
| | Inpatient services | Physician: 0% coinsurance<br>Facility: 0% coinsurance | Physician: 50% coinsurance<br>Facility: 50% coinsurance | None |
| **If you are pregnant** | Office visits | Primary Care Visit: $25 copay/visit and 0% coinsurance<br>Specialist Visit: $75 copay/visit and 0% coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply.<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).<br>Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount. |
| | Childbirth/delivery professional services | 0% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 0% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | 50% coinsurance | Limited to 30 visits per year. |
| | Rehabilitation services | 0% 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 | 0% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 0% coinsurance | 50% coinsurance | Limited to 60 days per year, combined with Inpatient Rehabilitation and Residential Treatment. |

| 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) | |
| | Durable medical equipment | 0% coinsurance | 50% coinsurance | Preauthorization required non-network for DME over $1,000 or benefit reduces to 50% of allowed amount. |
| | Hospice service | 0% coinsurance | 50% coinsurance | Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount. |
| **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** $5,000
- **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 | $5,000 |
| Copayments | $10 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $5,150 |

## 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** 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 | $5,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | $5,000 |

## 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** 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 | $2,700 |
| Copayments | $0 |
| 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