



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 <u>Network</u> \$4,000 / Family <u>Network</u> \$4,000 / Individual Out-of-Network \$8,000 / Family Out-of-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> \$4,000 individual / \$8,000 family; For <u>out-of-network providers</u> \$8,000 individual / \$16,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balanced-billed</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>Network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>copay/visit</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. Under age 19 – <u>Network</u> visits are covered at No Charge.
	<u>Specialist</u> visit	\$75 <u>copay/visit</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	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 <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Physician: 0% <u>coinsurance</u> Facility: 0% <u>coinsurance</u>	Physician: 50% <u>coinsurance</u> Facility: 50% <u>coinsurance</u>	Preauthorization required non-network for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Imaging (CT/PET scans, MRIs)	Physician: 0% <u>coinsurance</u> Facility: 0% <u>coinsurance</u>	Physician: 50% <u>coinsurance</u> Facility: 50% <u>coinsurance</u>	Preauthorization required non-network for certain services or benefit reduces to 50% of <u>allowed amount</u> .
If you need drugs to treat your illness or condition	Tier 1 drugs	Retail: \$10 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$25 <u>copay</u> , <u>deductible</u> does not apply. Specialty: \$10 <u>copay</u> , <u>deductible</u> does not apply.	Retail: \$10 <u>copay</u> , <u>deductible</u> does not apply.* Mail: \$25 <u>copay</u> , <u>deductible</u> does not apply.* Specialty: \$10 <u>copay</u> , <u>deductible</u> does not apply.*	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 <u>copay</u> applies per 31-day retail prescription.
	Tier 2 drugs	Retail: \$35 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$88 <u>copay</u> , <u>deductible</u> does not apply. Specialty: \$150 <u>copay</u> , <u>deductible</u> does not apply	Retail: \$35 <u>copay</u> , <u>deductible</u> does not apply.* Mail-Order: \$88 <u>copay</u> , <u>deductible</u> does not apply.* Specialty: \$150 <u>copay</u> , <u>deductible</u> does not apply*	You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.

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 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$188 <u>copay</u> , <u>deductible</u> does not apply. Specialty: \$350 <u>copay</u> , <u>deductible</u> does not apply	Retail: \$75 <u>copay</u> , <u>deductible</u> does not apply.* Mail-Order: \$188 <u>copay</u> , <u>deductible</u> does not apply.* Specialty: \$350 <u>copay</u> , <u>deductible</u> does not apply*	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. Certain drugs may have a <u>preauthorization</u> requirement. *If you use an <u>out-of-network pharmacy</u> (including a mail-order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> .
	Tier 4 drugs	Retail: \$250 <u>copay</u> , <u>deductible</u> does not apply. Mail-Order: \$625 <u>copay</u> , <u>deductible</u> does not apply. Specialty: \$500 <u>copay</u> , <u>deductible</u> does not apply	Retail: \$250 <u>copay</u> , <u>deductible</u> does not apply.* Mail-Order: \$625 <u>copay</u> , <u>deductible</u> does not apply.* Specialty: \$500 <u>copay</u> , <u>deductible</u> does not apply*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required non-network for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	Physician: \$75 <u>copay</u> /visit, <u>deductible</u> does not apply Surgeon: 0% <u>coinsurance</u>	Physician: 50% <u>coinsurance</u> Surgeon: 50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	ER Physician: 0% <u>coinsurance</u> Facility: \$300 <u>copay</u> /visit, and 0% <u>coinsurance</u>	ER Physician: 0% <u>coinsurance</u> * Facility: \$300 <u>copay</u> /visit, and 0% <u>coinsurance</u> *	* <u>Out-of-Network emergency services</u> are covered at the <u>Network</u> benefit level. *One <u>copay</u> is applied between the physician charge and the facility charge for <u>urgent care</u> visits. If you receive services in addition to <u>urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u> *	
	<u>Urgent Care</u>	<u>Urgent Care</u> Physician: \$50 <u>copay</u> /visit*, <u>deductible</u> does not apply Facility: \$50 <u>copay</u> /visit*, <u>deductible</u> does not apply	<u>Urgent Care</u> Physician: 50% <u>coinsurance</u> Facility: 50% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required non-network for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	Physician: 0% <u>coinsurance</u> Surgeon: 0% <u>coinsurance</u>	Physician: 50% <u>coinsurance</u> Surgeon: 50% <u>coinsurance</u>	

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 <u>copay/visit</u> , <u>deductible</u> does not apply Facility: 0% <u>coinsurance</u> for other outpatient services	Physician: 50% <u>coinsurance</u> Facility: 50% <u>coinsurance</u> for other outpatient services	<u>Network</u> partial hospitalization/intensive outpatient treatment 0% <u>coinsurance</u> , after <u>deductible</u>
	Inpatient services	Physician: 0% <u>coinsurance</u> Facility: 0% <u>coinsurance</u>	Physician: 50% <u>coinsurance</u> Facility: 50% <u>coinsurance</u>	None
If you are pregnant	Office visits	Primary Care Visit: \$25 <u>copay/visit</u> , <u>deductible</u> does not apply Specialist Visit: \$75 <u>copay/visit</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization required non-network for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Childbirth/delivery professional services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 30 visits per year.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	30 combined visits/year for <u>rehabilitation</u> and <u>habilitation</u> services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	

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)	
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 days per year, combined with Inpatient Rehabilitation and Residential Treatment.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required non-network for DME over \$1,000 or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Hospice service</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required non-network for certain services or benefit reduces to 50% of <u>allowed amount</u> .
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.)

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|------------------------------|--------------------------|---|------------------------|
| • 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.)

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| • Acupuncture – 10 visits/year | • Chiropractic Care – 20 visits/year | • Hearing aids – Limited to \$5,000 in Allowed Amounts every 36 months |
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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, kwijigo 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
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
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In this example, Joe would pay

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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
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In this example, Mia would pay

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,110

