Plan Highlights HE2850Rx10i80
All Savers® Alternate Funding

Note: This is only an illustration of the plan; it is not a complete list of benefits and limitations. Always refer to the most recent Summary Plan Description for current information about benefits, provisions, exclusions and limitations in your plan.

When you receive your health plan ID card in the mail, use it to register for the member website at **myallsaversconnect.com**. You can learn more about your coverage and track claims and explanation-of-benefits statements throughout the year.

This plan does not cover out-of-network services.

What are some of the benefits?

		Network Options	Out-of-Network Options
Copayments (Dependent on plan selected)	Copayments applied after deductible has been met.[2] • Level 1: Office visits • Level 2: Specialist office visits • Level 3: Urgent care visits • Level 4: Emergency room visits[1]	• Level 1: $0 • Level 2: $0 • Level 3: $0 • Level 4: $0	Not applicable
Deductibles	The amounts shown are individual deductibles. Family deductibles are 2 times the individual deductible.	$2,850	Not applicable
Coinsurance Rates	The rates shown are the percentage the medical benefit pays.	80%	Not applicable
Out-of-Pocket Limits	The amounts shown are individual limits. Family out-of-pocket limits are 2 times the individual limit.	$6,550	Not applicable
Pharmacy Copayments[4] (Dependent on plan selected)	Copayments applied after deductible has been met.[2] Drug tiers are based on cost. • Tier 1 • Tier 2 • Tier 3 • Tier 4	• Tier 1: $10 • Tier 2: $35 • Tier 3: $60 • Tier 4: $100	Not applicable
Lifetime Maximum	There is no lifetime maximum for eligible covered services.	Not applicable	

CONTINUED

Reimbursement of covered services

		Network Options	Out-of-Network Options
Preventive Care	• Wellness visits • Immunizations • Preventive screenings	100% covered	Not applicable
Copayment Levels 1–4 (Dependent on plan selected)	Copayments applied after deductible has been met.[2] • Level 1: Office visits • Level 2: Specialist office visits • Level 3: Urgent care visits • Level 4: Emergency room visits[1]	**Deductible; then coinsurance**	Not applicable
No Copayments	• Major diagnostics (CT scan, MRI, etc.) • Minor diagnostics (lab and X-ray) - covered at 100% after deductible has been met for network services • Inpatient facility • Outpatient facility • Ambulance (air or ground)[1] • Rehabilitation/physical therapy • Home health care • Skilled nursing • Transplants • Prosthetics • Durable medical equipment	Deductible; then coinsurance	Not applicable
Prescription Drugs[3,4] (Copayment is dependent on plan selected)	• Retail pharmacy prescriptions (30-day) • Mail-order prescriptions (90-day); copayments are 2.5 times the retail pharmacy copayment/coinsurance • Prescription copayment applied after the deductible has been met[2]	**Deductible; then coinsurance**	Not applicable

The following benefits apply to all All Savers plans:

Rehabilitation and Habilitative Outpatient Therapy[5]	Manipulation	Acupuncture	Home Health	Skilled Nursing
30 visits	20 visits	10 visits	30 visits	60 visits

10/2/2019 10:57 AM

HSA EPO Plan HE2850Rx10i80

[1] EPO plans exclude coverage for services provided by Out-of-Network Providers with the exception of (1) Services performed in a Network Facility by an out-of-network pathologist, emergency room physician, anesthesiologist, radiologist or assistant surgeons; and (2) Services performed under the Emergency Care benefit.

[2] Copayments on HSA plans (where applicable) will be required after the deductible has been met and will continue to be required until the annual out-of-pocket limit is met.

[3] Ancillary charge may apply when a covered prescription drug product is dispensed and there is another drug that is chemically the same available at a lower tier. You will pay the difference between the higher tiered drug and the lower tiered drug in addition to your copayment annual deductible and/or coinsurance that applies to the lowest tiered drug. An ancillary charge does not apply to any out-of-pocket limit.

[4] When utilizing the Essential PDL for plans HE1500Ess and HE2000XEss, a minimum coinsurance on tiers 3 and 4 will be applied.

[5] Outpatient rehabilitation services limit includes physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy and cognitive rehabilitation therapy.

All plans are subject to calendar year deductible/out-of-pocket limits unless otherwise stated. In select markets, the deductible/out-of-pocket limits are subject to plan year deductible/out-of-pocket limits if elected.

All plans may not be available in all markets. Plan availability is subject to change and is controlled via the quoting process on myallsavers.com

This is a summary only. It is not a solicitation of coverage; it does not contain a complete list of benefits and limitations. Some benefits listed above may have limits on the number of visits that are covered. For more information about the benefits, provisions, exclusions and limitations, refer to the brochure.

Administrative services provided by United HealthCare Services, Inc. or their affiliates. Stop-loss insurance is underwritten by All Savers Insurance Company (except MA, MN and NJ), UnitedHealthcare Insurance Company in MA and MN, and UnitedHealthcare Life Insurance Company in NJ. 3100 AMS Blvd., Green Bay, WI, 54313, 1-800-291-2634.

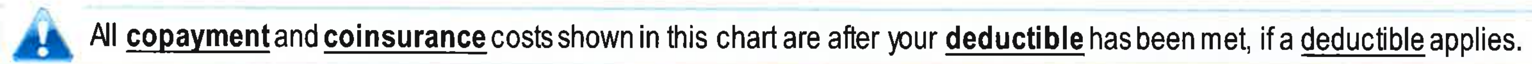
This product is not available in all states.

3908960.0 5/19 ©2019 United HealthCare Services, Inc. 19-12043-B

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at https://www.myallsavers.com/MyAllSavers/Plan or by calling 1-800-291-2634. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-291-2634 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,850 /Individual Network $5,700 /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 annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For network providers $6,550 individual / $13,100 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, balance-billed charges, health care this plan doesn't cover, and out-of-network 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit and 20% coinsurance	Not covered	Out-of-Network providers are not covered.
	Specialist visit	$0 copay/visit and 20% coinsurance	Not covered	
	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: 20% coinsurance Facility: 20% coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Sleep studies require a Prior Authorization or benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	Physician: 20% coinsurance Facility: 20% coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myallsavers.com	Tier 1 drugs	$10 retail copay/prescription or $25 mail-order copay/ prescription	Not covered	Out-of-network pharmacies are not covered. Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail prescription). If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain drugs may have a prior authorization requirement.
	Tier 2 drugs	$35 retail copay/prescription or $88 mail-order copay/ prescription	Not covered	
	Tier 3 drugs	$60 retail copay/prescription or $150 mail-order copay/ prescription	Not covered	
	Tier 4 drugs	$100 retail copay/prescription or $250 mail-order copay/ prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Out-of-network providers are not covered. 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: $0 copay/visit and 20% coinsurance Surgeon: 20% coinsurance	Physician: Not covered Surgeon: Not covered	
If you need immediate medical attention	Emergency room services	Physician: 20% coinsurance Facility: $0 copay/visit and 20% coinsurance	Physician: 20% coinsurance* Facility: $0 copay/visit and 20% coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	Out-of-Network providers are not covered.
	Urgent care	Physician: $0 copay/visit and 20% coinsurance Facility: $0 copay/visit and 20% coinsurance	Physician: Not covered Facility: Not covered	One copay is applied per network urgent care visit. Out-of-Network providers are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Out-of-Network providers are not covered. Prior Authorization is

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	Physician: $0 copay/visit and 20% coinsurance Surgeon: 20% coinsurance	Physician: Not covered Surgeon: Not covered	required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $0 copay/visit and 20% coinsurance Facility: 20% coinsurance/ other outpatient services	Physician: Not covered Facility: Not covered	None
	Inpatient services	Physician: $0 copay/visit and 20% coinsurance Facility: 20% coinsurance	Physician: Not covered Facility: Not covered	Out-of-Network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	Primary Care Visit: $0 copay/visit and 20% coinsurance Specialist Visit: $0 copay/visit and 20% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests. and services described elsewhere in the SBC (i.e. ultrasound). Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service. Out-of-network providers are not covered.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	30 visits/year. Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	20% coinsurance	Not covered	30 combined visits/year for rehabilitation and habilitation
	Habilitation services	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy. Out-of-network providers are not covered.
	Skilled nursing care	20% coinsurance	Not covered	60 visits/year. Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	20% coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required if greater than $1000. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	20% coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan documents for other excluded services.)		
• Bariatric surgery	• Long-term care	• Private-duty nursing
• Cosmetic surgery	• Non-emergency care when traveling outside the United States	• Routine eye care (adult)
• Dental care (adult)	• Out-of-network pharmacies	• Routine foot care, and
• Infertility treatment		• Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)	
• Acupuncture	• Hearing aids
• Chiropractic care	

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 to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: All Savers at 1-800-291-2634, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
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): 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	$2,850
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$30
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$4,640

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

The plan's overall deductible	$2,850
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$3,490

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

The plan's overall deductible	$2,850
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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