

# Plan Highlights

## 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](https://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
<b>Copayments</b> (Dependent on plan selected)	Copay is applied after the deductible has been met. <sup>2</sup> <ul style="list-style-type: none"> <li>• Level 1: Office visits</li> <li>• Level 2: Specialist office visits</li> <li>• Level 3: Urgent care visits</li> <li>• Level 4: Emergency room visits<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Level 1:</li> <li>• Level 2:</li> <li>• Level 3:</li> <li>• Level 4:</li> </ul>	Not applicable
<b>Deductibles</b>	The amounts shown are individual deductibles. Family deductibles are 2 times the individual deductible.		Not applicable
<b>Coinsurance Rates</b>	The rates shown are the percentage the medical benefit pays.		Not applicable
<b>Out-of-Pocket Limits</b>	The amounts shown are individual limits. Family out-of-pocket limits are 2 times the individual limit.		Not applicable
<b>Pharmacy Copayments<sup>4</sup></b> (Dependent on plan selected)	Copayments applied after deductible has been met. <sup>2</sup> Drug tiers are based on cost. <ul style="list-style-type: none"> <li>• Tier 1</li> <li>• Tier 2</li> <li>• Tier 3</li> <li>• Tier 4</li> </ul>	<ul style="list-style-type: none"> <li>• Tier 1</li> <li>• Tier 2</li> <li>• Tier 3</li> <li>• Tier 4</li> </ul>	Not applicable
<b>Lifetime Maximum</b>	There is no lifetime maximum for eligible covered services.	Not applicable	

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## Reimbursement of covered services

		Network Options	Out-of-Network Options
<b>Preventive Care</b>	<ul style="list-style-type: none"> <li>Wellness visits</li> <li>Immunizations</li> <li>Preventive screenings</li> </ul>	100% covered	Not applicable
<b>Copayment Levels 1–4</b> (Dependent on plan selected)	Copay is applied after the deductible has been met. <sup>2</sup> <ul style="list-style-type: none"> <li>Level 1: Office visits</li> <li>Level 2: Specialist office visits</li> <li>Level 3: Urgent care visits</li> <li>Level 4: Emergency room visits<sup>1</sup></li> </ul>		Not applicable
<b>No Copayments</b>	<ul style="list-style-type: none"> <li>Major diagnostics (CT scan, MRI, etc.)</li> <li>Minor diagnostics (lab and X-ray); depending on plan selected, minor diagnostics are covered at ded+coins or ded then 100% covered</li> <li>Inpatient facility</li> <li>Outpatient facility</li> <li>Ambulance (air or ground)<sup>1</sup></li> <li>Rehabilitation/physical therapy</li> <li>Home health care</li> <li>Skilled nursing</li> <li>Transplants</li> <li>Prosthetics</li> <li>Durable medical equipment</li> </ul>	Deductible; then coinsurance	Not applicable
<b>Prescription Drugs<sup>3,4</sup></b> (Copayment is dependent on plan selected)	<ul style="list-style-type: none"> <li>Retail pharmacy prescriptions (30-day)</li> <li>Mail-order prescriptions (90-day); copayments are 2.5 times the retail pharmacy copayment/coinsurance</li> <li>Prescription copayment applied after the deductible has been met<sup>2</sup></li> </ul>		Not applicable

## The following benefits apply to all All Savers plans:

Rehabilitation and Habilitative Outpatient Therapy <sup>5</sup>	Manipulation	Acupuncture	Home Health	Skilled Nursing
30 visits	20 visits	10 visits	30 visits	60 visits



### HSA EPO Plan

<sup>1</sup> ER and ambulance services outside the network are paid as if they were in the network.

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> When utilizing the Essential PDL for plans HP1500Ess and HP2000XEss, a tier 3 coinsurance with a \$150 minimum and a Tier 4 coinsurance with a \$300 minimum will be applied.

<sup>5</sup> 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](https://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.