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2021 Employee Benefits Packet For:

NSI Northwest Software Inc
The help you need

It's open enrollment for the NSI employee benefits program brought to you by Maddock & Associates. The effective date for your plans is January 1st. The purpose of this packet is to give you a brief overview of the available plans. Maddock & Associates is your insurance advocate. Please call us at 800-875-4490 with your questions or benefits issues. We are here to help you!

Detailed benefit summaries and forms are attached.

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NSI EMPLOYEE BENEFITS OPEN ENROLLMENT

It's employee benefits open enrollment, with the effective date of January 1st. The purpose of this packet is to provide you with benefit descriptions for the upcoming plan year. For full benefits and limitations, please refer to the attached summaries.

OPEN ENROLLMENT

If you choose not to enroll for benefits at this time, you will NOT be eligible to enroll until January 1, 2022, unless you meet specific requirements. In the case of involuntary loss of coverage through your spouse's employer, you may enroll in these plans if you apply immediately upon losing coverage.

OPEN ENROLLMENT INSTRUCTIONS

- **Online Plan Enrollment & Changes**
  Benefits enrollment and changes are done through an online benefits portal called Ease. You will be receiving an e-mail with your benefits enrollment log-in information. All employees must log-in to Ease to make their benefits enrollment selections. Employees who do not wish to enroll in the plans, must log-in to decline coverage. **Your enrollment will not be complete until you electronically sign the forms, which is the final step of the online enrollment process.**

  All changes must be made online by Thursday, December 10th.

- **Waiver Form**
  If you do not wish to enroll in the offered plans, please complete the waiver form. Your employer's medical plan is considered qualified coverage under the Affordable Care Act. Employees who decline coverage on the group plan will not be eligible for federal subsidy on the exchange plans.

2021 BENEFITS SUMMARY

MEDICAL INSURANCE: United Healthcare All Savers Plan. You will have a choice of a 2 PPO plans and 3 EPO Plans. The PPO plans provide the best coverage when you use a preferred provider in the **Choice Plus Network**, but care from providers outside the network is covered at a lower percentage. The EPO plans provide benefits **only** when you use a **Choice Plus Provider**. There are no benefits outside the network, with the exception of emergencies. Preferred providers can be found in the provider directory at www.myallsavers.com. Make sure you select **Choice Plus** as your network. Detailed information on your medical plans is contained in this packet.

ALL SAVERS WELLNESS: All Savers offers innovative wellness benefits which can be accessed at www.myallsaversconnect.com. Through **United Healthcare Motion**, you receive a special research-based activity tracker that rewards you for walking every day (up to over $1,000 per year). Through **Rally** you can take advantage of wellness surveys, missions, challenges, and rewards. Finally, All Savers Wellness gives you full access to Virtual Care. Through **HealthiestYou** you can connect to a doctor, get treated and get prescriptions, 24 hours a day, 7 days a week over the phone or via the mobile app.

DENTAL INSURANCE: Principal Financial. This plan covers preventive, basic restorative and major services. The deductible is waived for preventive care. You may use the dentist of your choice, however, your out-of-pocket costs will almost always be lower if you use a preferred dentist. A plan summary is attached. Preferred dentists can be found in the dental provider directory at: www.principal.com.

VISION INSURANCE: Principal Financial/VSP. Principal uses **VSP** to administer their vision plans. A list of VSP providers can be found at www.vsp.com. Select the **Choice Network**. It's important to go to VSP providers, not your medical providers, when you seek vision benefits. A plan summary is attached.

LIFE INSURANCE: **Principal Financial**. Each eligible employee will receive base group life and accidental death & dismemberment insurance. This policy pays double if death is accidental. A plan summary is attached.

VOLUNTARY LIFE INSURANCE: **Principal Financial**. Each eligible employee may opt to purchase voluntary life insurance for themselves and their dependents. Newly eligible employees under age 70 can purchase up to $100,000 with no health statement. A plan summary and rates are attached.

SHORT-TERM DISABILITY INSURANCE: Principal Financial. Each eligible employee will receive employer paid short-term disability insurance. Please see the attached plan summary for details.

LONG-TERM DISABILITY INSURANCE: Principal Financial. Each eligible employee will receive employer paid long-term disability insurance. Please see the attached plan summary for details.

EMPLOYEE ASSISTANCE PROGRAM (EAP): **Principal Financial/Magellan Healthcare EAP** This confidential service gives you free, 24-hour access to nurses, counselors, attorneys and financial consultants to answer your questions or direct you to the most appropriate resource for your personal, legal or financial concerns.

SECTION 125 PLAN: Section 125 of the Internal Revenue Code allows employers to set up a plan that allows you to pay for you and your dependents' portion of the insurance premiums on a tax-free basis. The premium amount is deducted from the payroll before taxes are figured, so you use your money tax-free. A brief summary of how this works is attached. Participation is voluntary. All employees will be automatically enrolled in the Section 125 plan. If you do not wish to have your dependent premiums taken on a pre-tax basis, you must notify your plan administrator within 30 days of the date you are eligible.

ELIGIBILITY: All employees working a minimum of 30 hours per week are eligible for coverage effective the first of the month following their date of hire.

COSTS: Your employer will pay $384.00 towards the cost of any medical plan. If the medical plan premium is less than this amount ($2,000 & $4,000 EPO plans), the difference will be applied to the dependent cost. In addition, your employer will pay 100% of the employee cost for the dental, vision, base life and disability insurance plans for employees who are enrolled on the medical plan. At your option and expense, you may choose to enroll your eligible dependents, and/or purchase voluntary life insurance coverage. The costs are listed on the attached page. The Child(ren) rates include all dependent children through age 25.

FOR FURTHER INFORMATION, feel free to contact any of the following:

Adisys Human Resources	(425) 519-9003
Maddock & Associates	(253) 854-0199
All Savers United Healthcare Medical	(800) 291-2634
All Savers United Healthcare Website	www.myallsavers.com
Principal Financial Dental, Life & Disability	(800) 986-3343
Principal Financial Website	www.principal.com
Principal/Vision Service Plan (VSP)	(800) 877-7195
Principal/Vision Service Plan Website	www.vsp.com
Principal EAP by Magellan Healthcare	(800) 450-1327
Principal Employee Assistance Program Website	http://MagellanAscend.com
Ease Online Enrollment Website	https://hrhub360.ease.com

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INSURANCE BENEFITS & RATES FOR:
NSI

	EPO MEDICAL PLANS					
	All Savers United Healthcare E4000i70		All Savers United Healthcare E2000i80		All Savers United Healthcare E500i80	
MEDICAL INSURANCE	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Deductible (Calendar Year)	$4,000/Person, 2X/Family	**No Coverage Out of Network Except for Emergency Care**	$2,000/Person, 2X/Family	**No Coverage Out of Network Except for Emergency Care**	$500/Person, 2X/Family	**No Coverage Out of Network Except for Emergency Care**
Percentage Plan Pays	70%		80%		80%	
Out of Pocket Max (Includ Deduc)	$8,150/Person, 2X/Family		$7,900/Person, 2X/Family		$3,000/Person, 2X/Family	
PRESCRIPTIONS	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Preferred Generic	$15 Co-pay (Tier 1), Deductible Waived		$15 Co-pay (Tier 1), Deductible Waived		$10 Co-pay (Tier 1), Deductible Waived	
Preferred Brand	$35 Co-pay (Tier 2), Deductible Waived		$35 Co-pay (Tier 2), Deductible Waived		$35 Co-pay (Tier 2), Deductible Waived	
Non-Preferred	$75 Co-pay (Tier 3), Deductible Waived		$75 Co-pay (Tier 3), Deductible Waived		$60 Co-pay (Tier 3), Deductible Waived	
Specialty	$250 Co-pay (Tier 4), Deductible Waived		$250 Co-pay (Tier 4), Deductible Waived		$200 Co-pay (Tier 4), Deductible Waived	
Mail-Order (90 Day Supply)	2.5 Times Pharmacy Cost		2.5 Times Pharmacy Cost		2.5 Times Pharmacy Cost	
PROFESSIONAL CARE	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Preventive Visits / Screenings	100%, Deductible Waived		100%, Deductible Waived		100%, Deductible Waived	
Office Visits Primary	$25 Co-pay, Deductible Waived		$25 Co-pay, Deductible Waived		$25 Co-pay, Deductible Waived	
Office Visits Specialist	$75 Co-pay, Deductible Waived		$75 Co-pay, Deductible Waived		$75 Co-pay, Deductible Waived	
Telehealth Virtual Care	100%, Deductible Waived (Healthiest You®)		100%, Deductible Waived (Healthiest You®)		100%, Deductible Waived (Healthiest You®)	
Urgent Care (Stand Alone Clinic)	$50 Co-pay, Deductible Waived		$50 Co-pay, Deductible Waived		$50 Co-pay, Deductible Waived	
Mental Health (Office Visit)	$75 Co-pay, Deductible Waived		$75 Co-pay, Deductible Waived		$75 Co-pay, Deductible Waived	
Diagnostic Lab & X-ray	100%, DW Diagnostic / Deductible, 70% Complex		100%, DW Diagnostic / Deductible, 80% Complex		100%, DW Diagnostic / Deductible, 80% Complex	
ALTERNATIVE CARE	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Chiropractic	$25 Co-pay, Deductible Waived, 20 Visits Per Year		$25 Co-pay, Deductible Waived, 20 Visits Per Year		$25 Co-pay, Deductible Waived, 20 Visits Per Year	
Acupuncture	$25 Co-pay, DW, 10 Vsts/Yr (Specific Diagnosis Only)		$25 Co-pay, DW, 10 Vsts/Yr (Specific Diagnosis Only)		$25 Co-pay, DW, 10 Vsts/Yr (Specific Diagnosis Only)	
Massage Therapy	Not Covered		Not Covered		Not Covered	
Physical Therapy	Deduc, then 70%, 30 Visits/Yr (Combined Rehab)		Deduc, then 80%, 30 Visits/Yr (Combined Rehab)		Deduc, then 80%, 30 Visits/Yr (Combined Rehab)	
FACILITY CARE	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Hospital	Deductible, then 70%		Deductible, then 80%		Deductible, then 80%	
Emergency Room	$300 Co-pay, then Deductible, then 70%		$300 Co-pay, then Deductible, then 80%		$300 Co-pay, then Deductible, then 80%	
DENTAL INSURANCE	**Principal Financial**					
Deductible	$50 Deductible, Waived for Preventive					
In-Network Coverage	100% Prev/90% Basic/60% Major					
Out of Network Coverage	100% Prev/80% Basic/50% Major					
Annual Maximum	$3,000 Maximum/Person/Year					
VISION INSURANCE	**Principal Financial/Vision Service Plan (VSP) - VSP Choice Network**					
	$10 Co-pay Exam/$25 Co-pay Hardware; Exam & Hardware Every 12 Months					
LIFE INSURANCE	**Principal Financial**					
Base Life Insurance	2X Annual Salary to a Maximum of $200,000 - Employer Paid for all Eligible Employees					
Voluntary Life Insurance	To $300,000, $100,000 Guarantee Issue for Newly Eligible Employees					
DISABILITY INSURANCE	**Principal Financial**					
Short-Term Disability	60% of Pre-Disability Income, to a Maximum Benefit of $1,500/Week					
Long-Term Disability	60% of Pre-Disability Income, to a Maximum Benefit of $6,000/Month					

The above is a summary description of benefits. For complete details, see the company brochure.

RATES - SEMI-MONTHLY PAYROLL DEDUCTIONS

	E4000i70 Medical Plan	E2000i80 Medical Plan	E500i80 Medical Plan	Dental Insurance	Vision Insurance
Employee Only	$0.00	$0.00	$0.00	$0.00	$0.00
Employee + Spouse	$133.54	$167.05	$230.47	$27.52	$3.72
Employee + Spouse + Child(ren)	$255.05	$301.69	$390.02	$73.41	$8.23
Employee + Child(ren)	$79.53	$107.22	$159.55	$40.97	$3.76

RATES - BI-WEEKLY PAYROLL DEDUCTIONS

	E4000i70 Medical Plan	E2000i80 Medical Plan	E500i80 Medical Plan	Dental Insurance	Vision Insurance
Employee Only	$0.00	$0.00	$0.00	$0.00	$0.00
Employee + Spouse	$123.27	$154.20	$212.74	$25.41	$3.44
Employee + Spouse + Child(ren)	$235.43	$278.48	$360.02	$67.76	$7.60
Employee + Child(ren)	$73.42	$98.97	$147.28	$37.82	$3.47

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INSURANCE BENEFITS & RATES FOR:
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	PPO MEDICAL PLANS			
	All Savers United Healthcare P200040		All Savers United Healthcare P50030	
MEDICAL INSURANCE	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Deductible (Calendar Year)	$2,000/Person, 2X/Family	$4,000/Person, 2X/Family	$500/Person, 2X/Family	$1,000/Person, 2X/Family
Co-insurance	80%	50%	80%	50%
Out of Pocket Max (Includ Deduc)	$4,000/Person, 2X/Family	$8,000/Person, 2X/Family	$3,000/Person, 2X/Family	$6,000/Person, 2X/Family
PRESCRIPTIONS	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Preferred Generic	$15 Co-pay (Tier 1), Deductible Waived		$10 Co-pay (Tier 1), Deductible Waived	
Preferred Brand	$35 Co-pay (Tier 2), Deductible Waived		$35 Co-pay (Tier 2), Deductible Waived	
Non-Preferred	$75 Co-pay (Tier 3), Deductible Waived		$60 Co-pay (Tier 3), Deductible Waived	
Specialty	$250 Co-pay (Tier 4), Deductible Waived		$200 Co-pay (Tier 4), Deductible Waived	
Mail-Order (90 Day Supply)	2.5 Times Pharmacy Cost		2.5 Times Pharmacy Cost	
PROFESSIONAL CARE	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Preventive Visits / Screenings	100%, Deductible Waived		100%, Deductible Waived	
Office Visits Primary	$40 Co-pay, Deductible Waived		$30 Co-pay, Deductible Waived	
Office Visits Specialist	$40 Co-pay, Deductible Waived		$30 Co-pay, Deductible Waived	
Telehealth Virtual Care	100%, Deductible Waived (Healthiest You®)		100%, Deductible Waived (Healthiest You®)	
Urgent Care (Stand Alone Clinic)	$100 Co-pay, Deductible Waived		$100 Co-pay, Deductible Waived	
Mental Health (Office Visit)	$40 Co-pay, Deductible Waived		$30 Co-pay, Deductible Waived	
Diagnostic Lab & X-ray	100%, DW Diagnostic / Deductible, 80% Complex		100%, DW Diagnostic / Deductible, 80% Complex	
ALTERNATIVE CARE	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Chiropractic	$40 Co-pay, Deductible Waived, 20 Visits Per Year		$30 Co-pay, Deductible Waived, 20 Visits Per Year	
Acupuncture	$40 Co-pay, DW, 10 Vsts/Yr (Specific Diagnosis Only)		$30 Co-pay, DW, 10 Vsts/Yr (Specific Diagnosis Only)	
Massage Therapy	Not Covered		Not Covered	
Physical Therapy	Deduc, then 80%, 30 Visits/Yr (Combined Rehab)		Deduc, then 80%, 30 Visits/Yr (Combined Rehab)	
FACILITY CARE	**United Healthcare Choice Plus Network**		**United Healthcare Choice Plus Network**	
Hospital	Deductible, then 80%		Deductible, then 80%	
Emergency Room	$300 Co-pay, then 80%, Deductible Waived		$300 Co-pay, then 80%, Deductible Waived	
DENTAL INSURANCE	**Principal Financial**			
Deductible	$50 Deductible, Waived for Preventive			
In-Network Coverage	100% Prev/90% Basic/60% Major			
Out of Network Coverage	100% Prev/80% Basic/50% Major			
Annual Maximum	$3,000 Maximum/Person/Year			
VISION INSURANCE	**Principal Financial/Vision Service Plan (VSP) - VSP Choice Network**			
	$10 Co-pay Exam/$25 Co-pay Hardware; Exam & Hardware Every 12 Months			
LIFE INSURANCE	**Principal Financial**			
Base Life Insurance	2X Annual Salary to a Maximum of $200,000 - Employer Paid for all Eligible Employees			
Voluntary Life Insurance	To $300,000, $100,000 Guarantee Issue for Newly Eligible Employees			
DISABILITY INSURANCE	**Principal Financial**			
Short-Term Disability	60% of Pre-Disability Income, to a Maximum Benefit of $1,500/Week			
Long-Term Disability	60% of Pre-Disability Income, to a Maximum Benefit of $6,000/Month			

The above is a summary description of benefits. For complete details and limitations, see company brochure.

RATES - SEMI-MONTHLY PAYROLL DEDUCTIONS

	P200040 Medical	P50030 Medical	Dental	Vison
Employee Only	$0.00	$17.32	$0.00	$0.00
Employee + Spouse	$230.11	$269.93	$27.52	$3.72
Employee + Spouse + Child(ren)	$389.43	$444.82	$73.41	$8.23
Employee + Child(ren)	$159.31	$192.21	$40.97	$3.76

RATES - BI-WEEKLY PAYROLL DEDUCTIONS

	P200040 Medical	P50030 Medical	Dental	Vison
Employee Only	$0.00	$15.99	$0.00	$0.00
Employee + Spouse	$212.41	$249.17	$25.41	$3.44
Employee + Spouse + Child(ren)	$359.47	$410.60	$67.76	$7.60
Employee + Child(ren)	$147.05	$177.42	$37.82	$3.47

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?	$4,000 /Individual Network $8,000 /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 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?	For network providers $8,150 individual / $16,300 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, and 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		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	Under age 19 - Network visits are covered at No Charge. Out-of-network providers are not covered.
	Specialist visit	$75 copay/visit Deductible does not apply.	Not covered	Out-of-network providers are 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: No charge Facility: No charge	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: 30% coinsurance Facility: 30% 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	$15 retail copay/prescription, or Deductible does not apply. $38 mail-order copay/ prescription Deductible does not apply.	Not covered	Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay applies per 30-day retail 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. Out-of-network pharmacies are not covered.
	Tier 2 drugs	$35 retail copay/prescription, or Deductible does not apply. $88 mail-order copay/ prescription Deductible does not apply.	Not covered	
	Tier 3 drugs	$75 retail copay/prescription, or Deductible does not apply. $188 mail-order copay/ prescription Deductible does not apply.	Not covered	
	Tier 4 drugs	$250 retail copay/prescription, or Deductible does not apply. $625 mail-order copay/ prescription Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% 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: $75 copay/visit Deductible does not apply. Surgeon: 30% coinsurance	Physician: Not covered Surgeon: Not covered	
If you need immediate medical attention	Emergency room care	ER Physician: 30% coinsurance Facility: $300 copay/visit and 30% coinsurance	ER Physician: 30% coinsurance* Facility: $300 copay/visit and 30% coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	30% coinsurance	30% coinsurance*	
	Urgent care	Urgent Care Physician: $50 copay/visit Deductible does not apply. Facility: $50 copay/visit Deductible does not apply.	Urgent Care Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. One copay is applied between the physician charge and the facility charge for urgent care visits. Lab, x-rays or diagnostic testing are not included in the urgent care copay and are subject to the applicable benefit for these

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)	
				services.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% 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: $75 copay/visit Deductible does not apply. Surgeon: 30% coinsurance	Physician: Not covered Surgeon: Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 30% coinsurance for other outpatient services	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 30% coinsurance	Physician: Not covered Facility: Not covered	
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	Out-of-network providers are 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 for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	30 visits/year. 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.

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

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)	
	Rehabilitation services	30% 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	30% coinsurance	Not covered	
	Skilled nursing care	30% coinsurance	Not covered	60 visits/year. 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.
	Durable medical equipment	30% 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	30% 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
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Out-of-network pharmacies
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- 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
- Chiropractic care
- Hearing aids

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.

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.

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

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	$4,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$4,000
Copayments	$60
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$5,880

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

The plan's overall deductible	$4,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,020

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

The plan's overall deductible	$4,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$2,200
Copayments	$500
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.

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?	$2,000 /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 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?	For network providers $7,900 individual / $15,800 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, and 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		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	Under age 19 - Network visits are covered at No Charge. Out-of-network providers are not covered.
	Specialist visit	$75 copay/visit Deductible does not apply.	Not covered	Out-of-network providers are 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: No charge Facility: No charge	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	$15 retail copay/prescription, or Deductible does not apply. $38 mail-order copay/ prescription Deductible does not apply.	Not covered	Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay applies per 30-day retail 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. Out-of-network pharmacies are not covered.
	Tier 2 drugs	$35 retail copay/prescription, or Deductible does not apply. $88 mail-order copay/ prescription Deductible does not apply.	Not covered	
	Tier 3 drugs	$75 retail copay/prescription, or Deductible does not apply. $188 mail-order copay/ prescription Deductible does not apply.	Not covered	
	Tier 4 drugs	$250 retail copay/prescription, or Deductible does not apply. $625 mail-order copay/ prescription Deductible does not apply.	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: $75 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: Not covered Surgeon: Not covered	
If you need immediate medical attention	Emergency room care	ER Physician: 20% coinsurance Facility: $300 copay/visit and 20% coinsurance	ER Physician: 20% coinsurance* Facility: $300 copay/visit and 20% coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	
	Urgent care	Urgent Care Physician: $50 copay/visit Deductible does not apply. Facility: $50 copay/visit Deductible does not apply.	Urgent Care Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. One copay is applied between the physician charge and the facility charge for urgent care visits. Lab, x-rays or diagnostic testing are not included in the urgent care copay and are subject to the applicable benefit for these

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)	
				services.
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 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: $75 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: Not covered Surgeon: Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 20% coinsurance for other outpatient services	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 20% coinsurance	Physician: Not covered Facility: Not covered	
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	Out-of-network providers are 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 for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	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. 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.

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

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)	
	Rehabilitation services	20% 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	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	60 visits/year. 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.
	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
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Out-of-network pharmacies
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- 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
- Chiropractic care
- Hearing aids

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.

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.

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

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	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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$50
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$3,670

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	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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$820

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	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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$500
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,530

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

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?	$500 /Individual Network $1,000 /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 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?	For network providers $3,000 individual / $6,000 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, balance-billed charges, and 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		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	Under age 19 - Network visits are covered at No Charge. Out-of-network providers are not covered.
	Specialist visit	$75 copay/visit Deductible does not apply.	Not covered	Out-of-network providers are 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: No charge Facility: No charge	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 Deductible does not apply. $25 mail-order copay/ prescription Deductible does not apply.	Not covered	Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay applies per 30-day retail 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. Out-of-network pharmacies are not covered.
	Tier 2 drugs	$35 retail copay/prescription, or Deductible does not apply. $88 mail-order copay/ prescription Deductible does not apply.	Not covered	
	Tier 3 drugs	$60 retail copay/prescription, or Deductible does not apply. $150 mail-order copay/ prescription Deductible does not apply.	Not covered	
	Tier 4 drugs	$200 retail copay/prescription, or Deductible does not apply. $500 mail-order copay/ prescription Deductible does not apply.	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: $75 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: Not covered Surgeon: Not covered	
If you need immediate medical attention	Emergency room care	ER Physician: 20% coinsurance Facility: $300 copay/visit and 20% coinsurance	ER Physician: 20% coinsurance* Facility: $300 copay/visit and 20% coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	
	Urgent care	Urgent Care Physician: $50 copay/visit Deductible does not apply. Facility: $50 copay/visit Deductible does not apply.	Urgent Care Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. One copay is applied between the physician charge and the facility charge for urgent care visits. Lab, x-rays or diagnostic testing are not included in the urgent care copay and are subject to the applicable benefit for these

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)	
				services.
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 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: $75 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: Not covered Surgeon: Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 20% coinsurance for other outpatient services	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 20% coinsurance	Physician: Not covered Facility: Not covered	
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	Out-of-network providers are 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 for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	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. 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.

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

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)	
	Rehabilitation services	20% 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	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	60 visits/year. 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.
	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
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Out-of-network pharmacies
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- 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
- Chiropractic care
- Hearing aids

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.

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.

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

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	$500
Specialist copayment	$75
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$50
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$2,470

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

The plan's overall deductible	$500
Specialist copayment	$75
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$820

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

The plan's overall deductible	$500
Specialist copayment	$75
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

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

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?	$2,000 /Individual Network $4,000 /Family Network $4,000 /Individual Out-of-Network $8,000 /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 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?	For network providers $4,000 individual / $8,000 family; for out-of-network providers $8,000 individual / $16,000 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, 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	No.	You can see the specialist you choose without a referral.

see a specialist?		

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	$40 copay/visit Deductible does not apply.	50% coinsurance	None
	Specialist visit	$40 copay/visit Deductible does not apply.	50% coinsurance	
	Preventive care/screening/ immunizations	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: No charge Facility: No charge	Physician: 50% coinsurance Facility: 50% coinsurance	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: 50% coinsurance Facility: 50% coinsurance	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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myallsavers.com	Tier 1 drugs	$15 retail copay/prescription, or Deductible does not apply. $38 mail-order copay/ prescription Deductible does not apply.	$15 retail copay/prescription, or Deductible does not apply. $38 mail-order copay/ prescription Deductible does not apply.	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 Deductible does not apply. $88 mail-order copay/ prescription Deductible does not apply.	$35 retail copay/prescription, or Deductible does not apply. $88 mail-order copay/ prescription Deductible does not apply.	
	Tier 3 drugs	$75 retail copay/prescription, or Deductible does not apply. $188 mail-order copay/ prescription Deductible does not apply.	$75 retail copay/prescription, or Deductible does not apply. $188 mail-order copay/ prescription Deductible does not apply.	

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

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)	
	Tier 4 drugs	$250 retail copay/prescription, or Deductible does not apply. $625 mail-order copay/ prescription Deductible does not apply.	$250 retail copay/prescription, or Deductible does not apply. $625 mail-order copay/ prescription Deductible does not apply.	If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	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: $40 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	
If you need immediate medical attention	Emergency room services	Physician: No charge Facility: $300 copay/visit Deductible does not apply.	Physician: No charge* Facility: $300 copay*/visit Deductible does not apply*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	
	Urgent care	Physician: $40 copay/visit Deductible does not apply. Facility: $100 copay/visit Deductible does not apply.	Physician: 50% coinsurance Facility: 50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	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: $40 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	

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

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: $40 copay/visit Deductible does not apply. Facility: 20% coinsurance for other outpatient services	Physician: 50% coinsurance Facility: 50% coinsurance	None
	Inpatient services	Physician: $40 copay/visit Deductible does not apply. Facility: 20% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	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: $40 copay/visit Deductible does not apply. Specialist Visit: $40 copay/visit Deductible does not apply.	50% coinsurance	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.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	30 visits/year. 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	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	20% coinsurance	50% coinsurance	

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

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	20% coinsurance	50% coinsurance	60 visits/year. 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	50% coinsurance	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	50% coinsurance	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	

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
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- 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
- Chiropractic care, and
- Hearing aids

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

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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.

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

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	$40
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	$2,000
Copayments	$80
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,040

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	$40
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	$2,000
Copayments	$300
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$3,120

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

The plan's overall deductible	$2,000
Specialist copayment	$40
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	$900
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

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

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?	$500 /Individual Network $1,000 /Family Network $1,000 /Individual Out-of-Network $2,000 /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 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?	For network providers $3,000 individual / $6,000 family; for out-of-network providers $6,000 individual / $12,000 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, 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	No.	You can see the specialist you choose without a referral.

see a specialist?		

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	$30 copay/visit Deductible does not apply.	50% coinsurance	None
	Specialist visit	$30 copay/visit Deductible does not apply.	50% coinsurance	
	Preventive care/screening/ immunizations	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: No charge Facility: No charge	Physician: 50% coinsurance Facility: 50% coinsurance	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: 50% coinsurance Facility: 50% coinsurance	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 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 Deductible does not apply. $25 mail-order copay/ prescription Deductible does not apply.	$10 retail copay/prescription, or Deductible does not apply. $25 mail-order copay/ prescription Deductible does not apply.	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 Deductible does not apply. $88 mail-order copay/ prescription Deductible does not apply.	$35 retail copay/prescription, or Deductible does not apply. $88 mail-order copay/ prescription Deductible does not apply.	
	Tier 3 drugs	$60 retail copay/prescription, or Deductible does not apply. $150 mail-order copay/ prescription Deductible does not apply.	$60 retail copay/prescription, or Deductible does not apply. $150 mail-order copay/ prescription Deductible does not apply.	

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

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)	
	Tier 4 drugs	$200 retail copay/prescription, or Deductible does not apply. $500 mail-order copay/ prescription Deductible does not apply.	$200 retail copay/prescription, or Deductible does not apply. $500 mail-order copay/ prescription Deductible does not apply.	If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	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: $30 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	
If you need immediate medical attention	Emergency room services	Physician: No charge Facility: $300 copay/visit Deductible does not apply.	Physician: No charge* Facility: $300 copay*/visit Deductible does not apply*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	
	Urgent care	Physician: $30 copay/visit Deductible does not apply. Facility: $100 copay/visit Deductible does not apply.	Physician: 50% coinsurance Facility: 50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	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: $30 copay/visit Deductible does not apply. Surgeon: 20% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	

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

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: $30 copay/visit Deductible does not apply. Facility: 20% coinsurance for other outpatient services	Physician: 50% coinsurance Facility: 50% coinsurance	None
	Inpatient services	Physician: $30 copay/visit Deductible does not apply. Facility: 20% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	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: $30 copay/visit Deductible does not apply. Specialist Visit: $30 copay/visit Deductible does not apply.	50% coinsurance	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.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	30 visits/year. 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	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	20% coinsurance	50% coinsurance	

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

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	20% coinsurance	50% coinsurance	60 visits/year. 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	50% coinsurance	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	50% coinsurance	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	

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
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- 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
- Chiropractic care, and
- Hearing aids

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

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

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.

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

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	$500
Specialist copayment	$30
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	$500
Copayments	$60
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,820

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

The plan's overall deductible	$500
Specialist copayment	$30
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	$500
Copayments	$200
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,820

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

The plan's overall deductible	$500
Specialist copayment	$30
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	$500
Copayments	$400
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$980

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

Principal®

Policyholder: NSI

Dental PPO Benefit Summary

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Benefits Payable				
Network	Dental Preferred Provider Organization (PPO)			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	$0	$0	100%	100%
Unit 2 – Basic	$50	$50	90%	80%
Unit 3 – Major	$50	$50	60%	50%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for basic and major procedures are combined. In-network Calendar year maximums are $3,000 per person. Non-network Calendar year maximums are $3,000 per person.			
Preventive Passport	This exempts preventive charges from applying to the Calendar year maximum benefit. Therefore, the maximum benefit will not be impacted by use of preventive services. Basic and Major charges will continue to be applied to the annual maximum.			

How Are Dental Procedures Covered?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams - two per calendar year • Routine cleaning (prophylaxis) - four per calendar year (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; subject to routine cleaning frequency limit (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Emergency exams – subject to Routine exam frequency limit • Second Opinion Consultation • Fluoride – two treatments each calendar year (covered only for dependent children under age 14) • Space maintainers - covered only for dependent children under age 14; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 14; one each tooth each 24 months • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	• Harmful Habit Appliance - covered only for dependent children under age 14 • Fillings and stainless steel crowns • Composite fillings on molars • General Anesthesia (covered only for specific procedures)/IV Sedation • Simple Oral Surgery • Complex Oral Surgical Procedures • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Periodontal Surgical Procedures – one each quadrant each 36 months • Simple Endodontics (root canal therapy for anterior teeth) • Complex Endodontics (root canal therapy for molar teeth) • Occlusal Guards – one guard per 36 months
Unit 3 – Major Procedures	• Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 84 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup - each 84 months per tooth • Implants – each 84 months • Bridges - Initial placement / Replacement of bridges 84 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Dental Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse (if not also enrolled as an employee) , qualified domestic partner and children, including those of your qualified domestic partner. Additional eligibility requirements may apply.

Open enrollment applies. Any employee or dependent that didn't enroll within 31 days of being eligible can only enroll during the open enrollment period.

How Do I Find A Participating Provider?

Use the Provider Directory on www.principal.com to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist.
2	Begin your search by picking the **state** where you would like to find a provider. Next, specify a **network**. Depending on the network chosen, you may be transferred to a partner site.
3	Enter the **name of the provider** you are looking for (if known). If you are looking for a nearby dentist, enter the **city and state and/or ZIP code**. Be sure to indicate **how far you are willing to travel**.
4	Select the **desired specialty** or use the No Specialty Preference default. Click **Continue**.
5	Select a **language** if your preference is other than English. Click **Continue**.

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through www.principal.com/refer-dental-provider.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Limitations & Exclusions	
Missing Tooth	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Policyholder: ADISYS CORPORATION

Vision Benefit Summary

This chart provides you a brief summary of the key benefits of the vision coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your vision coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS

Your Coverage with a VSP Preferred Provider		
Doctor Network	VSP Choice Network	
Covered Charges	**Benefit**	**Frequency**
Exams	$10 copay	One exam every 12 months
Prescription Glasses	$25 copay	
Lenses	Single vision, lined bifocal, lined trifocal and lenticular lenses; polycarbonate lenses for dependent children under age 18 Members pay for lens enhancements as an out-of-pocket expense after the copay; they are discounted 20-25% by VSP providers.***	Two lenses (one pair) every 12 months
Frames*	$150 allowance for a wide selection of frames; 20% off amount over allowance***	One set every 12 months
Elective Contacts	Up to $60 copay for your elective contact lens exam (fitting and evaluation) $150 allowance for elective contacts	Once every 12 months Contacts are instead of frames and lenses
Necessary Contacts**	$25 copay Covered in full for members who have specific conditions	Once every 12 months Contacts are instead of frames and lenses

Additional Savings ***	
Glasses and Sunglasses	Members save an average of 20-25% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last covered vision exam
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

VISION

Your Coverage with Other Providers (Non-Network)		
Covered Charges	**Scheduled Benefit Amount**	**Frequency**
Vision Exams	Up to $45	One per 12 month period
Single Vision lenses	Up to $30	One pair per 12 month period
Lined bifocal lenses	Up to $50	One pair per 12 month period
Lined trifocal lenses	Up to $65	One pair per 12 month period
Lenticular lenses	Up to $100	One pair per 12 month period
Frames	Up to $70	One set per 12 month period
Elective Contacts	Up to $105	In lieu of lenses and frame benefits
Necessary Contacts**	Up to $210	In lieu of lenses and frame benefits

*VSP has agreements established with some Participating Retail Chain Providers that may also provide benefits for this covered service. Up to a $80 allowance is given for a wide selection of frames. Please talk to your provider or contact VSP customer care for further details.

** Necessary contact lenses are prescribed to correct extreme visual problems that cannot be corrected with regular lenses.

*** Based on applicable laws; benefits may vary by doctor location.

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Vision Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for vision coverage before it can be offered to your dependents. Eligible dependents include your spouse (if not also enrolled as an employee), qualified domestic partner, state registered domestic partner and children, including those of your qualified domestic partner. Additional eligibility requirements may apply.

Open enrollment applies. Any employee or dependent that didn't enroll with 31 days of being eligible can only enroll during the open enrollment period.

How Do I Find a VSP Provider?

Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network. To speak to a representative by phone, please call 800-877-7195.

How Do I Submit A Claim?

When visiting a VSP provider for services, the provider submits the claim for payment. If visiting a non-network provider for services, you are responsible for submitting the claim to VSP. Obtain a claim form by logging on to vsp.com or by calling 800-877-7195. Include a copy of your itemized receipt with your claim form and mail it to the following address.

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Non-Medically Necessary Services	The coverage does not pay for visual analysis or vision aids that are not medically necessary.
Benefit Limitations	The following items are excluded under this coverage: • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing • Plano lenses (lenses with refractive correction of less than ± .50 diopter)
Contact Lens Limitations	The following items are not covered under the contact lens coverage: • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning • Refitting of contact lenses after the initial (90 day) fitting period
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

Policyholder: ADISYS CORPORATION

Group Term Life Benefit Summary

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	**ELIGIBLE MEMBERS**
Benefits Payable	
Employee Life Benefits	
Benefit Amount	200% of your annual salary, rounded to the next higher $1,000
Minimum	$10,000
Maximum	$200,000
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are Under 70: $200,000 If you are 70 and older: The lesser of $200,000 or the amount with the prior carrier
Age Reductions	35% benefit reduction at age 65, with an additional 15% reduction at age 70. If your employer provides coverage to retired members, please refer to your benefit booklet for possible reductions due to age. Age reductions apply to the benefit amount after proof of good health .
Additional Employee Benefits	
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived.
Accelerated Death Benefit	If you are terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.
Individual Purchase Rights	If coverage terminates, you may be able to convert coverage to an individual policy.
Limitations & Exclusions	
Coverage Outside of the US	Benefits will not be paid if you are outside the United States for certain reasons for more than six months.

GROUP TERM LIFE

Accidental Death & Dismemberment (AD&D) Coverage	
Benefit Amount	Your benefit is equal to your group term life benefit amount if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, your loss may be covered. You may be paid: • **Full benefit** when you lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • **Half of the benefit** when you lose: one hand / one foot / sight of one eye. • **One-fourth of the benefit** when you lose the thumb and index finger on the same hand. The loss must occur within 12 months of the accident.
Additional Benefits	
Seatbelt/Airbag	$10,000 if you are wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of your death
Repatriation	Up to $2,000 for preparation and transportation of your body if you die at least 100 miles from your permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months, the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
Limitations & Exclusions	
Other Limitations	The Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Understanding Your Life Coverage Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work or if your employer is providing coverage to you as a retired member, you may also be eligible for coverage.

Spouse and child coverage is not available.

What Additional Benefits Are Included?

Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived. You must be totally disabled for 9 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.
Accelerated Death Benefit	If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed $250,000, as long as: • Your life expectancy is 24 months or less (as diagnosed by a physician), and • Your death benefit is at least $10,000. If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in the premium.
Individual Purchase Rights	If coverage terminates, you may be able to convert coverage to an individual policy. Your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation. Contact Principal Life for details.
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.

NSI

Voluntary-term life/AD&D - employee

Estimated employee monthly premium amounts
End of the rate guarantee period: 12/31/2021

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$10,000	$0.93	$1.00	$1.40	$2.14	$3.19	$5.07	$7.85	$10.81
$20,000	$1.86	$2.00	$2.80	$4.28	$6.38	$10.14	$15.70	$21.62
$30,000	$2.79	$3.00	$4.20	$6.42	$9.57	$15.21	$23.55	$32.43
$40,000	$3.72	$4.00	$5.60	$8.56	$12.76	$20.28	$31.40	$43.24
$50,000	$4.65	$5.00	$7.00	$10.70	$15.95	$25.35	$39.25	$54.05
$60,000	$5.58	$6.00	$8.40	$12.84	$19.14	$30.42	$47.10	$64.86
$70,000	$6.51	$7.00	$9.80	$14.98	$22.33	$35.49	$54.95	$75.67
$80,000	$7.44	$8.00	$11.20	$17.12	$25.52	$40.56	$62.80	$86.48
$90,000	$8.37	$9.00	$12.60	$19.26	$28.71	$45.63	$70.65	$97.29
$100,000	$9.30	$10.00	$14.00	$21.40	$31.90	$50.70	$78.50	$108.10
$110,000	$10.23	$11.00	$15.40	$23.54	$35.09	$55.77	$86.35	$118.91
$120,000	$11.16	$12.00	$16.80	$25.68	$38.28	$60.84	$94.20	$129.72
$130,000	$12.09	$13.00	$18.20	$27.82	$41.47	$65.91	$102.05	$140.53
$140,000	$13.02	$14.00	$19.60	$29.96	$44.66	$70.98	$109.90	$151.34
$150,000	$13.95	$15.00	$21.00	$32.10	$47.85	$76.05	$117.75	$162.15
$160,000	$14.88	$16.00	$22.40	$34.24	$51.04	$81.12	$125.60	$172.96
$170,000	$15.81	$17.00	$23.80	$36.38	$54.23	$86.19	$133.45	$183.77
$180,000	$16.74	$18.00	$25.20	$38.52	$57.42	$91.26	$141.30	$194.58
$190,000	$17.67	$19.00	$26.60	$40.66	$60.61	$96.33	$149.15	$205.39
$200,000	$18.60	$20.00	$28.00	$42.80	$63.80	$101.40	$157.00	$216.20
$210,000	$19.53	$21.00	$29.40	$44.94	$66.99	$106.47	$164.85	$227.01
$220,000	$20.46	$22.00	$30.80	$47.08	$70.18	$111.54	$172.70	$237.82
$230,000	$21.39	$23.00	$32.20	$49.22	$73.37	$116.61	$180.55	$248.63
$240,000	$22.32	$24.00	$33.60	$51.36	$76.56	$121.68	$188.40	$259.44
$250,000	$23.25	$25.00	$35.00	$53.50	$79.75	$126.75	$196.25	$270.25
$260,000	$24.18	$26.00	$36.40	$55.64	$82.94	$131.82	$204.10	$281.06
$270,000	$25.11	$27.00	$37.80	$57.78	$86.13	$136.89	$211.95	$291.87
$280,000	$26.04	$28.00	$39.20	$59.92	$89.32	$141.96	$219.80	$302.68
$290,000	$26.97	$29.00	$40.60	$62.06	$92.51	$147.03	$227.65	$313.49
$300,000	$27.90	$30.00	$42.00	$64.20	$95.70	$152.10	$235.50	$324.30

Reduced benefit	65-69
$6,500	$12.86
$13,000	$25.73
$19,500	$38.59
$26,000	$51.45
$32,500	$64.32
$39,000	$77.18
$45,500	$90.04
$52,000	$102.91
$58,500	$115.77
$65,000	$128.64
$71,500	$141.50
$78,000	$154.36
$84,500	$167.23
$91,000	$180.09
$97,500	$192.95
$104,000	$205.82
$110,500	$218.68
$117,000	$231.54
$123,500	$244.41
$130,000	$257.27
$136,500	$270.13
$143,000	$283.00
$149,500	$295.86
$156,000	$308.72
$162,500	$321.59
$169,000	$334.45
$175,500	$347.31
$182,000	$360.18
$188,500	$373.04
$195,000	$385.91

Reduced benefit	70 & over
$5,000	$16.17
$10,000	$32.34
$15,000	$48.51
$20,000	$64.68
$25,000	$80.85
$30,000	$97.02
$35,000	$113.19
$40,000	$129.36
$45,000	$145.53
$50,000	$161.70
$55,000	$177.87
$60,000	$194.04
$65,000	$210.21
$70,000	$226.38
$75,000	$242.55
$80,000	$258.72
$85,000	$274.89
$90,000	$291.06
$95,000	$307.23
$100,000	$323.40
$105,000	$339.57
$110,000	$355.74
$115,000	$371.91
$120,000	$388.08
$125,000	$404.25
$130,000	$420.42
$135,000	$436.59
$140,000	$452.76
$145,000	$468.93
$150,000	$485.10

Note: Proof of good health/evidence of insurability is required to apply for benefit amounts greater than those highlighted above.

If your age changes to a different rate band during the guarantee period, your premium will change to reflect the new rate band effective on the next policy anniversary date.

Voluntary Term Life insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.
This summary is not a complete statement of the rights, benefits, limitations and exclusions of the coverage described here. For cost and coverage details, contact your Principal® representative.

Principal®

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NSI

Voluntary-term life/AD&D - spouse

Estimated spouse monthly premium amounts
End of the rate guarantee period: 12/31/2021

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$5,000	$0.47	$0.50	$0.70	$1.07	$1.60	$2.54	$3.93	$5.41
$10,000	$0.93	$1.00	$1.40	$2.14	$3.19	$5.07	$7.85	$10.81
$15,000	$1.40	$1.50	$2.10	$3.21	$4.79	$7.61	$11.78	$16.22
$20,000	$1.86	$2.00	$2.80	$4.28	$6.38	$10.14	$15.70	$21.62
$25,000	$2.33	$2.50	$3.50	$5.35	$7.98	$12.68	$19.63	$27.03
$30,000	$2.79	$3.00	$4.20	$6.42	$9.57	$15.21	$23.55	$32.43
$35,000	$3.26	$3.50	$4.90	$7.49	$11.17	$17.75	$27.48	$37.84
$40,000	$3.72	$4.00	$5.60	$8.56	$12.76	$20.28	$31.40	$43.24
$45,000	$4.19	$4.50	$6.30	$9.63	$14.36	$22.82	$35.33	$48.65
$50,000	$4.65	$5.00	$7.00	$10.70	$15.95	$25.35	$39.25	$54.05
$55,000	$5.12	$5.50	$7.70	$11.77	$17.55	$27.89	$43.18	$59.46
$60,000	$5.58	$6.00	$8.40	$12.84	$19.14	$30.42	$47.10	$64.86
$65,000	$6.05	$6.50	$9.10	$13.91	$20.74	$32.96	$51.03	$70.27
$70,000	$6.51	$7.00	$9.80	$14.98	$22.33	$35.49	$54.95	$75.67
$75,000	$6.98	$7.50	$10.50	$16.05	$23.93	$38.03	$58.88	$81.08
$80,000	$7.44	$8.00	$11.20	$17.12	$25.52	$40.56	$62.80	$86.48
$85,000	$7.91	$8.50	$11.90	$18.19	$27.12	$43.10	$66.73	$91.89
$90,000	$8.37	$9.00	$12.60	$19.26	$28.71	$45.63	$70.65	$97.29
$95,000	$8.84	$9.50	$13.30	$20.33	$30.31	$48.17	$74.58	$102.70
$100,000	$9.30	$10.00	$14.00	$21.40	$31.90	$50.70	$78.50	$108.10

Reduced benefit	65-69
$3,250	$6.44
$6,500	$12.86
$9,750	$19.30
$13,000	$25.73
$16,250	$32.16
$19,500	$38.59
$22,750	$45.03
$26,000	$51.45
$29,250	$57.89
$32,500	$64.32
$35,750	$70.75
$39,000	$77.18
$42,250	$83.62
$45,500	$90.04
$48,750	$96.48
$52,000	$102.91
$55,250	$109.34
$58,500	$115.77
$61,750	$122.21
$65,000	$128.64

Reduced benefit	70 & over
$2,500	$8.09
$5,000	$16.17
$7,500	$24.26
$10,000	$32.34
$12,500	$40.43
$15,000	$48.51
$17,500	$56.60
$20,000	$64.68
$22,500	$72.77
$25,000	$80.85
$27,500	$88.94
$30,000	$97.02
$32,500	$105.11
$35,000	$113.19
$37,500	$121.28
$40,000	$129.36
$42,500	$137.45
$45,000	$145.53
$47,500	$153.62
$50,000	$161.70

Note: Proof of good health/evidence of insurability is required to apply for benefit amounts greater than those highlighted above.

Child(ren) premium amounts (per family) *--Child(ren) are covered until age 26*
$10,000 $2.00

If your age changes to a different rate band during the guarantee period, your premium will change to reflect the new rate band effective on the next policy anniversary date.

Policyholder: ADISYS CORPORATION

Short Term Disability (STD) Benefit Summary

This chart provides you a brief summary of the key benefits of the short-term disability coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your short-term disability coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	**ELIGIBLE MEMBERS**
Eligible Members	All active, full time employees (except seasonal, temporary, or contract workers) who work at least 40 hours per week
Benefits Payable	
Primary Weekly Benefit	60% of your predisability earnings up to $1,500
Benefit Amount	Primary Weekly Benefit less other income sources
Definition of Earnings	Base wage
Benefit Qualification	
Elimination Period	Benefits begin on the 8th day for accident and 8th day for sickness
Benefit Payment Period	Up to 12 weeks after the elimination period is satisfied
Maternity	Treated the same as any other disability
Additional Benefits	
Rehabilitation Incentive Benefit	5% increase in the primary weekly benefit
Limitations & Exclusions	
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Understanding Your Short-Term Disability Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short-term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

How Do I Qualify For Benefits?

1) **Meet the Definition of Disability**. Disabilities must be solely and directly caused by sickness, injury, or pregnancy.

During the elimination period and the benefit payment period, one of these situations must apply:	• You cannot perform the majority of the substantial and material duties of your own occupation. • You are performing the duties of your own occupation on a modified basis and lose at least 20% of the income you earned before becoming disabled. • You are performing the duties of any other occupation and lose at least 20% of the income you earned before becoming disabled.

2) **Satisfy the Elimination Period.** The amount of time you must be disabled before receiving benefits is called the elimination period. Benefits begin on the 8th day when due to injury and begin on the 8th day when due to sickness. The elimination period can be satisfied with days of total or partial disability.

How Much Weekly Benefit Will I Receive?

Your benefits will be determined by using your base wage.

The benefit payment period is the length of time you will receive benefits for a qualifying disability after the elimination period is satisfied. When you are unable to work in any capacity during the benefit payment period, your primary weekly benefit is equal to 60% of your predisability earnings, up to $1,500. Your primary weekly benefit less income from other sources is the benefit amount you will receive. Your benefit amount will never be less than the $15 minimum benefit.

Benefits if Working If you are able to work while disabled, you may still be eligible to receive a disability benefit.

If you are working during the benefit payment period, your benefit amount is the lesser of:

- 100% of your predisability earnings, less income from other sources, less current earnings; or
- Your primary weekly benefit, less income from other sources.

You must work to your full medical and vocational capacity. If you choose not to, your benefits will be paid as if you are working to your full capacity.

Income you receive from other sources can be deducted from your primary weekly benefit. For a complete list of other sources, please refer to your booklet. Other sources may include: All retirement or disability benefits that you and your dependents receive or could have received from Social Security or other government agencies/ Salary continuance, personal time off or sick pay / Workers' Compensation benefits / Income from state disability plans / Disability or retirement benefits paid by pension plans sponsored by the policyholder / Income received from no-fault auto laws / Severance pay.

How Long Will I Receive My Benefits?

You are eligible to receive short-term disability benefits for 12 weeks after the elimination period is satisfied.

Your disability benefits will end when you: Recover / Cease to be under the regular and appropriate care of a physician / Fail to provide any required proof of disability / Fail to submit to a required medical examination / Fail to report income from other sources, or any other required earnings information / Fail to pursue Social Security disability benefits or Workers' Compensation benefits / Die.

If you recover and return to work for less than 30 continuous days during the benefit duration and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

What Additional Benefits Are Included?

Work Incentive Benefit	The Work Incentive Benefit is paid to you if you are disabled and you return to work on a limited or part-time basis. The Work Incentive Benefit equals the primary weekly benefit with no offset for work earnings unless the combination of work earnings, disability benefits and other income sources exceeds 100% of your predisability earnings. If this occurs, the Work Incentive Benefit will be reduced by the amount in excess of 100% of your predisability earnings.
Rehabilitation Plan	While disabled, you may qualify to participate in a rehabilitation plan. Our rehabilitation staff works with you, your physician(s) and your employer to create an individual rehabilitation plan to assist you in returning to work. If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own occupation, preventive rehabilitation services may be offered.
Rehabilitation Incentive Benefit	The Rehabilitation Incentive Benefit can increase the primary weekly benefit by 5% if you become totally disabled and participate in and satisfy the requirements of an individual rehabilitation plan.
Mandatory Rehabilitation	Your Mandatory Rehabilitation provision indicates that, if appropriate, you may be required to participate in an individual rehabilitation plan.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Policyholder: ADISYS CORPORATION

Long Term Disability (LTD) Benefit Summary

This chart provides you a brief summary of the key benefits of the long-term disability coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your long-term disability coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	**ELIGIBLE MEMBERS**
Eligible Members	All active, full time employees (except seasonal, temporary, or contract workers) who work at least 40 hours per week
Benefits Payable	
Primary Monthly Benefit	60% of your predisability earnings up to $6,000.
Benefit Amount	Primary monthly benefit less other income sources
Definition of Earnings	Base wage
Benefit Qualification	
Elimination Period	3 months
Own Occupation Period	2 years
Maximum Benefit Payment Period	To age 65
Additional Benefits	
Survivor Benefit	Three times your primary monthly benefit less other income sources to your survivor.
Limitations & Exclusions	
Pre-Existing Conditions	3 months prior/12 months insured
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Understanding Your Long-Term Disability (LTD) Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

How Do I Qualify For Benefits?

1) **Meet the Definition of Disability**. Disabilities must be solely and directly caused by injury or sickness (including pregnancy).

During the elimination period and the own occupation period, one of these situations must apply:	• You cannot perform the majority of the substantial and material duties of your own occupation. • You are performing the duties of your own occupation on a modified basis or any occupation and are unable to earn more than 80% of your indexed predisability earnings.
After completing the own occupation period, one of these situations apply:	• You cannot perform the majority of the substantial and material duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience. • You are performing the substantial and material duties of your own occupation or any occupation on a modified basis and are unable to earn more than 80% of your indexed predisability earnings.

2) **Satisfy the Elimination Period.** The amount of time you must be disabled before receiving benefits is called the elimination period. Long-Term Disability benefits begin after you have been disabled for 3 months. The elimination period can be satisfied with days of total or partial disability.

If you recover and return to work during the elimination period and become disabled again, you may not have to satisfy a new elimination period. If you become disabled again, your elimination period will pick up at the point where it was left off when you recovered. You have a period twice as long as the elimination period to satisfy the required number of days of disability.

How Much Monthly Benefit Will I Receive?

Your benefits will be determined based on your Base wage.

When you are unable to work in any capacity during the benefit payment period, your **monthly benefit** equals your primary monthly benefit, less income from other sources.

Your primary monthly benefit is equal to 60% of your predisability earnings, but will not exceed $6,000.

Your monthly benefit will not be less than the minimum monthly benefit of $100.

Benefits if Working

If you are able to work while disabled, you may still be eligible to receive a disability benefit.

If you are working during the benefit payment period, your monthly benefit for the 12 month work incentive period is the lesser of:

- 100% of the indexed earnings you received before becoming disabled, less income from other sources, less current earnings; or
- Your primary monthly benefit, less income from other sources.

After the work incentive period, your monthly benefit equals your primary monthly benefit, less income from other sources and multiplied by your income loss percentage.

Income you receive from other sources can be deducted from your primary monthly benefit. Other sources include: All retirement or disability benefits that you and your dependents receive, or could have received, from Social Security, or other government agencies /Salary continuance, personal time off or sick pay / Workers' Compensation benefits / Income from state disability plans / Payments from policies that provide coverage for time away from work, if paid in part by or deducted from payroll by the policyholder / Income from other group disability coverage policies / Disability or retirement benefits paid by pension plans sponsored by the policyholder / Income received from no-fault auto laws / Renewal commissions received from the policyholder / Severance pay / Any income you receive for services rendered prior to your Date of Disability will not be considered Other Income Sources.

How Long Will I Receive My Benefits?

The benefit payment period is the length of time you'll receive benefits for a qualifying disability after the elimination period is satisfied. Your age at the time disability occurs determines the length of time you are eligible to receive disability benefits.

Age Disability Occurs	Benefits are Payable:
Under Age 62	*Until the later of the date you reach age 65 or 42 months*
Age 62	*42 months*
Age 63	*36 months*
Age 64	*30 months*
Age 65	*24 months*
Age 66	*21 months*
Age 67	*18 months*
Age 68	*15 months*
Age 69 and over	*12 months*

Your disability benefits will end when you: Recover / Cease to be under the regular and appropriate care of a physician / Fail to provide any required proof of disability / Fail to submit to a required medical

examination / Fail to report income from other sources, or any other required earnings information / Fail to pursue Social Security disability benefits or Workers' Compensation benefits / Die.

If you recover and return to work for six months or less during the benefit payment period and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

What Additional Benefits Are Included?

Work Incentive Benefit	The Work Incentive Benefit is paid to you if you are disabled and you return to work on a limited or part-time basis. To receive benefits, you must be working. The Work Incentive Benefit equals the primary monthly benefit with no offset for work earnings unless the combination of work earnings, disability benefits and other income sources exceeds 100% of your predisability earnings. If this occurs, the Work Incentive Benefit will be reduced by the amount in excess of 100% of your predisability earnings.
Survivor Benefit	The Survivor Benefit is a lump sum payment issued to your survivors, should you die while receiving disability benefits. The benefit payment is equal to three times your primary monthly benefit less other income sources.
Rehabilitation Plan	While disabled, you may qualify to participate in a Rehabilitation Plan. Our rehabilitation staff works with you, your physician(s) and your employer to create an individual rehabilitation plan to assist you in returning to work. If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own occupation, preventive rehabilitation services may be offered.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Preexisting Conditions	A preexisting condition is an injury or sickness (including pregnancy) and all related conditions and complications, in the three months prior to your effective date under this policy, for which you: • Received medical treatment, consultation, care or service; or • Were prescribed or took prescription medications Benefits will not be paid for disabilities resulting from preexisting conditions unless, when you become disabled, you have been actively at work for one full day after being covered under the policy for 12 consecutive months. Preexisting condition exclusions also apply to benefit increases due to policy amendments and changes in earnings of 25% or greater.
Treatment of Mental Health Conditions and Drug and Alcohol Abuse Conditions	A disability is considered due to alcohol, drug or chemical abuse, dependency or addiction or a mental health condition if the disability is caused by one of these condition(s) and not by other disabling conditions. Maximum benefit payment periods for: Mental health conditions – 24 months Alcohol, drug or chemical abuse conditions – 24 months The benefit payment period listed above is a lifetime maximum for all periods of disability. All disabilities from conditions with the same maximum benefit payment period contribute towards one lifetime maximum. However, if at the end of the benefit payment period, you are confined in a hospital or any other type of facility providing treatment for any of these conditions, the benefit payment period may be extended to include the time period you are confined for treatment.

Group disability insurance

Help handling life's ups and downs

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the Employee Assistance Program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your family household members have access to free, confidential resources to help handle life's everyday — and not so everyday — challenges.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things:

- LifeMart Discount Center, with savings on a variety of products and services
- Self-care mobile apps to help with insomnia, anxiety, depression, substance use, obsessive compulsive disorder and chronic pain
- Health and wellness articles, guides, webinars and podcasts
- Online assistance with elder care, child care and other family life resources
- Help with teen and adolescent issues, including eating disorders and relationships
- Tips on parenting and grandparenting
- 24/7 phone consultation with licensed mental health professionals and referrals to supportive resources*
- Ongoing personal coaching sessions with scheduled telephonic appointments

Help when and where you need it — day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.

800-450-1327
International: 800-662-4504
TTY: 800-456-4006

MagellanAscend.com
When you create an account, use **Principal Core** for the company name.

* You're responsible for any fees resulting from referrals outside the EAP, including those associated with medical benefits.

Help is just a click or call away —24/7

Online: MagellanAscend.com
Enter **Principal Core** for the company name

Call: 800-450-1327 | **TTY:** 800-456-4006
International: 800-662-4504

Your Employee Assistance Program is provided by Magellan Healthcare.

Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs.(See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

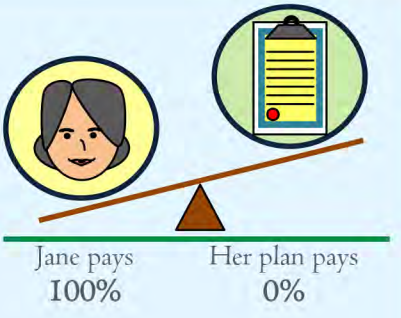
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

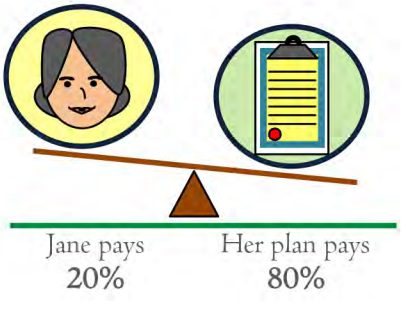
Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible


The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

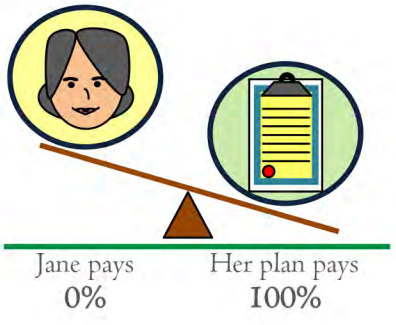
Co-insurance


Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Glossary of Health Coverage and Medical Terms (cont.)

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do *not* contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Pocket Limit


The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may *not* balance bill you for covered services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Getting Started Guide
All Savers®
Alternate Funding

Welcome.
We're glad you're here.

Getting the most out of your plan begins with understanding what it can do for you. That's why we've put together this guide to help you get started. It includes the top things you can do to maximize your benefits.

A friendly reminder: Remember to carry your health plan ID card with you wherever you go to make your health care experience easier.

Start with these 3 easy steps:

1. **Sign up for myallsaversconnect.com**
2. **Know your medical benefits**
3. **Understand your pharmacy benefits**

UnitedHealthcare®

Sign up for myallsaversconnect.com.

24/7 access to your health plan.

Sign up for **myallsaversconnect.com**, a personalized website that helps you easily access and manage your health plan. Here are some of the ways **myallsaversconnect.com** can help you:

- Find network doctors, hospitals and facilities.
- Check your coverage.
- Check your claims status.
- Get a list of covered prescription drugs.

Need help?

Don't have access to a computer, need language assistance or want to talk to us?

Call our Customer Care Advocates at **1-800-291-2634.**

CONTINUED

Know your medical benefits.

Get the most out of your health plan.

Our goal is to provide information and support to help you find care at a price that works for you. It starts with understanding your health plan to help you avoid surprise expenses and manage costs. Visit **myallsaversconnect.com** to see the details of your health plan.

Find network doctors, hospitals, laboratories and more.

You usually pay less for care when you use network providers and facilities. You can search for network doctors, mental health professionals, pharmacies, hospitals and labs through the physician directory on **myallsaversconnect.com**. Or, call the toll-free number on your ID card.

See a doctor from anywhere.

A Virtual Visit through **healthiestyou.com** lets you have a phone or video visit with a doctor from your mobile device, hotline phone number or computer about minor medical concerns. The doctor can provide a diagnosis and, if appropriate, send a prescription to your local pharmacy, 24/7/365 for **FREE**. Log in to **myallsaversconnect.com** to get started.

The service offerings, programs and partners of All Savers Wellness are subject to change. The All Savers Wellness service offerings are not available in all states.

Take advantage of preventive care at no cost.

Preventive care—like regular checkups, recommended screenings and immunizations—is usually covered at no cost to you when you see network doctors. Preventive care can be important to your overall health since it may help identify issues and conditions earlier.

Choose a primary care physician (PCP).

Although your plan may not require you to choose a PCP, it's a good idea to have one main doctor with in-depth knowledge of your health to help guide you on the best path of care. Find one at **myallsaversconnect.com** or call the toll-free number on your ID card.

Schedule your preventive care screenings.

Most UnitedHealthcare plans pay 100 percent of the cost of certain preventive care services with a network provider. Check your health plan documents for details. Visit **uhcpreventivecare.com** to find preventive care recommendations for everyone covered under your plan.

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, coinsurance or deductible.

CONTINUED

Know where to go.

With many options for getting care, how do you choose? This chart can help you understand where to go for what—and how you can save money.

Where to go	What it is	When to use it	Cost
Virtual Visits 	A Virtual Visit through **healthiestyou.com** lets you see a doctor using the camera on your smartphone, tablet or computer. You can even get a prescription sent to your local pharmacy, all in 30 minutes or less. Services may not be available at all times or in all locations. The service offerings, programs and partners of All Savers Wellness are subject to change. The All Savers Wellness service offerings are not available in all states.	• Allergies • Bladder infections • Bronchitis • Cough/colds • Diarrhea • Fever • Pinkeye • Rashes • Seasonal flu • Sinus problems • Sore throat • Stomachaches	$
Primary Care Physician 	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management	$$
Convenience Care Clinics 	Visit a convenience care clinic when you can't see your doctor and your health issue isn't urgent. These clinics are often in stores.	• Common infections (e.g., strep throat) • Minor skin conditions (e.g., poison ivy) • Vaccinations • Pregnancy tests • Minor injuries • Earaches	$$
Urgent Care 	Urgent care is usually ideal when you need care quickly, but it's not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life-threatening.	• Sprains • Strains • Small cuts that may need a few stitches • Minor burns • Minor infections • Minor broken bones	$$$
Emergency Room 	The ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911, or your local emergency number.	• Heavy bleeding • Large, open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Breathing difficulty • Major broken bones	$$$$

CONTINUED

Know your medical benefits.

Find out what's covered.

All Savers plans offer coverage for checkups, flu shots and hospital stays. Knowing exactly what's covered by your health plan can be key to managing your health care costs and avoiding financial surprises.

For complete details about your health plan, including your out-of-pocket costs, coverage, requirements and more, visit **myallsaversconnect.com**.

For a free printed copy of these documents, call the toll-free number on your ID card.

Important, cost-related terms to know.

There are 4 main terms to know when it comes to understanding what your health plan covers and what you'll have to pay:

Copayment:

The set amount you pay for a covered health care service, usually paid at the time you get care.

Coinsurance:

Your share of the costs for a covered health care service like a lab test.

Deductible:

The amount you owe for covered services before your health plan begins to pay.

Out-of-pocket limit:

The highest amount you'll pay during this year (also known as your "policy period") before your health plan begins to pay 100 percent of the amount. It's important to note a few things:

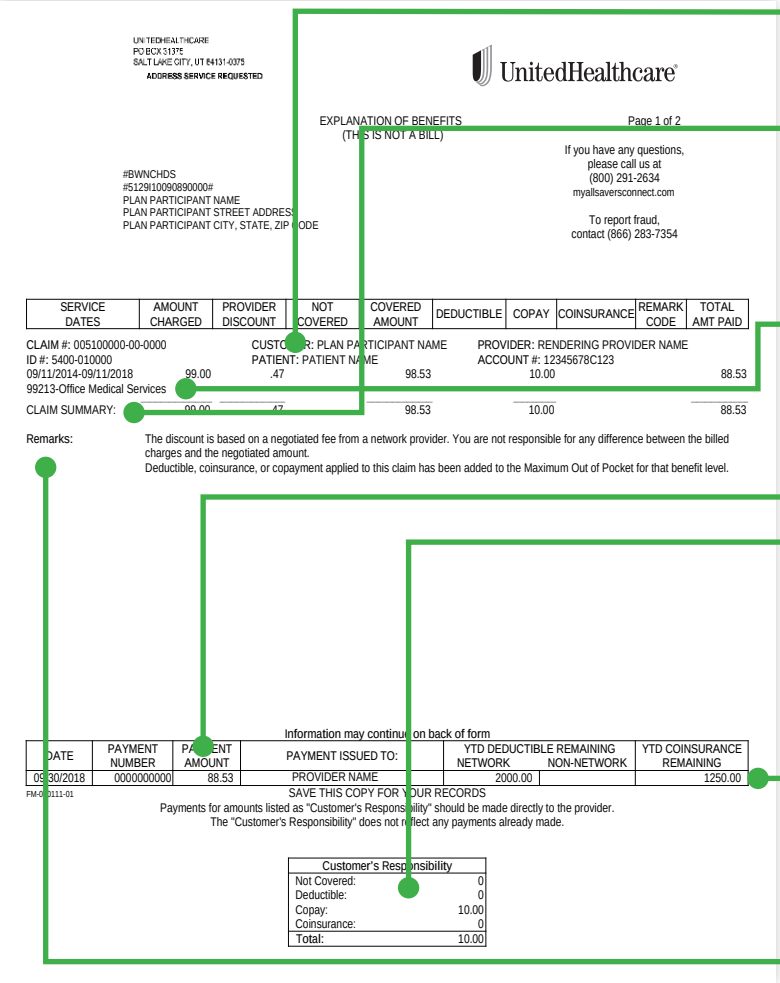
- This limit doesn't include your premium or some other changes.
- Some health plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Visit **justplainclear.com**, an online glossary of health and insurance terms, to get straightforward definitions of thousands of words (in both English and Spanish).

CONTINUED

Understanding your Explanation of Benefits.

An Explanation of Benefits (EOB) is sent when you or one of your covered dependents use your benefit plan. The EOB gives you an easy-to-read record of how your claim was processed. At a glance, you'll see how much was covered by your plan and what your out-of-pocket costs are.



UNITEDHEALTHCARE
PO BOX 31375
SALT LAKE CITY, UT 84131-0375
ADDRESS SERVICE REQUESTED

UnitedHealthcare

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

Page 1 of 2

If you have any questions, please call us at (800) 291-2634
myallsaversconnect.com

To report fraud, contact (866) 283-7354

#BWNCHDS
#5129I1009089000#
PLAN PARTICIPANT NAME
PLAN PARTICIPANT STREET ADDRESS
PLAN PARTICIPANT CITY, STATE, ZIP CODE

SERVICE DATES	AMOUNT CHARGED	PROVIDER DISCOUNT	NOT COVERED	COVERED AMOUNT	DEDUCTIBLE	COPAY	COINSURANCE	REMARK CODE	TOTAL AMT PAID
CLAIM #: 005100000-00-0000			CUSTOMER: PLAN PARTICIPANT NAME			PROVIDER: RENDERING PROVIDER NAME			
ID #: 5400-010000			PATIENT: PATIENT NAME			ACCOUNT #: 12345678C123			
09/11/2014-09/11/2018	99.00	.47		98.53		10.00			88.53
99213-Office Medical Services									
CLAIM SUMMARY:	99.00	.47		98.53		10.00			88.53

Remarks: The discount is based on a negotiated fee from a network provider. You are not responsible for any difference between the billed charges and the negotiated amount.
Deductible, coinsurance, or copayment applied to this claim has been added to the Maximum Out of Pocket for that benefit level.

Information may continue on back of form

DATE	PAYMENT NUMBER	PAYMENT AMOUNT	PAYMENT ISSUED TO:	YTD DEDUCTIBLE REMAINING NETWORK	YTD DEDUCTIBLE REMAINING NON-NETWORK	YTD COINSURANCE REMAINING
09/30/2018	0000000000	88.53	PROVIDER NAME	2000.00		1250.00

FM-0000111-01

SAVE THIS COPY FOR YOUR RECORDS
Payments for amounts listed as "Customer's Responsibility" should be made directly to the provider.
The "Customer's Responsibility" does not reflect any payments already made.

Customer's Responsibility	
Not Covered:	0
Deductible:	0
Copay:	10.00
Coinsurance:	0
Total:	10.00

1. Patient.
The name of the person who received the medical care.

2. Claims Summary.
This section shows the "math" with details on how much your plan paid, plan discounts and how much you may owe the provider.

3. Service description.
Description of services provided.

4. Payment amount.
The amount of benefits paid to the customer or provider.

5. Customer responsibility.
This section shows your responsibility for the services provided.

6. YTD deductible and coinsurance remaining.
Shows the patient's year-to-date deductible and coinsurance amounts remaining.

7. Remarks.
This section gives additional details about how the claim was paid or not paid.

How to submit a complaint:

A participant may contact Customer Service by calling the toll-free number on the ID card to try to resolve the complaint. If the issue can't be resolved over the phone, or the participant would rather send the complaint in writing, the request may be submitted to the address found on the back of the EOB or in the Policy.

CONTINUED

Understand your pharmacy benefits.

Lowering your pharmacy costs.

Here are some tips on how to get medication at the lowest cost.

Know your plan.

Your plan may require 1 or more of the following before you can fill your prescription:

- **Prior authorization** – approval to get a medication.
- **Step therapy** – trying 1 medication before another.
- **Quantity limits** – getting a certain amount of each prescription.

Check your prescription drug list (PDL).

Your PDL is a list of covered medications. The list is broken into sections called tiers. Choosing medications in lower tiers may save you money. Check your PDL often.

Consider generic drugs.

Generic medications usually have a lower copay than brand-name medications. Ask your doctor if there's a generic option for you.

Using your benefits.

OptumRx® is your All Savers plan's pharmacy care services manager. We're committed to providing you with safe, easy and cost-effective ways to get the medication you need. Here's how to manage your pharmacy benefits online:

Log in to myallsaversconnect.com to access your pharmacy and prescription information.

Filling your prescriptions.

Delivered to your door.

Order up to a 3-month supply of the medication you take regularly for less with home delivery.

- Log in to **myallsaversconnect.com** to manage your pharmacy and prescription information.
- Call the number on your ID card.

There is no charge for standard shipping to U.S. addresses.

Pick up at the pharmacy.

- Show your ID card at any UnitedHealthcare network retail pharmacy.
- To see a list of network pharmacies, visit **myallsaversconnect.com** or call the number on your ID card.

UnitedHealthcare®

Virtual care is available by app, web or phone.

What is HealthiestYou?

HealthiestYou is a health care service that offers convenient, confidential access to quality doctors 24/7, anytime, anywhere **at no cost to you**. By scheduling a phone or video visit with one of our U.S. board-certified and licensed medical doctors, you can be diagnosed, treated and prescribed medication, if necessary, for conditions like the flu, sinus infections, rashes and more. With HealthiestYou, you can also price prescriptions in your area, search for providers, get an expert medical opinion on an existing condition and more.

How do I access HealthiestYou?

Download the HealthiestYou app, visit the website at **member.healthiestyou.com** or call **1-866-703-1259** to set up your account. Once your account is set up, you can access all of your HealthiestYou services through the HealthiestYou app or website, and visits with a doctor can also be requested by calling.

What is Expert Medical Services?

In addition to the general medical services that HealthiestYou provides, you also have access to Expert Medical Services through HealthiestYou. If you're dealing with a difficult diagnosis or questioning a treatment plan or upcoming surgery, you can have your medical case reviewed **at no cost to you** by a leading expert who specializes in your condition and get a second opinion on conditions like cancer, orthopedic problems, digestive system issues, chronic illnesses and more. Access these services through the HealthiestYou app or by calling **1-866-904-0910**.

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Health & Wellness
Motion

All Savers® Alternate Funding UnitedHealthcare Motion®

Walk to earn over $1,000 a year.

What is it?

An innovative, web-based activity program that works with your activity tracker and an app. All Savers Alternate Funding recognizes the value of your steps; you can wear your tracker to earn rewards that reimburse qualified out-of-pocket medical expenses. Walking is not only good for your physical health, it may be one of the best medicines for mental health, too.

How does it work?

After you set up the tracker and sync it with your computer or smartphone, wear it daily—and walk—paying attention to its helpful reminders. Log in to a personal dashboard for near-real-time feedback on your progress and rewards earned. You can earn over $1,000 to help reduce your annual health care costs. Your tracker measures how often you walk, how fast you walk and the number of steps you take. The research used to develop this program proved it's significantly more beneficial to your health to 1) get up and move multiple times a day, 2) include one moderately intense walk and 3) reach a step-count goal. It's called FIT because Frequency, Intensity and Tenacity matter.

How to sign up:

1. Log in to your account at **myallsaversconnect.com** and click the UnitedHealthcare Motion® link.
2. Create your UnitedHealthcare Motion account, and receive a $55 credit just for registering.
3. Select an activity tracker of your choice using the $55 registration credit to be shipped to your home. If you already have a FIT-compatible activity, you can save the registration credit for reimbursement of qualified out-of-pocket medical expenses.
4. Follow the instructions to set up your activity tracker and sync it with your computer or smartphone.

For the maximum benefit, meet these daily goals:

- Take six brief walks, at least 1 hour apart (each 500 steps taking less than 7 minutes).
- Take 1 brisk walk (3,000 steps within 30 minutes).
- Walk at least 10,000 steps total.

Questions? Call **1-855-256-8669** or email **unitedhealthcaremotion@uhc.com**.

UnitedHealthcare®

Your Apple Watch:
Pay it off by walking it off.

Purchase your Apple Watch® through **unitedhealthcaremotion.com.** As you participate in the UnitedHealthcare Motion® program and meet your daily walking goals, our Walk-It-Off payment option[1] puts your earned rewards toward the cost of your Apple Watch.

Getting started is easy:

1. **Purchase your Apple Watch through the Motion website.**
2. **Pair your Apple Watch with your phone.**
3. **Start walking.**
4. **Pay off your watch.[2]**

Track your activity. Pay down your balance. Hit your stride.
Just a few reasons why Walk-It-Off can be a step in the right direction.
For more information on Motion, visit **unitedhealthcaremotion.com.**

For assistance, call 1-855-256-8669 (TTY 711)
or email unitedhealthcaremotion@uhc.com.

UnitedHealthcare®

[1] Terms and conditions apply. The Walk-It-Off payment option currently applies to the Apple Watch only. You cannot have any existing outstanding tracking device balances with Motion. You can only purchase one Apple Watch, under the Walk-It-Off payment option, at a time. Your total price = device price + administrative fee + taxes and shipping and handling. As you achieve your daily Frequency, Intensity, Tenacity (FIT) goals, your accrued monthly rewards will be applied toward the outstanding balance for your Apple Watch. The initial payment due at checkout will include taxes and shipping and handling. Any outstanding balance after 6.5 months will be billed to your stored credit card on file. Your credit card information is stored to facilitate automated billing. You can make changes to or update your credit card information at any time by visiting your profile page at UnitedHealthcareMotion.com. At that time, the Walk-It-Off option will be complete. At the 90-day mark, you must meet a weekly average of 3 FIT goal completions (any FIT goal combination); otherwise the outstanding device balance will be applied to the stored credit card on file. At that time, the Walk-It-Off option will be complete. Device returns can only be made within 14 days from the purchase date. Specific return criteria applies. If your Apple Watch is deemed to be defective, please contact Motion Member Services for additional details 1-855-256-8669. Device balances left unpaid will be secured from future FIT earnings until balances are paid in full.

[2] Please note, the 6.5 month Walk-It-Off timeline may not be enough to walk-off the entire device purchase price for select device models. Please contact consumer support if you are interested in a model impacted and have questions.

UnitedHealthcare Motion is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker and/or certain credits may have tax implications. You should consult an appropriate tax professional to determine if you have any tax obligations from receiving an activity tracker and/or certain credits under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. Contact us and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law.

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Set healthy goals and stay on target with Rally®.

What is it?

Rally® is a user-friendly digital experience that helps you make changes in your daily routine, set smart goals for yourself and stay on target.

How does it work?

Start by taking a quick survey to get your Rally Age—a snapshot view to help you assess your current health. You'll then get customized recommendations for Missions, simple activities designed to help improve your diet, fitness and mood. As you complete activities, you'll earn Rally Coins, which you can use for a chance to win rewards.

How to sign up:

- Log in to your account at **myallsaversconnect.com** and click the **Rally link**.
- Register for your Rally account and enjoy the path to healthy activities.
- Call **1-844-334-4944** with questions.

RALLY® | UnitedHealthcare®

Health & Wellness
Real Appeal

All Savers® Alternate Funding members* can lose the weight FREE and keep it off!

Real People. Real Appeal®.

Dave L.
Age 47

"I'm stronger. I have a lot more energy. Thank you, Real Appeal."

Tashawna O.
Age 37

"This is no diet—this is not a gimmick. I feel great!"

UnitedHealthcare®

We are excited to offer Real Appeal, a free digital program that provides you with up to a full year of support for lasting weight loss.* **On average, participants lose 10 pounds after attending just 4 online classes.** Your program includes:

Personal transformation coach.

- Step-by-step guidance and customization for a program that fits your needs, preferences and goals.
- Support and motivation for a full year to help you lose weight or maintain results.
- A personalized dashboard to keep track of your calories, fitness and goals.

24/7 convenience.

Staying accountable to your goals may be easier than ever with:

- Food, activity, weight and goal trackers.
- Unlimited access to digital content.
- Your online group class, which is designed to help you build camaraderie and accountability with others in the program.
- Weekly health tips from celebrities, athletes and health experts.

Success kit.

Resources to help you kick-start your weight loss and keep yourself on the road to results. Your kit will be delivered after your first class. It includes:

- Step-by-step Success Guides.
- Workout DVDs.
- Quick and simple recipes.
- Nutrition guide.
- And much more.

Join the thousands of members that have lost nearly 1 million pounds. Start today at success.realappeal.com. Spark your transformation with Real Appeal.

real appeal® | UnitedHealthcare®

*The Real Appeal program is provided to eligible members at no additional cost to you as part of your benefit plan.

Real Appeal is a voluntary weight loss program that is offered to eligible participants over age 18 as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Administrative services provided by United HealthCare Services, Inc. or their affiliates. Stop-loss insurance is underwritten by All Savers Insurance Company in all states (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.

SECTION 125 PREMIUM PLAN

Here's how it works:

This employee enrolled himself, spouse and children on the medical plan and dental plan for a monthly premium of $833.34. As you can see, he avoided paying taxes on the premiums he paid…and his spendable income increased.

ANNUAL SALARY: $30,000 MARITAL STATUS: Married

	Before Section 125 Plan	After Section 125 Plan
Annual Salary	$30,000.00	$30,000.00
Salary Reductions		
Health Insurance Premiums	0.00	$10,000.00
Taxable Income	$30,000.00	$20,000.00
Payroll Taxes		
7.65% FICA (fixed)	$2,295.00	$1,530.00
15% Federal Tax (variable)**	$4,500.00	$3,000.00
Total Taxes	$6,795.00	$4,530.00
After-Tax Pay	$23,205.00	$15,470.00
After-Tax Expenses		
Health Insurance Premiums	$10,000.00	0.00
Actual Spendable Income	$13,205.00	$15,470.00

Annual Increase in Take-Home Pay: **$2,265.00**

** Federal Income Tax savings will vary based on your income and personal tax situation. In most cases, individual income taxes are higher than 15% and savings are more.

Participation in the Section 125 Premium Only Plan is optional. Since it decreases the amount of Social Security taxes you pay, those nearing retirement may wish to evaluate the impact of their participation with a representative of the Social Security Administration.

EMPLOYEE BENEFITS COMPLIANCE & NOTIFICATION SHEET

Below is a list of rights and notices that apply to you through your Employee Benefit plan. Please visit https://hrhub360.ease.com to download details about this important information. You will receive your user name and password via e-mail. Paper copies are available upon request from your HR department.

1. ERISA Summary Plan Description
2. Cobra Notice
3. Section 125 Premium Reduction Plan Explanation of Benefits
4. Medicare Credible Coverage Notice
5. HIPAA Special Enrollment Rights & Preexisting Condition Exclusion Notice
6. Genetic Information Nondiscrimination Act
7. Mental Health Parity & Addiction Equity Act
8. The Newborns' & Mothers' Health Protection Act
9. Women's Health and Cancer Rights Act Notice
10. Uniform Services Employment and Reemployment Rights Act Notice
11. Medicaid & Children's Health Insurance Notice (CHIP)
12. New Health Insurance Marketplace Coverage Options

WAIVER RELEASE FORM

NSI

Are there any eligible person(s) in your family who are NOT enrolling on the medical, dental or vision insurance plans?

☐ Yes (Please Complete the Remainder of the Form)

WAIVER SECTION - Coverage that you do NOT want.

I do not want the indicated coverage(s) for the following family members:

Medical Insurance:	☐ Myself	☐ My Spouse	☐ My Child(ren)
Dental Insurance:	☐ Myself	☐ My Spouse	☐ My Child(ren)
Vision Insurance:	☐ Myself	☐ My Spouse	☐ My Child(ren)

REASON FOR WAIVING

☐ I am/they are currently covered with the military

☐ I am/they are covered by another group plan

Group Name:_____ Group #: _____

☐ I am/they are covered by Medicare

☐ I am/they are covered by an Individual Plan

☐ Other: _____

_____

I understand that I/they will not be able to enroll in the insurance plans until January 1, 2022, unless I/they meet certain specific requirements, such as loss of other coverage through a spouse's employer and I/they apply for coverage immediately upon losing the other coverage. **I ALSO UNDERSTAND THAT I MAY NOT BE ABLE TO ENROLL IN INDIVIDUAL PLANS OR THE HEALTH INSURANCE EXCHANGE.**

Print Name: _____ Date of Birth: _____

Signature: _____ Date of Hire: _____