2022 Employee Benefits Packet For:

It's open enrollment for the NSI employee benefit 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, 2023, 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 2nd.

  Employees who decline coverage on the group plan will not be eligible for federal subsidy on the exchange plans.

2022 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 approximately $423.20 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:

NSI 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

The above summary is an overview only and is not a guarantee of benefits.
For complete description of benefits and limitations see your benefit book.

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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	$141.59	$180.51	$255.58	$26.45	$3.72
Employee + Spouse + Child(ren)	$273.92	$328.07	$432.52	$70.55	$8.23
Employee + Child(ren)	$82.77	$114.92	$176.94	$39.37	$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	$130.70	$166.62	$235.92	$24.41	$3.44
Employee + Spouse + Child(ren)	$252.85	$302.83	$399.25	$65.12	$7.60
Employee + Child(ren)	$76.41	$106.08	$163.33	$36.34	$3.47

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INSURANCE BENEFITS & RATES FOR: NSI

	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	$20.35	$0.00	$0.00
Employee + Spouse	$255.05	$302.27	$26.45	$3.72
Employee + Spouse + Child(ren)	$431.61	$497.43	$70.54	$8.23
Employee + Child(ren)	$176.57	$215.53	$39.37	$3.76

RATES - BI-WEEKLY PAYROLL DEDUCTIONS

	P200040 Medical	P50030 Medical	Dental	Vison
Employee Only	$0.00	$18.78	$0.00	$0.00
Employee + Spouse	$235.43	$279.02	$24.41	$3.44
Employee + Spouse + Child(ren)	$398.41	$459.17	$65.12	$7.60
Employee + Child(ren)	$162.99	$198.95	$36.34	$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	

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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	$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.

Policyholder: ADISYS CORPORATION

Group dental insurance
Benefit summary

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
	Calendar-year deductible		Coinsurance your policy pays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	100%
Basic	$50	$50	90%	80%
Major	$50	$50	60%	50%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your deductibles that are in-network for basic and major services are combined. Your deductibles that are out-of-network for basic and major services are combined.			
Combined maximum	Maximums for basic and major procedures are combined. In-network calendar year maximums are $3,000 per person or non-network calendar year maximums are $3,000 per person.			
Preventive passport	Included			
Plan type	Unscheduled			

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

Which procedures are covered, and how often?

Preventive	
Routine exams	Twice per calendar year

Routine cleanings	Four per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Twice per calendar year (covered only for dependent children under age 14)
Sealants	Covered only for dependent children under age 14; once per tooth each 24 months
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit

Basic	
Fillings	Replacement fillings every 24 months
Composite (tooth colored)	Covered on posterior teeth
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered only for specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planning	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Occlusal guards (night guards)	One guard per 36 months
Harmful habit appliance	Covered only for dependent children under age 14

Major	
Crowns	Each 84 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 84 months per tooth
Implants	Each 84 months per tooth
Bridges	84 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
Preventive passport	Benefits paid for preventive services will not be applied to your annual benefit maximum
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-247-4695, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Missing tooth –The initial placement of bridges, partials, and dentures to replace teeth missing before this coverage starts won't be covered. If this policy replaces coverage with another carrier, continuous coverage under the prior plan may be applied to the missing tooth provision requirement. This doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information.

Policyholder: ADISYS CORPORATION

Group vision
Benefit summary

What's available to me?

Vision insurance is offered through Principal® and VSP® Vision Care. It provides choice, flexibility and savings through a VSP doctor.

If you buy this coverage, an established network of VSP doctors will provide quality care for you and your dependents.

VSP choice network	
Exams	Every 12 months, one exam is covered in full after $10 copay
Prescription glasses Lenses - 1 pair covered every 12 months Frames - covered up to $150 every 12 months; 20% off amount over allowance[1]	$25 copay • Single lenses • Lined bifocal lenses • Lined trifocal lenses • Lenticular lenses • Polycarbonate lenses for dependent children under age 18
Lens enhancements	Standard progressive lenses covered once every 12 months with a $0 copay[1] Most other popular lens enhancements are covered after a copay, saving our members an average of 30%[1]
Elective contacts	Covered up to $150 every 12 months. Contact lenses can be chosen instead of glasses.
Contact fitting and evaluation	Up to $60 copay
Necessary contacts	Covered in full after $25 copay every 12 months

[1]This can vary based on state laws and provider location Savings may not apply at participating retail chains.

Who can buy coverage?

- You can buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period.
- If you're covered, you may buy coverage for your dependents.

Additional eligibility requirements may apply.

What's the difference between elective and necessary contacts?

- Elective - when vision can be corrected by glasses, but contacts are worn.
- Necessary - when vision can't be corrected with glasses due to extreme vision problems.

Why am I charged an additional copay for contact fitting and evaluation?

- Contact lens wearers require an additional evaluation of the eyes' measurements, and possible follow-up appointments, for fitting and training on proper use of contact lenses.
- For these additional services, you won't pay more than $60 at in-network providers.

Are benefits the same for all VSP doctors?

- Yes, with the exception of Costco®, Walmart®, and Sam's Club®. The frame allowance at these locations is $80 which is equivalent to a $150 allowance at other VSP doctor locations. Not all providers at participating retail chains are in-network for exam services.
- Benefits may also vary by location due to state law.

How do I find a VSP doctor?

- Visit vsp.com to locate VSP doctors close to you -- or to see if your current eye care professional is in the VSP network.
  - You'll need to choose the "Choice" doctor network to view the VSP doctors for your coverage.
- Call 800-877-7195.

Will I get an ID card?

- Yes, your card will have a unique member ID that your doctor will use to verify benefits.

Will my doctor submit my claim?

- If you're seeing a VSP doctor, they'll submit the claim for you.
- If you're seeing someone outside the VSP network, you're responsible for submitting your own claim. You can get that form from vsp.com after logging in as a member using your member ID. Or call 800-877-7195.

Are there any additional savings with VSP?

- Glasses and sunglasses - you can save an average of 20-25% off glasses or sunglasses from any VSP doctor within 12 months of your last covered vision exam.
- Laser vision correction - you pay an average of 15% off the regular price and 5% off the promotional price. You'll only receive these discounts from contracted clinics.

These savings can vary based on state laws and provider location.

What benefits do I receive if my doctor is outside VSP's network?

Covered charges	Benefit	Frequency
Exams	Up to $45	Once every 12 months
Single lenses	Up to $30	One pair every 12 months
Lined bifocal lenses	Up to $50	One pair every 12 months
Lined trifocal lenses	Up to $65	One pair every 12 months
Lenticular lenses	Up to $100	One pair every 12 months
Frames	Up to $70	One set every 12 months
Elective contacts	Up to $105	Contacts are instead of frames and lenses
Necessary contacts	Up to $210	Contacts are instead of frames and lenses

What are the limitations of my benefits?

- Visual analysis or vision aids that aren't medically necessary aren't covered.
- No benefits will be paid for:
  - Non-prescription glasses
  - Medical or surgical treatment of the eyes
  - Claims submitted by a doctor who is part of your family

Once enrolled, you'll receive a booklet with more details regarding your plan limitations and exclusions.

Policyholder: ADISYS CORPORATION

Group term life insurance
Benefit summary

What's available to me?

Protect what means the most to you – the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries.

	Benefit	Minimum	Guaranteed issue[1]	Maximum	Benefit reduction[2]
You	200% of your annual salary , rounded to the next higher $1,000	$10,000	If you're under 70: $200,000 If you're 70 or older: The lesser of $200,000 or the amount with the prior carrier	$200,000	35% reduction at age 65, with an additional 15% reduction at age 70

[1]Amount of coverage you may buy without answering medical questions.
[2]As you get older, your life insurance benefit amount decreases. Age reductions apply to the benefit amount after providing health information.

Who receives coverage?

- You'll receive coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
- If you were covered as an employee, you may be eligible as a retiree.

Additional eligibility requirements may apply.

Do I need to provide health information?

Benefit amounts over the guaranteed issue shown in the table above will require health information.

What benefits does Accidental Death and Dismemberment (AD&D) provide?

If you're accidentally injured on or off the job, you may receive a benefit equal to your life benefit.

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%

Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	$10,000
Repatriation - If you die at least 100 miles from your home	Up to $2,000
Education - If your children are enrolled in an accredited post-secondary school at the time of your death	$3,000/year for up to 4 years
Loss of use or paralysis - total loss of movement for 12 consecutive months or permanent paralysis	
Quadriplegia	100%
Paraplegia, hemiplegia, or loss of use of both hands or both feet or one hand and one foot.	50%
Loss of use of one arm, one leg, one hand or one foot	25%
Loss of speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears	100%
Loss of speech or hearing in both ears	50%
Loss of hearing in one ear	25%

Additional benefits:

Accelerated death benefit	If you're terminally ill, you may be able to receive a portion of your life benefit.
Coverage during disability	If you're disabled, you may be able to continue your coverage and not pay premium.
Conversion of terminated coverage	If coverage terminates, you may be able to convert coverage to an individual policy.

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

Principal®

principal.com

This is a summary of group term life coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: ADISYS CORPORATION

Group voluntary term life insurance
Benefit summary

What's available to me?

Protect what means the most to you – the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries.

	Benefit	Minimum	Guaranteed issue[1]	Maximum	Benefit reduction[2]
You	Select a benefit in increments of $10,000	$10,000	If you're under 70: $70,000 If you're 70 or older: $10,000	$300,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your spouse[3]	Select a benefit in increments of $5,000	$5,000	If your spouse is under 70: $20,000 If your spouse is 70 or older: $10,000	$100,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your child(ren)[3]	Options[4]: • $10,000				

[1]Amount of coverage you may buy without providing health information.
[2]As you get older, your life insurance benefit amount decreases.
[3]Amount of coverage may not exceed 100% of your benefit.
[4]Dependent children under 14 days old receive a $1,000 benefit.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - o If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you may need to provide health information for review, or if you have a qualifying event.
- If you're covered, you may buy coverage for your dependents, if they're not confined at home, in a hospital or skilled nursing facility (this is referred to as Period of Limited Activity).

Additional eligibility requirements may apply.

Do I need to provide health information?

Benefit amounts over the guaranteed issue shown in the table above for you and your spouse will require you to provide health information.

May I increase my benefit later?

- You may be able to enroll for or increase your benefit and your dependent's benefit two increments per year during your open enrollment period without providing health information.
- If you have a qualifying life event (marriage, birth of a child, etc.), you may enroll or increase your benefit up to the guaranteed issue amount within 31 days without having to provide health information.

What benefits does Accidental Death and Dismemberment (AD&D) provide?

If you're accidentally injured on or off the job, you may receive a benefit equal to your life benefit. Your spouse may receive a benefit if they are injured off the job.

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%
Loss of speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears	100%
Loss of speech or hearing in both ears	50%
Loss of hearing in one ear	25%

Occupational coverage	For your covered spouse, benefits will not be paid for an injury arising from or during employment for wage or profit.

Additional benefits:

Accelerated death benefit	If you're terminally ill, you may be able to receive a portion of your life benefit.
Coverage during disability	If you're disabled, you may be able to continue your coverage and not pay premium.
Portability	If you no longer qualify for coverage, you may be able to continue coverage for yourself and your covered dependents.
Conversion of terminated coverage	If coverage terminates, you may be able to convert coverage to an individual policy.

What are the limitations and exclusions of my coverage?

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

NORTHWEST SOFTWARE INC

Voluntary-term life/AD&D - employee

Estimated employee monthly premium amounts
End of the rate guarantee period: 12/31/2022

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®

NORTHWEST SOFTWARE INC

Voluntary-term life/AD&D - spouse

Estimated spouse monthly premium amounts
End of the rate guarantee period: 12/31/2022

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

Group short-term disability insurance
Benefit summary

Eligibility	
Eligible employees	All active, full-time employees working at least 30 hours a week
Benefits	
Primary weekly benefit	60% of your earnings up to $1,500
Benefit amount	Your primary weekly benefit minus other income sources
Elimination period	8th day for accidents and 8th day for sickness
Benefit payment period	Up to 12 weeks
Maternity	Pregnancy and childbirth are treated the same as any other disability

What's available to me?

Help protect one of your most valuable assets - the ability to earn an income. If you're temporarily disabled and can't work for a short amount of time, you can rely on short-term disability insurance to replace a portion of your weekly income.

Your primary weekly benefit is 60% of your earnings prior to your disability up to $1,500 minus other income sources. Other income sources could include but aren't limited to Social Security, other earnings, worker's compensation, state disability (if applicable), and salary continuance.

Your benefits are determined by your base wage. This is your definition of earnings and is outlined further in the booklet you'll receive following enrollment.

Compensation for business owners covers business profits plus salaries averaged over the prior two years.

Who receives coverage?

- You'll receive coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees aren't eligible.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll need to provide health information for us to review for approval, or if you have a qualifying event.

Additional eligibility requirements may apply.

When do I begin receiving disability benefits?

Your elimination period is completed on the 8th day for accidents and the 8th day for sickness. The elimination period is the amount of time before you start receiving benefits.

Once I start receiving benefits, how long will they continue?

Short-term disability benefits can continue up to 12 weeks.

What types of conditions may qualify as a disability?

You'll be considered disabled due to sickness or injury, or pregnancy.

During your elimination period and your benefit payment period (how long benefit is paid), one of the following must apply:

- You're unable to perform the majority of substantial duties of your own job; or
- You're unable to earn 80% of your income prior to your disability while working in a modified capacity.

Additional benefits:

Work incentive benefit	If you're working on a limited or part-time basis, you can keep your work earnings and may still receive your disability benefit. You can't receive more than 100% of your earnings prior to your disability.
Rehabilitation plan	If you're disabled, our staff may work with you, your physician and employer to create an individual rehabilitation plan to help you return to work. You may also receive this benefit if you're not disabled but have a condition that prevents you from working.
Rehabilitation incentive benefit	If you're totally disabled and satisfy the requirements of an individual rehabilitation plan, your benefit percentage may increase by 5%.
Mandatory rehabilitation	You may be paid for any expenses associated with an approved rehabilitation plan.

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This is a summary of short-term disability coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: ADISYS CORPORATION

Group long-term disability insurance
Benefit summary

Eligibility	
Eligible employees	All active, full-time employees working at least 30 hours a week
Benefits	
Primary monthly benefit	60% of your earnings up to $6,000
Benefit amount	Your primary monthly benefit minus other income sources
Elimination period	3 months
Own occupation period	2 year
Benefit payment period	Varies based on your age when you become disabled, see chart below
Limitations & exclusions	
Pre-existing conditions	3 months prior / 12 months insured
Other limitations	A complete list is included in your booklet

What's available to me?

Your income is important - you depend on it for almost everything. If you're too sick or hurt to work for a long period of time, you can rely on long-term disability insurance to replace a portion of your monthly income.

Your primary monthly benefit is 60% of your earnings prior to your disability up to $6,000 minus other income sources. Other income sources could include but aren't limited to Social Security for you and your dependents, other earnings, worker's compensation, state disability (if applicable) and salary continuance.

Your benefits are determined by your base wage. This is your definition of earnings and is outlined further in the booklet you'll receive following enrollment.

Compensation for business owners covers business profits plus salaries averaged over the prior two years.

Who receives coverage?

- You'll receive coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees aren't eligible.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll need to provide health information for us to review for approval, or if you have a qualifying event.

Additional eligibility requirements may apply.

When do I begin receiving disability benefits?

Your elimination period is 3 months. The elimination period is the amount of time before you start receiving benefits.

If you recover and return to work during your elimination period and become disabled again, you may not have to satisfy a new elimination period. If you qualify for this, your elimination period will pick up at the point where it was left off when you recovered.

Once I start receiving benefits, how long will they continue?

Age disability occurs	Benefits are payable until the later of:
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

Do I need to provide health information?

- Amounts above $6,000 require you to provide health information.

What types of conditions may qualify as a disability?

You'll be considered disabled due to sickness or injury, or pregnancy.

During the first 2 years of receiving benefits, your disability is based on your own occupation, known as the own occupation period. This is the occupation you're routinely performing at the time of disability. After 2 years, we'll evaluate for any occupation based on education, training or experience.

During your elimination period and your own occupation period, one of the following must apply:

- You're unable to perform the majority of the substantial and material duties of your own occupation; or
- You're unable to earn 80% of your indexed income prior to your disability while working in a modified capacity.

After completing the own occupation period, one of the following must apply:

- You're unable to 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're 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 income prior to your disability.

Do I qualify if I have a preexisting condition?

- You may. If you haven't been seen by a doctor or prescribed medication for an injury or sickness in the last 3 months or if your disability happens after 12 consecutive months of coverage, you may qualify.

Are mental nervous and drug/alcohol covered?

- It'll be considered a disability if it's caused by:
  - A mental health condition for up to a lifetime maximum of 24 months
  - Abuse, dependency, or addiction to alcohol, drug, or chemicals for up to a lifetime maximum of 24 months
- The amount of time you receive benefits for these covered conditions will be limited to a combined lifetime maximum of 24 months.

Additional benefits:

Work incentive benefit	If you're working on a limited or part-time basis, you can keep your work earnings and may still receive your disability benefit for 12 months. You can't receive more than 100% of your earnings prior to your disability.
Rehabilitation plan	If you're disabled, our staff may work with you, your physician and employer to create an individual rehabilitation plan to help you return to work. You may also receive this benefit if you're not disabled but have a condition that prevents you from working.
Survivor benefit	If you haven't been paid an accelerated survivor benefit, your survivors will receive 3 times your primary monthly benefit minus other income sources, which includes but is not limited to Social Security.

What are the limitations and exclusions of my coverage?

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.

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This is a summary of long-term disability coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

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.)

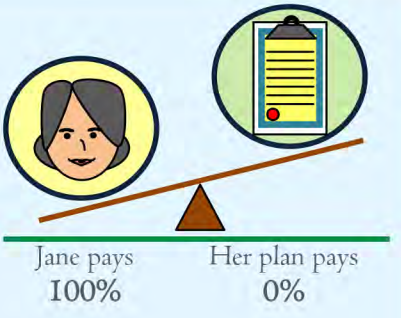
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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.

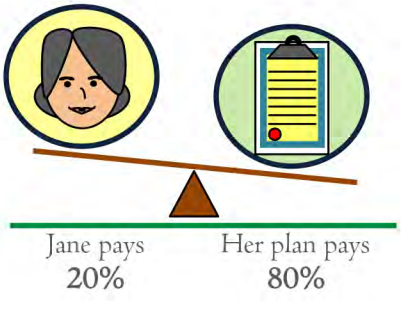
Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health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

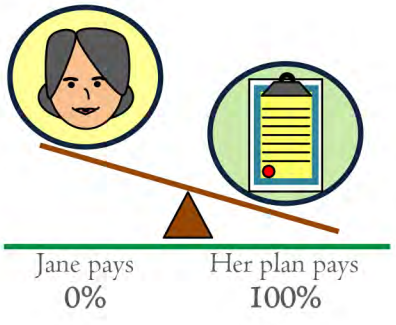
Co-insurance


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:

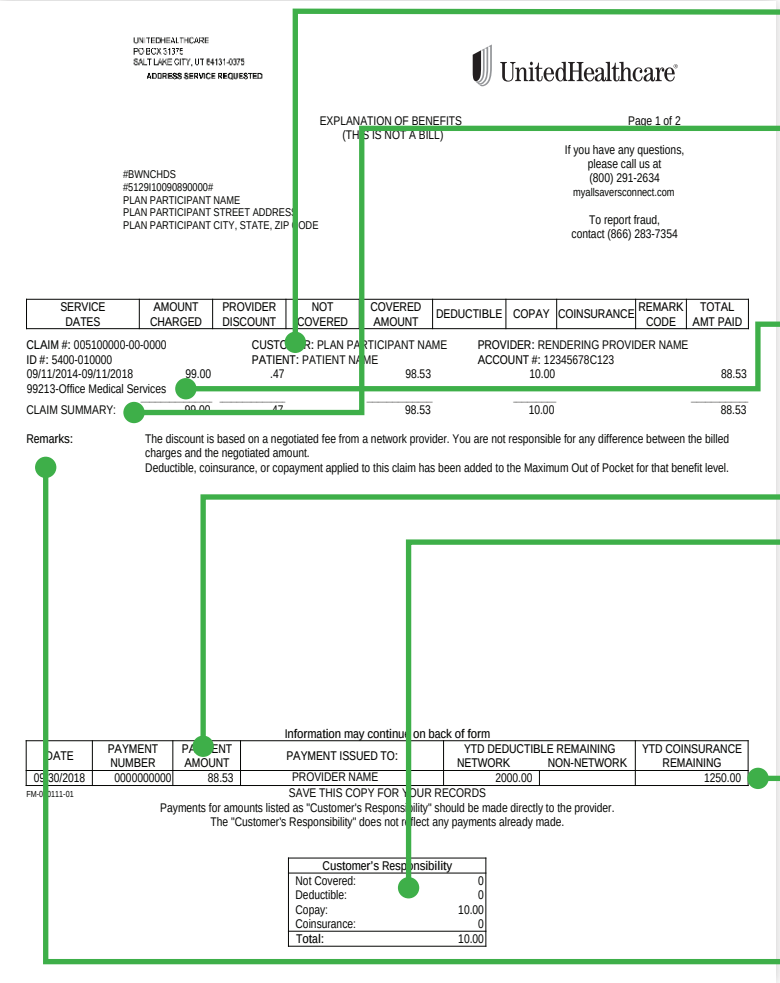
- This limit doesn't include your premium or some other changes.
- Some health plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

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-0111-01

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.

healthiestyou By Teladoc.

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**.

UnitedHealthcare®

This program is not insurance.

All trademarks are the property of their respective owners.

Note: The above services list is not all-inclusive. This information is solely provided for general informational purposes only and is not intended to take the place of legal or tax advice regarding HSA eligibility. Please consult your own legal or tax professional.

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.

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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