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 www.acsbenefitservices.com. 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 1-866-257-3259 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers $2,500 individual / $5,000 family; Non-network providers Not Applicable.	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?	Nurse Navigator coordinated services including, but not limited to, second opinions, advanced imaging, surgeries, mental health, physical therapy, Durable medical equipment, and diabetes management, (see below): $0 responsibility when the member engages prior to care and chooses the high-quality option. Yes. Network: Services in which a copayment applies; Preventive care/screening/immunizations; advanced cancer screening; Urgent care; nutritional counseling; allergy injections/serum/testing; and diabetic supplies.	This plan covers some items and services even if you haven't met the 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?	Network providers $5,000 individual / $10,000 family; Non-network providers Not Applicable. Includes deductibles, coinsurance, and copayments.	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums; balance billing charges; health care this plan doesn't cover; penalties; reductions; and expenses exceeding plan limits.	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. For a list of PPO preferred network providers visit MedCost VHN at www.medcost.com or call 1-800-824-7406 for NC/SC network providers or call 1-800-989-3837 for VA network providers. Also visit First Health at	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 a non-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).

* For more information about limitations and exceptions, see the plan or policy document or call 1-866-257-3259.

Important Questions	Answers	Why This Matters:
	www.myfirsthealth.com or call 1-800-453-7536 for outside of primary network.	Be aware, your network provider might use a non-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)	Non-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 copayment/visit deductible does not apply	Not covered	Includes OB/GYN. Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Specialist visit	$50 copayment/visit deductible does not apply	Not covered	If you would like to schedule a Specialist visit, please contact your Nurse Navigator first. Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	If you would like to schedule a Diagnostic test, please contact your Nurse Navigator first. There may be high quality, lower cost options available.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	If you would like to schedule a test (imaging), please contact your Nurse Navigator first. There may be high quality, lower cost options available. Including services rendered in a physician's office. Services may be denied if not preauthorized.

* For more information about limitations and exceptions, see the plan or policy document or call 1-866-257-3259.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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.drexi.com.	Retail: 1–30-day supply	Rx Formulary Tier 1 drug: $0.00-$9.99 = 100%-member responsibility Rx Formulary Tier 2 drug: $10.00-$99.99 = 25%-member responsibility Rx Formulary Tier 3 drug: $100.00+ = 35% up to $300 member responsibility		Deductible does not apply. Member responsibility is per prescription or refill. Certain preventive drugs are covered with $0 copayment, including prescribed generic contraceptives and tobacco cessation medications. All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list.
	Retail/Mail Order: 31-90 days' supply	Rx Formulary Tier 1 drug: $0.00-$19.99 = 100%-member responsibility Rx Formulary Tier 2 drug: $20.00-$199.99 = 25%-member responsibility Rx Formulary Tier 3 drug: $200.00+ = 35% up to $600 member responsibility		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	If you would like to schedule a surgery, please contact your Nurse Navigator first. There may be high quality, lower cost options available. Services may be denied if not preauthorized.
	Physician/surgeon fees	30% coinsurance	Not covered	If you would like to schedule a surgery, please contact your Nurse Navigator first. There may be high quality, lower cost options available.
If you need immediate medical attention	Emergency room care	40% coinsurance		None
	Emergency medical transportation	30% coinsurance		None
	Urgent care	$25 copayment/visit deductible does not apply	Not covered	FastMed Urgent Care, Urgent Care Down East: No charge, deductible does not apply.

* For more information about limitations and exceptions, see the plan or policy document or call 1-866-257-3259.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Services may be denied if inpatient hospitalization is not preauthorized.
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copayment/visit deductible does not apply; Outpatient: 30% coinsurance	Not covered	If you need mental health, behavioral health, or substance abuse services, please contact your Nurse Navigator first. There may be virtual options available at no or low cost.
	Inpatient services	30% coinsurance	Not covered	Services may be denied if inpatient hospitalization is not preauthorized.
If you are pregnant	Office visits	See specific services	Not covered	AHH Maternity Management is a voluntary Employee wellness program, focused on educating expectant mothers and mentoring them through each trimester of Pregnancy. The Deductible for the baby is waived if the Plan Participant enrolls in AHH Maternity Management during her first trimester. A Plan Participant who enrolls in the first trimester will have the option of receiving a gift card or a $500 credit to the Plan's In-Network Deductible upon graduation from the program. See Human Resources for more information. Cost sharing does not apply to preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Coverage is provided for covered employee and spouse only.
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

* For more information about limitations and exceptions, see the plan or policy document or call 1-866-257-3259.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	90 visit limit for home health care per person per calendar year (visit limits are a combination of network providers and non-network providers).
	Rehabilitation services	30% coinsurance	Not covered	If you need physical therapy, please contact your Nurse Navigator first. There may be high quality, lower cost options available. Visit limits for rehabilitation services are per person per calendar year (visit limits are a combination of network providers and non-network providers). 30 visit limit each for occupational, physical and speech therapy. Services may be denied if inpatient rehabilitation is not preauthorized. Separate limit from Habilitation services.
	Habilitation services	30% coinsurance	Not covered	Visit limits for habilitation services are per person per calendar year (visit limits are a combination of network providers and non-network providers). 30 visit limit each for occupational, physical and speech therapy. Limits do not apply when related to autism. Separate limit from Rehabilitation services.
	Skilled nursing care	30% coinsurance	Not covered	100 days limit for inpatient skilled nursing facility care per person per calendar year (visit limits are a combination of network providers and non-network providers). Services may be denied if an inpatient skilled nursing facility stay is not preauthorized.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	Not covered	If you need Durable medical equipment, please contact your Nurse Navigator first. There may be high quality, lower cost options available. Charges for rental of durable medical equipment that exceed the allowed charge for such equipment are not covered.
	Hospice services	30% coinsurance	Not covered	Services may be denied if inpatient hospice is not preauthorized.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	Limited to vision screening only.
	Children's glasses	Not covered		No coverage provided.
	Children's dental check-up	No charge, deductible does not apply	Not covered	Limited to oral health risk assessment only.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (20 visit limit per calendar year)
- Private-duty nursing (90 visit limit per calendar year)

Your Rights to Continue Coverage: For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 ACS Benefit Services at 1-866-257-3259.

* For more information about limitations and exceptions, see the plan or policy document or call 1-866-257-3259.

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 1-866-257-3259.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-257-3259.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-257-3259

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-257-3259.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist copayment	$50
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	$2,500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,060

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

The plan's overall deductible	$2,500
Specialist copayment	$50
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	$900
Copayments	$300
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,720

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

The plan's overall deductible	$2,500
Specialist copayment	$50
Hospital (facility) coinsurance	40%
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	$2,500
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,710

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

* For more information about limitations and exceptions, see the plan or policy document or call 1-866-257-3259.