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 1-800-849-5370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	There are no deductibles	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan operates in conjunction with your employer's major medical plan. See the Summary of Benefits and Coverage for your major medical plan.
Is there an overall annual limit on what the plan pays?	Yes. $600 employee-only	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. This plan operates in conjunction with your employer's major medical plan. See the Summary of Benefits and Coverage for your major medical plan.
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?	This plan has no out-of-pocket limit.	This plan operates in conjunction with your employer's major medical plan. See the Summary of Benefits and Coverage for your major medical plan.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	No	This plan treats providers the same in determining payment for the same services. This plan operates in conjunction with your employer's major medical plan. See the Summary of Benefits and Coverage for your major medical plan.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral. This plan operates in conjunction with your employer's major medical plan. See the Summary of Benefits and Coverage for your major medical plan.

* For more information about limitations and exceptions, see the plan or policy document or call 1-800-849-5370.

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	Not Applicable	Not Applicable	This plan covers only those charges that are covered by your medical plan and are applied to your medical plan deductible.
	Specialist visit	Not Applicable	Not Applicable	"See above"
	Preventive care/screening/ immunization	Not Applicable	Not Applicable	"See above"
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable	Not Applicable	"See above"
	Imaging (CT/PET scans, MRIs)	Not Applicable	Not Applicable	"See above"
If you need drugs to treat your illness or condition	Generic drugs	Not Applicable		Not Applicable
	Preferred brand drugs	Not Applicable		
	Non-preferred brand drugs	Not Applicable		
	Specialty drugs	Not Applicable		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	Not Applicable	"See above"
	Physician/surgeon fees	Not Applicable	Not Applicable	"See above"
If you need immediate medical attention	Emergency room care	Not Applicable		"See above"
	Emergency medical transportation	Not Applicable		"See above"
	Urgent care	Not Applicable	Not Applicable	"See above"
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	Not Applicable	"See above"
	Physician/surgeon fees	Not Applicable	Not Applicable	"See above"
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Not Applicable	"See above"
	Inpatient services	Not Applicable	Not Applicable	"See above"

* For more information about limitations and exceptions, see the plan or policy document or call 1-800-849-5370.

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 are pregnant	Office visits	Not Applicable	Not Applicable	"See above"
	Childbirth/delivery professional services	Not Applicable	Not Applicable	
	Childbirth/delivery facility services	Not Applicable	Not Applicable	
If you need help recovering or have other special health needs	Home health care	Not Applicable	Not Applicable	"See above"
	Rehabilitation services	Not Applicable	Not Applicable	"See above"
	Habilitation services	Not Applicable	Not Applicable	"See above"
	Skilled nursing care	Not Applicable	Not Applicable	"See above"
	Durable medical equipment	Not Applicable	Not Applicable	"See above"
	Hospice services	Not Applicable	Not Applicable	"See above"
If your child needs dental or eye care	Children's eye exam	Not Applicable	Not Applicable	"See above"
	Children's glasses	Not covered		No coverage provided.
	Children's dental check-up	Not Applicable	Not Applicable	"See above"

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.)

- This plan covers only those charges that are covered by your medical plan that are applied to your medical plan deductible. See your medical plan Summary of Benefits and Coverage.

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

- This plan covers only those charges that are covered by your medical plan that are applied to your medical plan deductible. See your medical plan Summary of Benefits and Coverage.

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 Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying 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 1-800-849-5370; or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272); or www.dol.gov/ebsa/healthreform.

* For more information about limitations and exceptions, see the plan or policy document or call 1-800-849-5370.

Does this plan provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." The Summary of Benefits and Coverage (SBC) for the medical plan will disclose whether this plan or policy does or does not provide minimum essential coverage.

Does this plan meet the Minimum Value Standards?

The Affordable Care Act establishes a Minimum Value Standards of benefits of a health plan. The minimum value standard is 60% (actuarial value). The Summary of Benefits and Coverage (SBC) for the medical plan will disclose whether this plan or policy does or does not meet the minimum value standard for the benefits it provides.Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-849-5370.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-849-5370.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-849-5370

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-849-5370.

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

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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 *[cost sharing]*	*
Hospital (facility) *[cost sharing]*	*
Other *[cost sharing]*	*

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	*
Coinsurance	*
What isn't covered	
Limits or exclusions	*
The total Peg would pay is	$*

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 *[cost sharing]*	*
Hospital (facility) *[cost sharing]*	*
Other *[cost sharing]*	*

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	$2,500
Copayments	*
Coinsurance	*
What isn't covered	
Limits or exclusions	*
The total Joe would pay is	$*

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

The plan's overall deductible	$2,500
Specialist *[cost sharing]*	*
Hospital (facility) *[cost sharing]*	*
Other *[cost sharing]*	*

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	*
Coinsurance	*
What isn't covered	
Limits or exclusions	*
The total Mia would pay is	$*

*This plan covers only those charges that are covered by your employer's medical plan that are applied to your medical plan's deductible. Thus, this plan will cover the amount of $600 employee-only that was applied to the medical plans deductible. See the Summary of Benefits and Coverage for your major medical plan.

* For more information about limitations and exceptions, see the plan or policy document or call 1-800-849-5370.