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, www.myhealthbenefits.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 www.healthcare.gov/sbc-glossary or call 1-888-256-2750 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Open Access:** **$3,400** / Individual **$5,000** / Family The Edison services deductible is $1,700. This is integrated with the annual HDHP deductible of $3,400 for an individual and $5,000 for the family.	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 and services covered at "No Charge".	This plan covers some items and services without meeting a deductible. But a copayment or coinsurance may apply. For example, this plan certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gove/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?	**Open Access:** **$3,500** / Individual **$7,000** / 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, the overall family members in this plan they must 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, penalties for preauthorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	No. The plan is open access	**Provider Services**: For a list of providers, visit www.primehealthpon.primehealthservices.com **Facility Services:** There is no network for facilities. The Prime Network is for Providers/Ancillary Services only, facilities are not included in this network. All facilities and non-network providers are repriced by ClaimDOC. Contact ClaimDOC at 1-888-330-7295 or visit portal.claim-doc.com for assistance with introducing the plan to your providers/facilities or finding a new provider/facility.
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, unless otherwise indicated.

		Open Access Provider What You Will Pay	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after the deductible	**Telemedicine:** Teladoc: PCP/Specialist: $57 copay after deductible Non Teladoc: PCP/Specialist: 80% after deductible
	Specialist visit	20% coinsurance after the deductible	
	Preventive care/screening/ immunization	No Charge	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. See a list of covered preventive services at https://www.healthcare.gove/coverage/preventive-care-benefits/.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after the deductible	None No charge, after Edison deductible, when using Edison providers. When using Edison, pre-authorization is not required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after the deductible	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-256-2750.

Important Questions	Answers			Why This Matters:
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **BMRx: BMR (bmr-inc.com)**	Generic drugs	Retail: 25% copay, not to exceed $10 per prescription, after deductible Mail Order: $25 copay/prescription, after deductible	Not covered	Prescription costs are subject to the Medical Out-of-Pocket. Generic FDA approved forms of contraceptives for women and generic preventive care drugs, as required under PPACA. If a generic is available and you choose the brand name, you will be responsible for the co-pay plus the difference in cost between the brand name and generic prescription. When purchased outside the Retail Plan or Mail Order Plan: Applicable co-pay applies; subject to the Medical Out-of-Pocket. Prior authorization may be required on certain prescription drug. Orphan drugs are excluded.
	Preferred brand drugs	Retail: 30% copay, not to exceed $20 per prescription, after deductible Mail Order: $50 copay/prescription, after deductible	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **BMR (bmr-inc.com)**	Non-preferred brand drugs	Retail: 30% copay, not to exceed $45 per prescription, after deductible Mail Order: $112.50 copay/prescription, after deductible	Not covered	
	Specialty drugs	Retail Only: 50% copay, not to exceed $90 per prescription, after deductible	Not covered	Specialty drugs must be filled through **BMRx**. Case Management required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after the deductible		Preauthorization required. Participants are encouraged to call BRMS prior to surgery at 1-888-256-2750.
	Physician/surgeon fees	20% coinsurance after the deductible		
If you need immediate medical attention	Emergency room care	20% coinsurance after the deductible		None
	Emergency medical transportation	Ground Ambulance: 20% coinsurance after the deductible Air Ambulance: 20% coinsurance after the deductible and Medically Necessary. Non-Emergency: Not Covered 20% coinsurance after the deductible		You are responsible for balance billing if not a true emergency.

Important Questions	Answers	Why This Matters:	
	Urgent care	20% coinsurance after the deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after the deductible	Preauthorization required. Participants are encouraged to call BRMS prior to any inpatient stay at 1-888-256-2750. No charge, after Edison deductible, when using Edison providers.
	Physician/surgeon fees	20% coinsurance after the deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after the deductible	None.
	Inpatient services	20% coinsurance after the deductible	Preauthorization required. Participants are encouraged to call BRMS prior to any inpatient stay at 1-888-256-2750.
If you are pregnant	Office visits	No Charge	None
	Childbirth/delivery professional services	20% coinsurance after the deductible	Home Delivery not covered. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Professional fees rendered in a facility setting are covered at 100% after deductible.
	Childbirth/delivery facility services	20% coinsurance after the deductible	Participants are encouraged to call BRMS prior to delivery at 1-888-256-2750. Preauthorization is only required for stay exceeding 48 hours after normal delivery or 96 hours after C-section.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after the deductible	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-256-2750. Maximum of 100 visits per Calendar Year.
	Rehabilitation services	20% coinsurance after the deductible	Preauthorization is required. Participants are encouraged to call BRMS prior to receiving services at 1-888-256-2750. Massage Therapy not covered.

Important Questions	Answers		Why This Matters:
			Occupational Therapy: Maximum of 50 visits per illness or injury combined with Speech and Physical Therapy.
	Habilitation services	20% coinsurance after the deductible	Massage Therapy not covered. Occupational Therapy: Maximum of 50 visits per illness or injury combined with Speech and Physical Therapy.
	Skilled nursing care	20% coinsurance after the deductible	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-256-2750. Maximum of 60 days per Calendar Year
	Durable medical equipment	20% coinsurance after the deductible	Preauthorization is required for equipment over $500. Participants are encouraged to call BRMS prior to receiving services at 1-1-888-256-2750. Maximum for Foot Orthotics: Covered Person aged 19 and over: 1 pair per 12 months Covered Person up to age 19: 1 pair per 6 months
	Hospice services	Inpatient/Home: 20% coinsurance after the deductible	Preauthorization is required. Participants are encouraged to call BRMS prior to receiving services at 1-888-256-2750. Includes coverage for bereavement counseling within 6 months after the patient's death.
If your child needs dental or eye care	Children's eye exam	Not Covered	None
	Children's glasses	Not Covered	None
	Children's dental check-up	Not Covered	None

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Wigs
- Infertility Treatment
- Long-term care
- Non-Emergency care when traveling outside of the U.S.
- Private Duty Nursing
- 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.)

- Acupuncture (Limited to Maximum of $500 per Calendar Year)
- Chiropractic Care (Limited to Maximum of 25 visits per Calendar Year)
- Hearing Aids (Limited to Maximum of $1,500 per ear, per 4-year period)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: BRMS at 1-888-256-2750 or myhealthbenefits.com or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 1-888-256-2750.

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 pre-natal care and a hospital delivery)

The plan's overall deductible	$3,400
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other (generic drug) 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	$3,400
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	$3,400
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other (brand drug) 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	$3,400
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

The plan's overall deductible	$3,400
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other (generic drug) 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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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