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, contact your employer. 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 855-490-8070 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,200 Individual / $5,000 Family for In-Network Deductible is embedded	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. In-Network preventive care and services covered at "No charge".	This plan covers some items and services even if you haven't yet 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?	Yes. Edison Deductible: $1,600 Individual / $3,200 Family for In-Network The Edison Deductible is included in the overall deductible.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,500 Individual / $7,000 Family for In-Network Out-Of-Pocket Limit is embedded.	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-billing charges, and health care this plan doesn't cover.	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 physicians and all other covered professional services. For list of network providers, visit www.marpaihealth.com or call 855-490-5070. For a list of low-cost providers visit Guide@EdisonEHS.com or call (855) 633-2684. Facilities not available through the PPO are hospitals, ambulatory health care centers, dialysis, and other ancillary facilities.	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**.**

Benefits and cost sharing accumulate on a Calendar Year basis from 01/01 through 12/31 each year. NOTE: This plan is integrated with a Health Savings Account (HSA). Deductibles, Copayments, and other qualified out-of-pocket expenses may be reimbursable under the HSA.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies, unless otherwise stated.

Common Medical Event	Services You May Need	What You Will Pay Medical Benefits (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	None
	Specialist visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	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)	20% coinsurance	$300 penalty if genetic testing and sleep studies not Pre-Certified. Member is not responsible for penalty. No charge, after Edison deductible, when using Edison providers. When using Edison, pre-authorization is not required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	$300 penalty if not Pre-Certified. Member is not responsible for penalty. No charge, after Edison deductible, when using Edison providers. When using Edison, pre-authorization is not required.

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay Medical Benefits (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bmr-inc.com	Generic drugs	Retail: 25% copay, not to exceed $10 per prescription, after deductible Mail Order: $25 copay/prescription, after deductible	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 drugs. 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	
	Non-preferred brand drugs	Retail: 30% copay, not to exceed $45 per prescription, after deductible Mail Order: $112.50 copay/prescription, after deductible	
	Specialty drugs	Retail Only: 50% copay, not to exceed $90 per prescription, after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	$300 penalty if certain surgical procedures not Pre-Certified. Member is not responsible for penalty. No charge, after Edison deductible, when using Edison providers.
	Physician/surgeon fees	20% coinsurance	No charge, after Edison deductible, when using Edison providers.
If you need immediate medical attention	Emergency room care	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	None
	Urgent care	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$300 penalty if not Pre-Certified. Member is not responsible for penalty. No charge, after Edison deductible, when using Edison providers.
	Physician/surgeon fees	20% coinsurance	None

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay Medical Benefits (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	No charge, after Edison deductible, when using Edison providers.
	Inpatient services	20% coinsurance	$300 penalty if not Pre-Certified. Member is not responsible for penalty.
If you are pregnant	Office visits	20% coinsurance; Routine Prenatal Care: No charge, deductible does not apply	None
	Childbirth/delivery professional services	No charge after deductible; Routine Prenatal Care: No charge, deductible does not apply	None
	Childbirth/delivery facility services	20% coinsurance	$300 penalty if admissions exceeding 48/96 hours not Pre-Certified. Member not responsible for penalty.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Limited to maximum of 100 visits per Calendar Year. No charge, after Edison deductible, when using Edison providers.
	Rehabilitation services	20% coinsurance	Physical Therapy, Occupational Therapy, Speech Therapy are limited to a combined 50 visits per Illness. No charge, after Edison deductible, when using Edison providers.
	Habilitation services	20% coinsurance	
	Skilled nursing care	20% coinsurance	Limited to maximum of 60 days per Calendar Year.
	Durable medical equipment	20% coinsurance	$300 penalty if DME over $1,000 not Pre-Certified. Member is not responsible for penalty. No charge, after Edison deductible, when using Edison providers.
	Hospice services	20% coinsurance	None
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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

* For more information about limitations and exceptions, see the plan document.

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: the Department of Labor's Employee Benefits 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 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 your employer 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 855-490-8070.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-490-8070.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855-490-8070.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-490-8070.

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 document.

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	$3200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services: In 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	$3,200
Copayments	$30
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,450**

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

The plan's overall deductible	$3200
Specialist coinsurance	20%
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 *(Insulin)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,920
Copayments	$895
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,835**

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

The plan's overall deductible	$3200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency Department: Facility *(including medical supplies)*
Diagnostic Services *(radiology)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,790
Copayments	$5
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,795**

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