**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2025 – 12/31/2025**

**Navajo County HSA Coverage for:** Individual + Family **| Plan Type:** HDHP

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| --- |
| Picture of exclamation point to label important information**The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan.**](https://www.healthcare.gov/sbc-glossary/#plan) **The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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](http://www.myhealthbenefits.com). For general definitions of common terms, such as [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [balance billing,](https://www.healthcare.gov/sbc-glossary/#balance-billing) [coinsurance,](https://www.healthcare.gov/sbc-glossary/#coinsurance) [copayment,](https://www.healthcare.gov/sbc-glossary/#copayment) [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider,](https://www.healthcare.gov/sbc-glossary/#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](http://www.healthcare.gov/sbc-glossary%20or%20call%201-888-256-2750) to request a copy. |

| **Important Questions** | | **Answers** | | **Why This Matters:** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | | **Open Access:**  **$3,300 /** Individual  **$5,000 /** Family  The Edison services deductible is integrated with the annual HDHP deductible of $3,300 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**](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | | **No.** | | You don’t have to meet deductibles for specific services. | | | | |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#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. | | | | |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | | No. The plan is open access | | **Provider Services**: For a list of providers, visit [www.primehealthpon.primehealthservices.com](http://www.primehealthpon.primehealthservices.com)  **Facility Services:** There is no network for facilities.  Contact ClaimDOC at 1-888-330-7295 or visit [portal.claim-doc.com](https://portal.claim-doc.com/login?returnUrl=%2F) for assistance with introducing the plan to your providers/facilities or finding a new provider/facility. | | | | |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | | No. | | You can see the specialist you choose without a referral. | | | | |
| Picture of exclamation point to label important informationAll [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, unless otherwise indicated. | | | | | | |
|  |  | | **Open Access Provider**  **What You Will Pay** | | |  | |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | | 20% coinsurance after the deductible | | | **Telemedicine:**  Teladoc: PCP/[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist): 100%, deductible waived.  Non Teladoc: PCP/[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist): 80% after deductible | |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | | 20% coinsurance after the deductible | | |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#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. | |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug** **coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [**BMRx**](http://www.anthem.com)**:** [**BMR (bmr-inc.com)**](https://bmr-inc.com/)  **If you need drugs to treat your illness or condition**  More information about [**prescription drug** **coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [**BMR (bmr-inc.com)**](https://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 |
| 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](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | | 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](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | | 20% coinsurance after the deductible | | | None | |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#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. | |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#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 | | | No charge, after Edison deductible, when using Edison providers. | |
| 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.  No charge, after Edison deductible, when using Edison providers. | |
| **If you are pregnant** | Office visits | | 20% coinsurance after the deductible. 100% after deductible; routine prenatal care covered at 100%, deductible waived | | | 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.  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. | |
| Childbirth/delivery facility services | | 20% coinsurance after the deductible | | |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#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.  Occupational Therapy: Maximum of 50 visits per illness or injury combined with Speech and Physical Therapy. | |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/#marketplace) visit [www.HealthCare.gov](http://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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim.](https://www.healthcare.gov/sbc-glossary/#claim) This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal.](https://www.healthcare.gov/sbc-glossary/#appeal) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim.](https://www.healthcare.gov/sbc-glossary/#claim) Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information on how to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits).

**Does this plan meet the Minimum Value Standards?** **Yes**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards,](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard) you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace)

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-256-2750.

***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#plan) ***might cover costs for a sample medical situation, see the next section.***

**About these Coverage Examples:**

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| Picture of exclamation point to label important information**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). 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](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $3,200

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [co](https://www.healthcare.gov/sbc-glossary/#cost-sharing)payment 20%

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#cost-sharing) 20%

◼ Other (generic drug) [co](https://www.healthcare.gov/sbc-glossary/#cost-sharing)payment 20%

**This EXAMPLE event includes services like:**

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) office visits *(prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(ultrasounds and blood work)*

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
| --- | --- |
| **In this example, Peg would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $3,200 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $30 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#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 care of a well- controlled condition)

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $3,200

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [co](https://www.healthcare.gov/sbc-glossary/#cost-sharing)payment 20%

◼ Hospital (facility) [coins](https://www.healthcare.gov/sbc-glossary/#cost-sharing)urance 20%

◼ Other (brand drug) [co](https://www.healthcare.gov/sbc-glossary/#cost-sharing)payment 20%

**This EXAMPLE event includes services like:**

[Primary care physician](https://www.healthcare.gov/sbc-glossary/#primary-care-physician) office visits *(including disease education)*

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(blood work)*

[Prescription drugs](https://www.healthcare.gov/sbc-glossary/#prescription-drugs)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(glucose meter)*

| **Total Example Cost** | **$5,600** |
| --- | --- |
| **In this example, Joe would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $1,920 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $895 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,835** |

**Mia’s Simple Fracture**

(emergency room visit and follow up care)

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $3,200

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [co](https://www.healthcare.gov/sbc-glossary/#cost-sharing)payment 20%

◼ Hospital (facility) [co](https://www.healthcare.gov/sbc-glossary/#cost-sharing)insurance 20%

◼ Other (generic drug) [co](https://www.healthcare.gov/sbc-glossary/#cost-sharing)insurance 20%

**This EXAMPLE event includes services like:**

[Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) *(including medical supplies)*

[Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (*x-ray*)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(crutches)*

[Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) *(physical therapy)*

| **Total Example Cost** | **$2,800** |
| --- | --- |
| **In this example, Mia would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $2,790 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $5 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,795** |

The [plan](https://www.healthcare.gov/sbc-glossary/#plan) would be responsible for the other costs of these EXAMPLE covered services.