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, [insert contact information]. 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.myhealthbenefits.com or call 1-888-256-2750 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Open Access:** Individual **$3,300** / Family **$5,000** Edison is available at no charge for PPO Plan participants.	Generally, you must pay all 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 listed in your complete terms of coverage.	The 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?	No	You don't have to meet the deductible for specific services.
What is the out-of-pocket limit for this plan?	**Open Access:** Individual **$3,500** / Family **$7,000**	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 for these expenses, they don't count toward the out-of-pocket limit.
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, if a **deductible** applies.

Common Medical Event	Services You May Need	Open Access Provider What You Will Pay		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	$30 copay deductible waived		**Telemedicine:** Teladoc: PCP/Specialist: 100%, deductible waived. Non Teladoc: PCP: $30 copay deductible waived Specialist: $60 copay deductible waived
	Specialist visit	$60 copay deductible waived		None
	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.
If you have a test	Diagnostic test (x-ray, blood work)	Office: No Charge after copay All other places of service: 20% coinsurance after the deductible		None No charge 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** is available at **BMRx: BMR (bmr-inc.com)**	Generic drugs (Tier 1)	Retail: 25% copay, not to exceed $10 per prescription Mail Order: $25 copay/prescription	Not covered	Prescription cost are subject to the 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 copay plus the difference in cost between the brand name and generic prescription. When purchased outside the Retail or Mail Order Plan applicable copay applies; subject to the Medical out-of-pocket. Prior authorization may be required on certain prescription drugs. Orphan drugs are excluded.
	Preferred brand drugs (Tier 2)	Retail: 30% copay, not to exceed $20 per prescription Mail Order: $50 copay/prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: 30% copay, not to exceed $45 per prescription Mail Order: $112.50 copay/prescription	Not covered	
	Specialty drugs	Retail Only: 50% copay, not to exceed $90 per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after the deductible		

[* For more information about limitations and exceptions, see the plan or policy document at www.healthcare.gov/sbc-glossary

Common Medical Event	Services You May Need	Open Access Provider What You Will Pay	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	20% coinsurance after the deductible	Preauthorization required. Participants are encouraged to call BRMS prior to surgery at 1-888-256-2750.No charge when using Edison provider.
If you need immediate medical attention	Emergency room care	Emergency: $500 copay Non Emergency: 20% coinsurance after the deductible	If patient is admitted from the emergency department, the copay is waived, and the deductible/coinsurance apply.
	Emergency medical transportation	Ground Ambulance: 20% coinsurance after the deductible Air Ambulance: 20% coinsurance after the deductible and Medically Necessary. Non-Emergency: Not Covered	You are responsible for balance billing if not a true emergency.
	Urgent care	$100 copay deductible waived	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 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	$30 copay deductible waived	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. 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	

Common Medical Event	Services You May Need	Open Access Provider What You Will Pay	Limitations, Exceptions, & Other Important Information
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	$60 copay deductible waived	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	$60 copay deductible waived	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	20% coinsurance after 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

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Common Medical Event	Services You May Need	Open Access Provider What You Will Pay	Limitations, Exceptions, & Other Important Information
	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
- Wigs

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 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 [insert telephone number 1-888-256-2750

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number 1-888-256-2750

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 or policy document at www.healthcare.gov/sbc-glossary

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** **$3,300**
- **Specialist copay** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other 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	$3,300
Copayments	$0
Coinsurance	$200
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** **$3,300**
- **Specialist copay** **$60**
- **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
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$400
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

- **The plan's overall deductible** **$3,300**
- **Specialist copay** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other 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	$,1300
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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