**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, call BRMS at 1-888-287-2731 or visit 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 1-866-995-2450 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0 /** Individual<br>**$0 /** Family | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes. There is no deductible for covered services | You don't have to meet deductibles for covered items and services. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing. See a list of covered preventive services at http://www.healthcare.gov/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?** | Medical:<br>**$1,500 /** Individual<br>**$3,000 /** Family<br><br>Pharmacy:<br>**$7,200** / Individual<br>**$14,400** / 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, 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, 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?** | **Yes.** See www.anthem.com or call 1-866-995-2450 for a list of network providers. | 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-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 | $10/visit | Not covered | Telemedicine with your primary physician or specialist will be covered the same as any other office visit. |
| | Specialist visit | $10/visit | Not covered | Telemedicine with your primary physician or specialist will be covered the same as any other office visit. |
| | Preventive care/screening/ immunization | No Charge | Not covered | 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.<br><br>See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not covered | Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.anthem.com** | Generic drugs | **Retail**: $5/prescription<br><br>**Mail Order** $10/prescription | Not applicable | Certain medications considered preventative care under ACA are payable at no cost-share to the member.<br><br>**Retail:** up to a 90-day supply<br>**Mail Order:** up to a 90-day supply<br><br>All contraceptives covered at 100%.<br><br>Maintenance drugs must be filled through mail order – **CarelonRx.** |
| | Preferred brand drugs | **Retail**: $20/prescription<br><br>**Mail Order** $40/prescription | Not applicable | |
| | Non-preferred brand drugs | **Retail**: $50/prescription<br><br>**Mail Order** $100/prescription | Not applicable | |
| | Specialty drugs | 20% coinsurance up to $250 max/prescription | Not applicable | Specialty drugs must be filled through **CarelonRx**. Case Management required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | Not covered | Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731. |
| | Physician/surgeon fees | No Charge | Not covered | |
| **If you need immediate medical attention** | Emergency room care | $50 / visit | Covered as in-network | Copayment does not apply if admitted. |
| | Emergency medical transportation | No Charge | Covered as in-network | Preauthorization is required for non-emergency ambulance services.<br><br>You are responsible for balance billing if not a true emergency. |
| | Urgent care | $10/visit | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Not covered | Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731. |
| | Physician/surgeon fees | No Charge | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10/visit | Not covered | Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731. |
| | Inpatient services | No Charge | Not covered | |
| **If you are pregnant** | Office visits | No Charge | Not covered | Cost sharing does not apply to preventive services. |
| | Childbirth/delivery professional services | No Charge | 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% |
| | Childbirth/delivery facility services | No Charge | Not covered | Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay. |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not covered | Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731. |
| | Rehabilitation services | $10/visit | Not covered | Includes physical, speech, occupational, and other rehabilitative therapies. Cardiac therapy is limited to 40 visits/year. Pulmonary therapy is limited to 30 visits/year. Physical, speech, and occupational therapy limited to 24 visits/year. Additional visits may be approved if medically necessary. |
| | Habilitation services | $10/visit | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Skilled nursing care | No Charge | Not covered | Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731.<br><br>Maximum of 100 days per Calendar Year. |
| | Durable medical equipment | No Charge | Not covered | Preauthorization required for any equipment exceeding $500. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731. |
| | Hospice services | No Charge | Not covered | Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-287-2731. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Not Covered |
| | Children's glasses | Not Covered | Not Covered | Not Covered |
| | Children's dental check-up | Not Covered | Not Covered | Not Covered |

## 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.)**

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long-term care
- Non-Emergency care when traveling outside of the U.S.
- Routine eye care
- 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 $20 copay, limited to 20 visits for acupuncture and chiropractic services combined per *calendar year*.
- Private Duty Nursing – as part of home health.
- Hearing Aids, $1000 every 36 months.
- Chiropractic Care $20 copay, limited to 20 visits for acupuncture and chiropractic services combined per *calendar year.*

**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, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-866-995-2450 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 1-866-995-2450.

*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 in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) coinsurance** | **0%** |
| **Other coinsurance** | **0%** |

**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 | $0 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$70** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) coinsurance** | **0%** |
| **Other coinsurance** | **0%** |

**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 | $0 |
| Copayments | $410 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$430** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) coinsurance** | **0%** |
| **Other coinsurance** | **0%** |

**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 | $0 |
| Copayments | $110 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$110** |

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