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, see www.mybronsonbenefits.com and/or call 1-800-211-1534. 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.cciio.cms.gov or call 1-800-211-1534 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** individual / **$600** family for Bronson Network providers; **$500** individual / **$1,000** family for BCBMS Network providers; **$1,000** individual / **$2,000** family for Out-of-Network providers. Copays and coinsurance do not count towards the deductible.	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. Preventative care and primary care services are covered before you meet your deductible.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,500** Individual / **$5,000** family for Bronson Network and BCBMS providers; **Unlimited** individual / **Unlimited** family for Out-of-Network providers.	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. Certain pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	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?	Yes. See www.mybronsonbenefits.com or call 1-800-211-1534 for a list of network providers.	You pay the least if you use a provider in Bronson Network. You pay more if you use a provider in BCBSM 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.

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	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Bronson Network Provider (You will pay the least)	BCBSM Network Provider	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	$20 copay/visit	$40 copay/visit	50% coinsurance	——————none——————
	Specialist visit	$40 copay/visit	$60 copay/visit	50% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge	No charge	50% coinsurance	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)	15% coinsurance	30% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	50% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is	Generic drugs	10% coinsurance ($5 minimum, $75 maximum) retail / 10% coinsurance ($15 minimum) mail order	10% coinsurance ($5 minimum, $75 maximum) retail / 10% coinsurance ($15 minimum) mail order	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).

[* For more information about limitations and exceptions, see the plan or policy document at www.mybronsonbenefits.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Bronson Network Provider (You will pay the least)	BCBSM Network Provider	Out-of-Network Provider (You will pay the most)	
available at www.express-scripts.com	Preferred brand drugs	20% coinsurance ($10 minimum, $125 maximum) retail / 20% coinsurance ($30 minimum) mail order	20% coinsurance ($10 minimum, $125 maximum) retail / 20% coinsurance ($30 minimum) mail order	Not covered	Tier 1 prescriptions are covered under Bronson Outpatient Pharmacy; Tier 2 prescriptions are covered under Express Scripts.
	Non-preferred brand drugs	30% coinsurance ($30 minimum) retail / 30% coinsurance ($70 minimum) mail order	30% coinsurance ($30 minimum) retail / 30% coinsurance ($70 minimum) mail order	Not covered	
	Specialty drugs	Contact your PBM	Contact your PBM	Contact your PBM	Please see "Important Questions" regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	50% coinsurance	Some procedures require pre-certification. Services that have not been pre-certified will be subject to a reduction in eligible expenses to 50% of the fee schedule amount.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copay + 15% coinsurance	$50 copay + 15% coinsurance	$50 copay + 15% coinsurance	No copayment, deductible, or coinsurance applies to Non-Network if the Network Cost Sharing Maximum has been reached.
	Emergency medical transportation	15% coinsurance	15% coinsurance	15% coinsurance	——————none——————
	Urgent care	15% coinsurance	30% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	50% coinsurance	Pre-admission review is required, or benefits will be reduced by 50% of the fee schedule amount.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Bronson Network Provider (You will pay the least)	BCBSM Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	$20 copay/visit	50% coinsurance	——————none——————
	Inpatient services	15% coinsurance	15% coinsurance	50% coinsurance	Prior authorization is required, or benefits will be reduced by 50% of the fee schedule amount.
If you are pregnant	Office visits	15% coinsurance	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventative services. Depending on the type of service a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Services excluded for Dependent Daughters.
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	50% coinsurance	Services excluded for Dependent Daughters.
	Childbirth/delivery facility services	15% coinsurance	30% coinsurance	50% coinsurance	Prior authorization is required for vaginal deliveries requiring more than a 48-hour hospital stay and for cesarean section deliveries requiring more than a 96-hour stay, or benefits will be reduced by 50%. Services excluded for Dependent Daughters.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not covered	Not covered	Pre-certification required. Services that have not been pre-certified will be subject to a reduction in eligible expenses to 50% of the fee schedule amount.
	Rehabilitation services	15% coinsurance	30% coinsurance	50% coinsurance	——————none——————
	Habilitation services	15% coinsurance	30% coinsurance	50% coinsurance	——————none——————
	Skilled nursing care	15% coinsurance	30% coinsurance	50% coinsurance	Pre-certification required. Services that have not been pre-certified will be subject to a reduction in eligible expenses to 50% of the fee schedule amount.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Bronson Network Provider (You will pay the least)	BCBSM Network Provider	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	15% coinsurance	15% coinsurance	50% coinsurance after Bronson Network deductible	Pre-certification required in excess of $1,000. Services that have not been pre-certified will be subject to a reduction in eligible expenses to 50% of the fee schedule amount.
	Hospice services	15% coinsurance	15% coinsurance	50% coinsurance	Pre-certification required. Services that have not been pre-certified will be subject to a reduction in eligible expenses to 50% of the fee schedule.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	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.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S., it's protectorates, or Canada
- 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.)

- Bariatric surgery
- Infertility treatment

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 plan at 1-800-211-1534, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.gov, or you may contact your state insurance department. 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: the plan, administered by US Health and Life, at 1-800-211-1534 or www.mybronsonbenefits.com. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-297-2323 x61565 or www.cciio.cms.gov.

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 1-800-211-1534.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-211-1534.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-211-1534.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-211-1534.]

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.mybronsonbenefits.com.]

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** **$300**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$300
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,160**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$300
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$300
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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