BRONSON

2023 Schedule of Benefits: PPO Plan

Deductibles	Bronson Provider Tier 1	BCBS Provider Tier 2	Out of Network Tier 3	Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum. Tier 1 and Tier 2 deductibles cross apply and accumulate together.
Individual	**$500**	**$900**	**$1,400**	
Family	**$1,000**	**$1,800**	**$2,800**	
Out-of-Pocket	**Bronson Provider Tier 1**	**BCBS Provider Tier 2**	**Out of Network Tier 3**	Individual Deductible is satisfied for an individual family member will have no additional Deductible taken for that individual family member. Claims paid after the Family Deductible is satisfied will have no additional Deductible taken for the entire family.
Individual Maximum	**$2,500**		**N/A**	
Family Maximum	**$5,000**		**N/A**	

Pre-Certification: Certain services require pre-certification for benefits as described in this plan (e.g., Inpatient Hospital admissions, certain outpatient surgeries, etc.) If the member does not receive pre-certification, the benefit payment will be reduced by 10% of billed amount and will not apply to the cost sharing maximum.

In-Network benefits are based on the Preferred Provider Organization's approved amount. Out-of-Network benefits are based on the Reasonable and Customary amount. Benefits are determined after any applicable Deductible and Coinsurance, and are subject to Annual, Lifetime and Other Maximums, General Exclusions and other applicable limitations.

CHARGES FOR PREVENTATIVE CARE SERVICES		
The following Preventive Care and Screening Services: (Please refer to Page 3) • Annual Adult Preventive Exam • Annual Gynecological Exam • Well Baby Care • Well Child Care • Routine Immunizations • Annual Mammogram • Colonoscopy Screening • Prostate Specific Antigen (PSA)	Bronson and BCBS Providers	Out of Network Provider
	Covered at 100%	**50 % after deductible**

Benefit	Bronson Provider	BCBS Provider	Out of Network Provider	Limitations
Urgent Care	85% after deductible	70 % after deductible	50% after deductible	
Emergency Room (Facility)	$50 copay, then 85% after deductible	$50 copay, then 85% after deductible	$50 copay, then 85% after deductible	No copayment, deductible, or coinsurance applies to Out-of-Network emergency services if the In-Network Cost Sharing Maximum has been reached. Out-of-Network providers will be reimbursed at the same level of benefits as In-Network providers, and they may bill you for the balance.
Emergency Room (Physician)	85% after deductible	85% after deductible	85% after deductible	
Emergency Room Non-Emergent (Facility)	$100 copay, then 50% after deductible	Not Covered	Not Covered	
Emergency Room Non-Emergent (Physician)	50% after deductible	Not Covered	Not Covered	
Ambulance (Emergent)	85% after deductible	85% after deductible	85% after deductible	
Ambulance (Non-Emergent)	85% after deductible	85% after deductible	50% after deductible	Requires Precertification

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Benefit	Bronson Provider	BCBS Provider	Out of Network Provider	Limitations
Human Organ Transplant	85% after deductible	85% after deductible	50% after deductible	Requires Precertification. Transportation/accommodations limited to $100 per day up to $5,000 per transplant.
Primary Care Physician	$20 Copay	$40 Copay	50% after deductible	
Specialist	$40 Copay	$60 Copay	50% after deductible	
Telemedicine	$10 Copay	$25	Not Covered	Bronson Connect Video Visit and BCBS Providers.
Dietician Services	$40 Copay	$50 copay	50% after deductible	Nutritional counseling by a registered dietician where dietary assessment and therapy is prescribed by a physician and is integral to the treatment guidelines for illness.
Outpatient Mental Health/ Substance Abuse	$20 Copay	$20 Copay	50% after deductible	
Inpatient Labs and X-Rays	85% after deductible	70% after deductible	50% after deductible	
Outpatient Labs and X-Rays	$40 Copay	70% after deductible	50% after deductible	
Diagnostic Testing	85% after deductible	70% after deductible	50% after deductible	Includes advanced imaging.
Inpatient Mental Health/ Substance Abuse	85% after deductible	85% after deductible	50% after deductible	Facility and Physician Requires precertification
Outpatient Surgery	85% after deductible	70% after deductible	50% after deductible	Facility and Physician, certain procedures may require precertification
Inpatient Surgery	85% after deductible	70% after deductible	50% after deductible	Facility and Physician requires precertification
Mammograms	100%, no deductible	100%, no deductible	50% after deductible	When routine and preventative. If performed at Bronson Facility, physician interpretation is covered at 100% for Tier and Tier 3.
Mammograms	85% after deductible	70% after deductible	50% after deductible	Non-Routine for physician and facility.
Allergy Testing and Injections	85% after deductible	70% after deductible	50% after deductible	Not performed during an office visit.
Durable Medical Equipment	85% after deductible	85% after deductible	50% after deductible	Equipment charges over $1,000 requires precertification. Diabetic test strips, lancets, lancet devices are available for reimbursement at any retailer (e.g., Meijer, CVS, etc.)
Orthotics	85% after deductible	70% after deductible	50% after deductible	Equipment over $1,000 requires precertification.
Breast Pumps	100%, no deductible	100%, no deductible	50% after deductible	Eligible for 1 pump every 2 years.
Bra for Breast Prosthesis	85% after deductible	85% after Tier 1 deductible	85% after Tier 1 deductible	Bras limited to 2 per Calendar Year.

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Benefit	Bronson Provider	BCBS Provider	Out of Network Provider	Limitations
Prosthetic Wigs	85% after deductible	85% after Tier 1 deductible	85% after Tier 1 deductible	Limited to $1,000 per covered individual every 3 years.
Fertility Testing/Diagnosis	85% after deductible	70% after deductible	50% after deductible	This includes genetic counseling and physician charges.
Infertility Treatment	85% after deductible	70% after deductible	50% after deductible	Plan coverage limited to $10,000 lifetime max per member. Requires precertification.
Hearing Examination	85% after deductible	70% after deductible	50% after deductible	Audiology test covered with medical diagnosis.
Hearing Aids	85% after deductible	85% after Tier 1 deductible	50% after deductible	When medically necessary for illness or injury.
Male Sterilization	85% after deductible	70% after deductible	50% after deductible	
Bariatric Surgery	85% after deductible	85% after Tier 1 deductible	Not Covered	Precertification Required. Patients must complete the designated programs prior to surgery and the patient must be covered under the Plan for one year prior to surgery. Limited to 1 surgery per covered individual per lifetime and surgery must be performed by designated providers.
Hospice	85% after deductible	85% after deductible	50% after deductible	Requires precertification.
Home Health Care	85% after deductible	Not Covered	Not Covered	Requires precertification.
Skilled Nursing Care	85% after deductible	70% after deductible	50% after deductible	Requires precertification.
Physical/ Occupational/ Speech Therapy	$40.00 copay	$60.00 copay	50% after deductible	Annual maximum for PT/OT/ST/Chiro: 60 visits combined.
Chiropractic Visit	No T1 Providers	$40 copay	50% after deductible	Annual maximum for PT/OT/ST/Chiro: 60 visits combined.
Rehabilitative Services	85% after deductible	70% after deductible	50% after deductible	Includes services such as Outpatient Cardiac Therapy, Pulmonary Rehab
COVID-Related Treatment	85% after deductible	70% after deductible	50% after deductible	Note: Testing and immunizations for COVID19 will continue to be covered at $0 cost sharing per Federal guidelines.

NOTE: Any maximums listed are applicable to all plan options, unless otherwise specified. If a new plan option is elected, any amounts applied toward the maximums in the current/previous plan option will be applied to the new plan option. Plan maximums do not start over when a new plan option is elected.

Preventive Care and Screening Services and Immunizations for children, adolescents and adults that:
-Have a rating of A or B in the current United States Preventive Services Task Force recommendations, or
-Are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or
-Are provided for in comprehensive guidelines supported by the Health Resources and Services Administration, with respect to the individual involved.
-Includes annual routine vision exam as part of a physical to determine vision loss.

Please consult the recommendations and guidelines for age, frequency and other guidelines. Some examples of screening include high blood pressure, breast cancer (mammograms), cervical cancer (PAP), cholesterol, depression, diabetes, colorectal cancer (colonoscopies), and prostate cancer (PSA). Examples of immunizations include HIV, DTP, Hepatitis A, Hepatitis B, HIB, HPV, MMR, and Flu Shots.
Copies of the recommendations and guidelines may be obtained from the following web sites:
https://www.healthcare.gov/what-are-my-preventive-care-benefits/
http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html
www.hrsa.gov
You may also call 844-501-3466 to obtain a no-cost paper copy from Automated Benefits Services, Inc.

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Prescription Drug Benefits Bronson Healthcare Group prescription drug plan is administered by Express Scripts (800) 711-0917	
Annual Deductible of $25 per covered person. Once the deductible is met, benefits are covered after the copay is indicated below:	
Annual Out-of-Pocket Drug Maximum (Includes Prescription Drug Deductible and Copays)	**Individual** $2,500 **Family** $5,000
Bronson Outpatient Pharmacy (30 Day Supply)	
Generic	10%, $5 minimum; $75 maximum
Preferred	20%, $10 minimum; $125 maximum
Non-Preferred	30%, $30 minimum
Express Scripts Retail (30 Day Supply)	
Generic	20%, $10 minimum
Preferred	30%, $25 minimum
Non-Preferred	40%, $45 minimum
Express Scripts Mail Order (90 Day Supply)	
Generic	10%, $15 minimum
Preferred	20%, $30 minimum
Non-Preferred	30%, $70 minimum
Specialty Medications	
Certain Oncology and Other Specialty Medications	Prior Authorizations Required

Diabetic Medication Copay Assistance Program Lower Copays on Oral and Injectable Diabetes Medication and Diabetes Medication/Insulin Prescription Copays.	
Diabetic Supplies will be eligible under both the Medical and Prescription Plans.	
Bronson Outpatient Pharmacy	
Generic	$5 per 30 day or $10 per 90 days supply
Preferred	$5 per 30 day or $15 per 90 days supply
Non-Preferred	$15 per 30 day or $45 per 90 days supply
Express Scripts Retail	
Generic	$15 per 30 days supply
Preferred	$20 per 30 days supply
Non-Preferred	$45 per 30 days supply
Express Scripts Mail Order	
Generic	$15 per 90 days supply
Preferred	$30 per 90 days supply
Non-Preferred	$60 per 90 days supply