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.bronsonhg.org 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?	**$1,700** individual / **$3,400** family for Bronson Network providers; **$2,000** individual / **$4,000** family for BCBMS Network providers; **$3,950** individual / **$7,900** 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, the overall deductible must be paid before the plan begins to pay.
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?	**$4,500** Individual / **$9,000** 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.	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.bronsonhg.org 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).
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 (You will pay more)	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	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	——————none——————
	Specialist visit	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge	No charge	Deductible + 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)	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	10% coinsurance ($5 minimum / $75 maximum) Retail and Mail Order	20% coinsurance ($10 minimum) Retail / 10% coinsurance ($15 minimum) Mail Order	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Specialty drugs coverage is limited to a 30-day supply. Tier 1 prescriptions are covered under Bronson Outpatient Pharmacy; Tier 2 prescriptions are covered under Express Scripts.
	Preferred brand drugs	20% coinsurance ($10 minimum / $125 maximum) Retail and Mail Order	30% coinsurance ($25 minimum) Retail / 20% coinsurance ($30 minimum) Mail Order	Not covered	
	Non-preferred brand drugs	30% coinsurance ($30 minimum) Retail and Mail Order	40% coinsurance ($45 minimum) Retail / 30% coinsurance ($70 minimum) Mail Order	Not covered	

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 (You will pay more)	Out-of-Network Provider (You will pay the most)	
	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)	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 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	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	See above
If you need immediate medical attention	Emergency room care	$50 copay+ Deductible + 10% coinsurance	$50 copay+ Deductible + 10% coinsurance	$50 copay+ In-Network Deductible + 10% coinsurance	No copayment, deductible, or coinsurance applies to Non-Network if the Network Cost Sharing Maximum has been reached.
	Emergency medical transportation	Deductible + 10% coinsurance	Deductible + 10% coinsurance	In-Network Deductible + 10% coinsurance	——————none——————
	Urgent care	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	Pre-admission review is required, or benefits will be reduced by 50% of the fee schedule amount.
	Physician/surgeon fees	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% coinsurance	Deductible + 10% coinsurance	Deductible + 50% coinsurance	——————none——————
	Inpatient services	Deductible + 10% coinsurance	Deductible + 10% coinsurance	Deductible + 50% coinsurance	Prior authorization is required, or benefits will be reduced by 50% of the fee schedule amount.
If you are pregnant	Office visits	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	Depending on the type of service a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

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 (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	Pre-admission review is required for vaginal deliveries requiring more than a 48 hour stay, and for cesarean section deliveries requiring more than a 96 hour stay, or benefits will be reduced by 10% up to $2,000.
If you need help recovering or have other special health needs	Home health care	Deductible + 10% 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	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	————none————
	Habilitation services	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	Annual maximum for PT/OT/ST/Chiro 60 visits combined.
	Skilled nursing care	Deductible + 10% coinsurance	Deductible + 30% coinsurance	Deductible + 50% coinsurance	Pre-certification required.
	Durable medical equipment	Deductible + 10% coinsurance	Deductible + 10% coinsurance	Deductible + 50% coinsurance	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	Deductible + 10% coinsurance	Deductible + 10% coinsurance	Deductible + 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.

* For more information about limitations and exceptions, see the plan or policy document at www.bronsonhg.org.

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 833-600-1311.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-600-1311.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-600-1311.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-600-1311.

*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.bronsonhg.org.

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** **$1,700**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$1,700
Copayments	$50
Coinsurance	$1,260
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$1,700
Copayments	$0
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,840**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$1,700
Copayments	$50
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,940**

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