




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](http://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](http://www.cciio.cms.gov) or call 1-800-211-1534 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$500</b> individual / <b>\$1,000</b> family for Bronson Network providers; <b>\$900</b> individual / <b>\$1,800</b> family for BCBMS Network providers; <b>\$1,400</b> individual / <b>\$2,800</b> family for Out-of-Network providers. Copays and coinsurance do not count towards the deductible.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall <a href="#">deductible</a> must be paid before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Preventative care and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$2,500</b> Individual / <b>\$5,000</b> family for Bronson Network and BCBMS providers; <b>Unlimited</b> individual / <b>Unlimited</b> family for Out-of-Network providers.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.bronsonhg.org">www.bronsonhg.org</a> or call 1-800-211-1534 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in Bronson Network. You pay more if you use a <a href="#">provider</a> in BCBMS Network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing).
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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	\$20 <a href="#">copay</a> /visit	\$40 <a href="#">copay</a> /visit	Deductible + 50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	\$60 <a href="#">copay</a> /visit	Deductible + 50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Deductible + 50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	Outpatient Labs and X-Rays covered at \$40 <a href="#">copay</a> /visit (Bronson Network Provider).
	Imaging (CT/PET scans, MRIs)	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	10% <a href="#">coinsurance</a> (\$5 minimum / \$75 maximum) Retail and Mail Order	20% <a href="#">coinsurance</a> (\$10 minimum) Retail / 10% <a href="#">coinsurance</a> (\$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% <a href="#">coinsurance</a> (\$10 minimum / \$125 maximum) Retail and Mail Order	30% <a href="#">coinsurance</a> (\$25 minimum) Retail / 20% <a href="#">coinsurance</a> (\$30 minimum) Mail Order	Not covered	
	Non-preferred brand drugs	30% <a href="#">coinsurance</a> (\$30 minimum) Retail and Mail Order	40% <a href="#">coinsurance</a> (\$45 minimum) Retail / 30% <a href="#">coinsurance</a> (\$70 minimum) Mail Order	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bronsonhg.org](http://www.bronsonhg.org).

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)	
	<a href="#">Specialty drugs</a>	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 + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	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 + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	See above
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> + Deductible + 15% <a href="#">coinsurance</a>	\$50 <a href="#">copay</a> + Deductible + 15% <a href="#">coinsurance</a>	\$50 <a href="#">copay</a> + In-Network Deductible + 15% <a href="#">coinsurance</a>	No copayment, deductible, or coinsurance applies to Non-Network if the Network Cost Sharing Maximum has been reached.
	<a href="#">Emergency medical transportation</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 15% <a href="#">coinsurance</a>	In-Network Deductible + 15% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Urgent care</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	Pre-admission review is required, or benefits will be reduced by 50% of the fee schedule amount.
	Physician/surgeon fees	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /visit	\$20 <a href="#">copay</a> /visit	Deductible + 50% <a href="#">coinsurance</a>	—————none—————
	Inpatient services	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	Prior authorization is required, or benefits will be reduced by 50% of the fee schedule amount.
If you are pregnant	Office visits	\$20 <a href="#">copay</a> /visit	\$40 <a href="#">copay</a> /visit	Deductible + 50% <a href="#">coinsurance</a>	Depending on the type of service a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bronsonhg.org](http://www.bronsonhg.org).

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 + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	—————none—————
	Childbirth/delivery facility services	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible + 15% <a href="#">coinsurance</a>	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.
	<a href="#">Rehabilitation services</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit	\$60 <a href="#">copay</a> /visit	Deductible + 50% <a href="#">coinsurance</a>	Annual maximum for PT/OT/ST/Chiro 60 visits combined.
	<a href="#">Skilled nursing care</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 30% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	Pre-certification required.
	<a href="#">Durable medical equipment</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	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.
	<a href="#">Hospice services</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 15% <a href="#">coinsurance</a>	Deductible + 50% <a href="#">coinsurance</a>	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.
<b>If your child needs dental or eye care</b>	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](http://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., its 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](http://www.dol.gov/ebsa/healthreform), the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.gov](http://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](http://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](http://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](http://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](http://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, kwijigo holne' 833-600-1311.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$1,860
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,510</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$240
<a href="#">Coinsurance</a>	\$1,060
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,860</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$170
<a href="#">Coinsurance</a>	\$240
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.