



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, visit [www.mybwbenefits.com](http://www.mybwbenefits.com) or by calling 1-855-576-9816. 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.mybwbenefits.com](http://www.mybwbenefits.com) or call 1-855-576-9816 to request a copy.

Important Questions	Answers	Why this Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>\$500</b>/individual / <b>\$1,000</b>/all other tiers In-network  <b>\$1,000</b>/individual / <b>\$2,000</b>/all other tiers Out-of-network</p>	<p>Generally, you must pay all 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>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a>.</p>	<p>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></p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. <b>\$100</b>/individual benefit deductible per calendar year for prescription drug expenses In-network and <b>\$600</b> copay per admission for out-of-network hospital stay.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>\$4,000</b>/individual / <b>\$8,000</b>/all other tiers In-network  <b>\$8,000</b>/individual / <b>\$16,000</b>/all other tiers Out-of-network</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Penalties, <a href="#">premiums</a>, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.mybwbenefits.com">www.mybwbenefits.com</a> or call 1-855-576-9816 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. 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 (a <a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 Copay per visit; Deductible Waived	40% Coinsurance	None
	<a href="#">Specialist</a> visit	\$40 Copay per visit; Deductible Waived	40% Coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; Deductible Waived	40% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge; Deductible Waived office setting; 20% Coinsurance outpatient setting	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	No charge; Deductible Waived office setting; 20% Coinsurance outpatient setting	40% Coinsurance	Preauthorization is required.
<b>If you need drugs to treat your illness or condition.</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.umar.com">www.umar.com</a> .	Generic drugs (Tier 1)	\$15 Copay per prescription (retail); \$30 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	Out-of-pocket limit applies  Covers up to a 30-day supply (retail & specialty); 31-90 day supply (retail & mail order)  You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary.
	Preferred brand drugs (Tier 2)	\$35 Copay per prescription (retail); \$70 Copay per prescription (mail order)		
	Non-preferred brand drugs (Tier 3)	\$60 Copay per prescription (retail); \$120 Copay per prescription (mail order)		
	<a href="#">Specialty drugs</a> (Tier 4)	\$15 Copay per prescription (generic); \$35 Copay per prescription (preferred brand); \$60 Copay per prescription (non-preferred brand)		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Preauthorization is required. <b>\$750</b> penalty per admission.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	Preauthorization is required. <b>\$750</b> penalty per admission.
<b>If you need immediate</b>	<a href="#">Emergency room care</a>	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
medical attention	<a href="#">Emergency medical transportation</a>	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	<a href="#">Urgent care</a>	\$50 Copay per visit; Deductible Waived	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 Copay per admission; 20% Coinsurance	\$600 Copay per admission; 40% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$750 of the total cost of the service. Additionally, benefits will be reduced by 50% for any charges applied outside of the pre-admission certified days.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	Preauthorization is required. <b>\$750</b> penalty per admission.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$25 Copay per visit; Deductible Waived office visits; 20% Coinsurance other outpatient services	40% Coinsurance	Preauthorization is required for Partial hospitalization & Intensive outpatient. <b>\$750</b> penalty per admission.
	Inpatient services	\$300 Copay per admission; 20% Coinsurance	\$600 Copay per admission; 40% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$750 of the total cost of the service. Additionally, benefits will be reduced by 50% for any charges applied outside of the pre-admission certified days.
If you are pregnant	Office visits	No charge; Deductible Waived	40% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services,

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$300 Copay per admission; 20% Coinsurance	\$600 Copay per admission; 40% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% Coinsurance	40% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required.
	<a href="#">Rehabilitation services</a>	\$25 Copay per visit; Deductible Waived	40% Coinsurance	60 Maximum visits per calendar year combined with Chiropractic care
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	20% Coinsurance	40% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$750 of the total cost of the service. Additionally, benefits will be reduced by 50% for any charges applied outside of the pre-admission certified days.
	<a href="#">Durable medical equipment</a>	20% Coinsurance	40% Coinsurance	Preauthorization is required for DME for all rentals or \$1,500 for purchases.
	<a href="#">Hospice service</a>	20% Coinsurance	40% Coinsurance	Preauthorization is required. <b>\$750</b> penalty per admission.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Habilitation

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery (In-network only Surgeon Charges Lifetime max \$10,000)
- Chiropractic care (combined with Rehabilitation Services)

**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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.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](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 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at [www.HealthCare.gov](http://www.HealthCare.gov) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

### Does this [plan](#) Provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this [plan](#) Meet the Minimum Value Standard? 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 1-855-576-9816.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## 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="#">copayment</a>	\$300
■ Other <a href="#">coinsurance</a>	20%

#### 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>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$400
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,900</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="#">copayment</a>	\$300
■ Other <a href="#">coinsurance</a>	20%

#### 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>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$600
Copayments	\$1,800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</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="#">copayment</a>	\$300
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic tests (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.mybwbenefits.com](http://www.mybwbenefits.com) or call 1-855-576-9816.

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.