



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:
What is the overall <a href="#">deductible</a> ?	\$3,000 person / \$6,000 family In-network \$6,000 person / \$12,000 family Out-of-network	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> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> 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>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,000 person / \$12,000 family In-network \$12,000 person / \$24,000 family Out-of-network \$6,000 In-network / \$12,000 Out-of-network Maximum amount that any one person will satisfy towards the annual family out-of-pocket	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties, <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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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> .	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 <a href="#">plan's 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 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.
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> .



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	20% Coinsurance	50% Coinsurance	None
	<a href="#">Specialist</a> visit	20% Coinsurance	50% Coinsurance	None
	<a href="#">Preventive care/screening/</a> immunization	No charge; Deductible Waived	50% Coinsurance	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 <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% Coinsurance	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required.

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 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> .	Tier 1 (generic and some brand-name)	20% Coinsurance	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.	Deductible and Out-of-pocket limit applies  Covers up to a 30-day supply (retail); 31-90 day supply (mail order); Covers up to a 30-day supply (specialty)  No charge; Deductible Waived for Diabetic supplies  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, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the Out-of-pocket is met
	Tier 2 (preferred brand-name and some generic)	20% Coinsurance		
	Tier 3 (nonpreferred brand-name and nonpreferred generic)	20% Coinsurance		
	Tier 4 ( <a href="#">specialty drugs</a> )	20% Coinsurance		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	<a href="#">Emergency medical transportation</a>	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	<a href="#">Urgent care</a>	20% Coinsurance	50% 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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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 fees	20% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required for Partial <a href="#">hospitalization</a> & Intensive treatment.
	Inpatient services	20% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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	50% Coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	50% 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	50% Coinsurance	60 Maximum visits per calendar year; <a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	20% Coinsurance	50% Coinsurance	None
	<a href="#">Habilitation services</a>	20% Coinsurance	50% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	<a href="#">Skilled nursing care</a>	20% Coinsurance	50% Coinsurance	60 Maximum days per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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	50% Coinsurance	<a href="#">Preauthorization</a> is required for DME in excess of \$1,500 for purchases or all rentals.
	<a href="#">Hospice service</a>	20% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required.
<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 <a href="#">Plan</a> Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery (In-network only)</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li></ul>

**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

[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 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.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-576-9816.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-576-9816.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-855-576-9816.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-576-9816.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-576-9816.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-576-9816.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-855-576-9816.

*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 [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

- [Specialist](#) office visits (*pre-natal 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:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,710</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,320</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</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.