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.bwxt.com/enrollment. 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.healthcare.gov/sbc-glossary/ or call (844) 344-7419 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000**/person or **$2,000**/family for In-Network Providers. **$2,000**/person or **$4,000**/family for Out-of-Network Providers.	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, prescription drugs, and emergency room visits for In-Network Providers. Preventive care and emergency room visits for Out-of-Network Providers.	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?	**$5,600**/person or **$11,200**/family for In-Network Providers. **$11,200**/person or **$22,400**/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, health care this plan doesn't cover, penalties for failure to obtain precertification for services and charges that exceed eligible expenses.	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	Yes, Blue Card PPO. See www.anthem.com or call (844)	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive

302506081 v1

* For more information about limitations and exceptions, see **plan** or policy document at www.bwxt.com/enrollment.

provider?	344-7419 for a list of network providers.	a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **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 Provider (You will pay the least)	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	$30 copayment/visit	50% coinsurance	--------none--------
	Specialist visit	$45 copayment/visit	50% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	Includes preventive health services specified in the health care reform law. 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)	20% coinsurance	50% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Tier 1 - Generic	Retail: $10 copay/prescription Mail: $25 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription) or a 31-90 supply (mail order prescription). Free generic prescription drugs are available for certain chronic conditions, after deductible. Refer to SPD for details. Select preventive prescription drugs are available at no cost. Refer to SPD for details. Tier 4 drugs: Covers up to a 30-day supply and can only be filled at an Express-Scripts (ESI) specialty pharmacy.
	Tier 2 - Preferred Brand	Retail: 25% coinsurance /prescription ($30 min./$75 max.) Mail: $100 copay/prescription	Not covered	
	Tier 3 - Non-Preferred	Retail: 35% coinsurance /prescription ($45 min./$110 max.) Mail: $150 copay/prescription	Not covered	

* For more information about limitations and exceptions, see **plan** or policy document at www.bwxt.com/enrollment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 - Specialty	20% coinsurance /prescription up to maximum of $125 copay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	Physician charge based on location of service; other supplies and services subject to deductible and 20% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$150/visit deductible does not apply	Covered as In-Network	--------none--------
	Emergency medical transportation	No charge	Covered as In-Network	First trip to and from a hospital for any one injury, sickness, or pregnancy.
	Urgent care	$45/visit deductible does not apply	$45/visit deductible does not apply	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$300/admission then 20% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $30/visit	Office Visit 50% coinsurance	--------none--------
	Inpatient services	$300/admission then 20% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Office visits	$30/visit for PCP, $45/visit for Specialist deductible does not apply	50% coinsurance	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	$300/admission then 20% coinsurance	50% coinsurance	
If you need help recovering or have	Home health care	20% coinsurance	50% coinsurance	80 visits/benefit period.
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical and occupational therapy - 60 visits combined/benefit period
	Habilitation services	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see **plan** or policy document at www.bwxt.com/enrollment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs				Chiropractic therapy - 30 visits/benefit period Speech therapy - 30 visits/benefit period
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/benefit period.
	Durable medical equipment	20% coinsurance	50% coinsurance	--------none--------
	Hospice services	20% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

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
- Dental care (adult)
- Long- term care
- Weight loss programs
- Routine foot care unless you have been diagnosed with diabetes.
- Hearing aids
- Routine eye care (adult)
- Cosmetic surgery
- Children's eye exam
- Children's glasses
- Children's dental check-up

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

- Chiropractic care
- Bariatric surgery (only if there is a diagnosis of morbid obesity, as defined by the National Health Institute)
- Infertility treatment (only treatment underlying condition)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing (outpatient only).

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: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage

* For more information about limitations and exceptions, see **plan** or policy document at www.bwxt.com/enrollment.

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 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 ATTN: Grievances and Appeals, BWX Technologies, Inc., 800 Main Street, Lynchburg, VA 24504 or 434-522-3800, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform or the Member Services number on the back of your ID card.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 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 (844) 344-7419.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (844) 344-7419.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**(844) 344-7419.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (844) 344-7419.

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 **plan** or policy document at www.bwxt.com/enrollment.

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	$1,000
Specialist *copayment*	$45
Hospital (facility) *copayment*	$300
Other *coinsurance*	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)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$60
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$3,636**

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

The plan's overall deductible	$1,000
Specialist *copayment*	$45
Hospital (facility) *copayment*	$300
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$841
Copayments	$330
Coinsurance	$27
What isn't covered	
Limits or exclusions	$6,041
The total Joe would pay is	**$7,239**

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

The plan's overall deductible	$1,000
Specialist *copayment*	$45
Hospital (facility) *copayment*	$300
Other *coinsurance*	20%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$414
Copayments	$585
Coinsurance	$64
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,063**

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

Nondiscrimination and Language Access Services:

Discrimination is Against the Law

The BWXT Medical Plan ("Medical Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Medical Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Medical Plan provides:

- appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with the Medical Plan, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and other formats); and
- language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call the Member Services number on your ID card for help (TTY/TDD: 711). If you believe that these services have not been appropriately provided, or that you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. If you need help filing a complaint, our Compliance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

(TTY/TDD: 711)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (844) 344-7419.
ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (844) 344-7419.
請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：(844) 344-7419**。**
XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (844) 344-7419.
알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 344-7419. **번으로 전화하십시오.**
PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (844) 344-7419.
ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (844) 344-7419.
العربية تنبيه: إذا كنت تتحدث **Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ (844) 344-7419.
ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (844) 344-7419.
ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (844) 344-7419.
ATTENTION: Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (844) 344-7419.
UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (844) 344-7419.
注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。(844) 344-7419 **にお電話ください。**
ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (844) 344-7419.
ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (844) 344-7419 an.

توجه: اگر زبان شما **فارسی (**Farsi**)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باش(7419-344 (844) ماس بگیرید.