




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.WIBenefitsHelp.com](http://www.WIBenefitsHelp.com) or call 1-888-971-7377. 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.WIBenefitsHelp.com](http://www.WIBenefitsHelp.com) or call 1-888-971-7377 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall <u>deductible</u> ?		Network	Non-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
	Per participant:	\$1,500	\$1,500	
	Per Family:	\$3,000	\$3,000	
	The deductibles are combined for network and non-network providers. Satisfying one helps satisfy the other.			
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered without cost sharing.			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.			
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?		Network	Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
	Per participant:	\$3,500	\$5,000	
	Per family:	\$7,000	\$10,000	
	The out-of-pocket limits are combined for network and non-network providers. Satisfying one helps satisfy the other.			
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, pre-certification penalties, and non-medically necessary services.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, for medical: Anthem BlueCross BlueShield. For a list of network providers, call your Care Coordinator, at 1-888-971-			This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider in the plan's network. You will pay the most if you use an

	7377 or visit <a href="http://www.WIBenefitsHelp.com">www.WIBenefitsHelp.com</a> . <b>Yes, for prescription drugs:</b> Navitus. For a list of retail and mail pharmacies, call your Care Coordinator, at 1-888-971-7377 or visit <a href="http://www.WIBenefitsHelp.com">www.WIBenefitsHelp.com</a> .	<u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	<b>No.</b>	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at 1-888-971-7377 or <a href="http://www.WIBenefitsHelp.com">www.WIBenefitsHelp.com</a>	Preferred generic drugs	20% co-insurance after deductible	20% co-insurance after deductible (retail only)	Covers up to a thirty (30) day supply for retail pharmacy or up to a ninety (90) day supply for mail order pharmacy. An additional \$20 surcharge will apply to the third fill of a maintenance prescription drug when the mail order pharmacy is not utilized.
	Preferred brand and non-preferred generic drugs	25% co-insurance after deductible	25% co-insurance after deductible (retail only)	
	Non-preferred brand drugs	30% co-insurance after deductible	30% co-insurance after deductible (retail only)	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at <a href="http://www.WIBenefitsHelp.com">www.WIBenefitsHelp.com</a> or call 1-888-971-7377.
	<u>Specialty drugs</u>	30% co-insurance after deductible	Not Covered	You must fill specialty drugs through Worthington Industries Pharmacy or Lumicera,

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				Navitus' specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	20% co-insurance after deductible	20% co-insurance after deductible	_____none_____
	<u>Emergency medical transportation</u>	20% co-insurance after deductible	20% co-insurance after deductible	_____none_____
	<u>Urgent care</u>	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required</b> for intensive outpatient treatment and partial hospitalization.
	Inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
If you are pregnant	Office visits	20% co-insurance after deductible	40% co-insurance after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	Childbirth/delivery facility services	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required</b> for inpatient stays in excess of forty-eight (48) hours of a normal delivery and ninety-six (96) hours of a cesarean delivery.
If you need help recovering or have other special needs	<u>Home health care</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
	<u>Rehabilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Habilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
	<u>Skilled nursing care</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Annual Benefit Maximum:</b> Sixty (60) days per plan participant combined network/non-

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				network. <b>Pre-certification is required.</b>
	<u>Durable medical equipment</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required</b> for all rentals and any purchase over \$1,500.
	<u>Hospice services</u>	No charge after deductible	No charge after deductible	<b>Pre-certification is required.</b>
<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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                           |                         |   |
|---------------------------|-------------------------|---|
| • Cosmetic surgery        | • Infertility treatment | • Routine eye care (adult)                |
| • Dental care (adult)     | • Long-term care        | • Routine foot care (except for diabetic) |
| • Hearing Aids (standard) | • Private-duty nursing  | • Weight-loss programs                    |

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

- |                                      |  |  |
|--------------------------------------|--|--|
| • Acupuncture (limited to 20 visits) | • Chiropractic care (limited to 20 visits) | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery                  |  |  |

**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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). You may also contact the Plan's COBRA Administrator, BenefitExpress, at P.O. Box 2798, Omaha, NE 68103, 1-877-837-5017. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

You may also contact the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

Quantum Health Care Coordinators  
7450 Huntington Park Drive, Suite 100  
Columbus, OH 43235  
1-888-971-7377

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

### 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 1-888-971-7377.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-971-7377.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-971-7377.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-971-7377.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> cost sharing	20%
■ Hospital (facility) <u>cost sharing</u>	20%
■ Other <u>cost sharing</u>	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>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,720</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> cost sharing	20%
■ Hospital (facility) <u>cost sharing</u>	20%
■ Other <u>cost sharing</u>	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>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,300</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> cost sharing	20%
■ Hospital (facility) <u>cost sharing</u>	20%
■ Other <u>cost sharing</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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