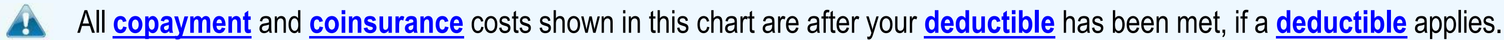
**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://hr.wellspan.org, call 717-851-5959 or WellSpan Population Health Services at 1-800-842-1768. 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.wellspanpophealth.org.com or call 1-800-842-1768 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | WellSpan Facilities and Providers and in Network: **$3,200**. Out of Network: **$5,600** | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and primary care services are covered before you meet your deductible. | 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?** | Yes. $150 for injectable drugs under the medical plan benefits. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For network providers **$12,000** family; for out-of-network providers **$27,600** family | The out-of-pocket limit is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | Copayments for certain services, premiums, balance-billing charges, penalties for failure to obtain preauthorization, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit.<br>$250 penalty for non-compliance for preauthorization. |
| **Will you pay less if you use a network provider?** | Yes. See http://hr.wellspan.org., www.wellspanpophealth.org, and questbh.com for a list of or network providers. | 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 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?** | Yes. For referrals to a transplant center. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |


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: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | Enhanced Tier $10 copay/visit<br>Core Tier: $30 copay/ visit | 50% after deductible | None |
| | Specialist visit | Enhanced Tier $30 copay/visit<br>Core Tier: $40 copay/visit | 50% after deductible | None |
| | Preventive care/screening/ immunization | No charge | 50% after deductible | Coverage limited to services required by the Affordable Care Act (ACA). |
| If you have a test | Diagnostic test (x-ray, blood work) | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | Some services require preauthorization. |
| | Imaging (CT/PET scans, MRIs) | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at https://www.cap-rx.com/ | Generic drugs<br>Core Tier and out-of-network - $10 minimum | Enhanced Tier: $10 copay/retail<br>$20 copay/100 day or mail; Core Tier: 30% coinsurance/retail | 30% coinsurance/retail | Coverage limited to 34-day supply (retail). 35-100 day supply (mail order or at a WellSpan Pharmacy only).<br>Maintenance Medications are required to be filled through WellSpan Pharmacies.<br>Some prescription drugs require preauthorization by Capital Rx. Non-payment penalty for non-compliance.<br>If a generic is available, the cost would be the copay or coinsurance plus any amount over the generic cost.<br>Some injectable and other drugs require preauthorization (see http://hr.wellspan. org) or call WellSpan Population Health Services. |
| | Preferred brand drugs<br>Core Tier and out-of-network - $40 minimum | Enhanced Tier: $40 copay/retail<br>$80 copay/100 day or mail Core Tier: 35% coinsurance/retail | 35% coinsurance/retail | |
| | Non-preferred brand drugs<br>Core Tier and out-of-network - $65 minimum | Enhanced Tier: $65 copay/retail | 50% coinsurance/retail | |

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| Prescription Out of Pocket Maximum per Calendar year: For network providers $12,000 family; for out- of-network providers $27,600 family | | $130 copay/100 day or mail Core Tier: 50% coinsurance/retail | | Specialty drugs are only covered if obtained through WellSpan Pharmacies. Specialty drugs are limited to a 30-day fill ***For the Medical/Behavioral Health out-of-pocket, please see above "What is the out-of-pocket for this plan"** |
| | Specialty drugs 20% coinsurance; $150 maximum on all specialty medications | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | Preauthorization may be required. |
| | Physician/surgeon fees | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | |
| **If you need immediate medical attention** | Emergency room care | $200 copay after deductible | | Facility room charge not covered for non-emergency |
| | Emergency medical transportation | $0 copay or coinsurance | | None |
| | Urgent care | Enhanced Tier: $30 copay after deductible Primary Care, $60 copay after deductible Specialist; Core Tier: $30 copay after deductible Primary Care, $80 copay after deductible Specialist | 50% after deductible | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Enhanced Tier: 10% after deductible, Core | 50% after deductible | Preauthorization is required. |

[* For more information about limitations and exceptions, see the plan or policy document at https://hr.wellspan.org.]

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Tier: 30% after deductible | | |
| | Physician/surgeon fees | Enhanced Tier: 10% after deductible, Core Tier: 30% after deductible | 50% after deductible | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Enhanced Tier: $10 copay after deductible, Core Tier: $30 copay after deductible | 50% after deductible | None |
| | Inpatient services | Enhanced Tier: 10% after deductible, Core Tier: 30% after deductible | 50% after deductible | Requires preauthorization with Quest |
| **If you are pregnant** | Office visits | Enhanced Tier: $30 copay after deductible Core Tier: $40 copay after deductible | 50% after deductible | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Requires preauthorization. |
| | Childbirth/delivery professional services | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | |
| | Childbirth/delivery facility services | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | 120 visits/year; requires preauthorization |
| | Rehabilitation services | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | Includes physical therapy, speech therapy, and occupational therapy. |

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | Habilitation services | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | |
| | Skilled nursing care | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | Requires preauthorization |
| | Durable medical equipment | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | Some services require preauthorization. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | Hospice services | Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible | 50% after deductible | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | | Coverage limited to one exam/year. |
| | Children's glasses | Not covered | | None |
| | Children's dental check-up | 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
- Dental care (Adult)
- Glasses, except after cataract surgery
- Weight loss programs
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine eye care (Adult & child)
- Routine foot care, except for those with a metabolic, neurological, or peripheral-vascular disease.

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private duty nursing – max 240 hours
- Weight loss programs
- Infertility treatment limited to $10,000 lifetime maximum in combination with the Adoption Policy

[* For more information about limitations and exceptions, see the plan or policy document at https://hr.wellspan.org.]

**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: www.dol.gov/ebsa. 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 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: [insert applicable contact information from instructions].

**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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

***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 plan's overall deductible** **$3,200**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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** | **$12,700** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,200 |
| Copayments | $10 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,370** |

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

- **The plan's overall deductible** **$3,200**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $3,200 |
| Copayments | $500 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,780** |

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

- **The plan's overall deductible** **$3,200**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles* | $3,200 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$3,200** |

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: HR_Service_Center@wellspan.org.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. The plan would be responsible for the other costs of these EXAMPLE covered services.