




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](http://www.wellspanpophealth.org.com) or call 1-800-842-1768 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>Enhanced Tier: \$550 per person, \$1,100 family; Core Tier: \$1,200 per person, \$2,400 family; Out-of-Network: \$2,050 per person, \$4,050 family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> and primary care 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><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>Yes. \$150 for injectable drugs under the medical plan benefits.</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><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For <a href="#">network providers</a> \$4,500 individual / \$8,250 family; for <a href="#">out-of-network</a> providers \$6,750 individual / \$12,750 family</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. ***For Prescription out-of-pocket information, see below "If you need Drugs."***</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Copayments</a> for certain services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a>, 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>. \$250 penalty for non-compliance for <a href="#">preauthorization</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://hr.wellspan.org">http://hr.wellspan.org</a>, <a href="http://www.wellspanpophealth.org">www.wellspanpophealth.org</a>, and <a href="http://questbh.com">questbh.com</a> for a list of or <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 <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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>Yes. For referrals to a transplant center.</p>	<p>This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a>.</p>

 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)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	<a href="#">Primary care</a> visit to treat an injury or illness	Enhanced Tier \$20 <a href="#">copay</a> /visit Core Tier: \$30 <a href="#">copay</a> /visit	50% <a href="#">after deductible</a>	None
	<a href="#">Specialist</a> visit	Enhanced Tier \$40 <a href="#">copay</a> /visit Core Tier: \$45 <a href="#">copay</a> /visit	50% <a href="#">after deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">after deductible</a>	Coverage limited to services required by the Affordable Care Act (ACA).
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% after <a href="#">deductible</a>	50% <a href="#">after deductible</a>	Some services require <a href="#">preauthorization</a> .
	Imaging (CT/PET scans, MRIs)	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% after <a href="#">deductible</a>	\$250 copay per test, then 50% <a href="#">after deductible</a>	
<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="https://www.cap-rx.com/">https://www.cap-rx.com/</a>	Generic drugs Core Tier and out-of-network - \$10 minimum	Enhanced Tier: \$10 <a href="#">copay</a> /retail \$20 <a href="#">copay</a> /100 day or mail; Core Tier: 30% <a href="#">coinsurance</a> /retail	30% <a href="#">coinsurance</a> /retail	Coverage limited to 34-day supply (retail). 35- 100 day supply (mail order or at a WellSpan Pharmacy only). Maintenance Drugs are required to be filled through WellSpan Pharmacies. Some prescription drugs require <a href="#">preauthorization</a> by Capital Rx. Non-payment penalty for non-compliance. If a generic is available, the cost would be the <a href="#">copay</a> or <a href="#">coinsurance</a> plus any amount over the generic cost. Some injectable and other drugs require <a href="#">preauthorization</a> (see <a href="http://hr.wellspan.org">http://hr.wellspan.org</a> ) or call WellSpan Population Health Services).
	Preferred brand drugs Core Tier and out-of-network - \$40 minimum	Enhanced Tier: \$40 <a href="#">copay</a> /retail \$80 <a href="#">copay</a> /100 day or mail Core Tier: 35% <a href="#">coinsurance</a> /retail	35% <a href="#">coinsurance</a> /retail	
	Non-preferred brand drugs Core Tier and out-of-network - \$65 minimum	Enhanced Tier: \$65 <a href="#">copay</a> /retail; \$130 <a href="#">copay</a> /100 day or mail; Core Tier: 50% <a href="#">coinsurance</a> /retail	50% <a href="#">coinsurance</a> /retail	

[\* 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
Prescription Out of Pocket Maximum per Calendar year: For <a href="#">network providers</a> \$3,000 individual / \$5,250 family; for <a href="#">out-of-network providers</a> \$10,250 individual / \$20,250 family	<a href="#">Specialty drugs</a> 20% coinsurance; \$150 maximum on all specialty medications.	Not Covered	Not Covered	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"***
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: \$250 <a href="#">copay</a> per procedure; 30% <a href="#">after deductible</a>	50% <a href="#">after deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% <a href="#">after deductible</a>	50% <a href="#">after deductible</a>	50% <a href="#">coinsurance</a> for anesthesia.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a>		Facility room charge not covered for non-emergency
	<a href="#">Emergency medical transportation</a>	0% <a href="#">copay</a> or <a href="#">coinsurance</a>		None
	<a href="#">Urgent care</a>	Enhanced Tier: \$30 Primary Care, \$60 <a href="#">copay</a> Specialist; 0% after deductible. Core Tier: \$50 <a href="#">copay</a> Primary Care, \$80 <a href="#">copay</a> Specialist; 30% after deductible	50% <a href="#">after deductible</a>	If you use WellSpan Online Urgency Care, there is no <a href="#">copayment</a> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Enhanced Tier: 10% after <a href="#">deductible</a> , Core Tier: \$250 <a href="#">copay</a> per admission; 30% <a href="#">after deductible</a>	50% <a href="#">after deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service.

[\* 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees/anesthesia fees	Enhanced Tier: 10% after <a href="#">deductible</a> , Core Tier: 20% after <a href="#">deductible</a>	50% <a href="#">after deductible</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Enhanced Tier: \$20 copay no <a href="#">deductible</a> , Core Tier: \$30 copay no <a href="#">deductible</a>	50% <a href="#">after deductible</a>	None
	Inpatient services	Enhanced Tier: 10% after <a href="#">deductible</a> , Core Tier: 30% after <a href="#">deductible</a>	50% <a href="#">after deductible</a>	Requires <a href="#">preauthorization</a> with Quest
If you are pregnant	Office visits	Enhanced Tier: \$40 <a href="#">copay</a> Core Tier: \$45 <a href="#">copay</a>	50% <a href="#">after deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Requires <a href="#">preauthorization</a> .
	Childbirth/delivery professional services	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% after <a href="#">deductible</a>	30% <a href="#">after deductible</a>	
	Childbirth/delivery facility services	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% after <a href="#">deductible</a>	50% <a href="#">after deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% after <a href="#">deductible</a>	50% <a href="#">after deductible</a>	120 visits/year; requires <a href="#">preauthorization</a>
	<a href="#">Rehabilitation services</a>	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% after <a href="#">deductible</a>	50% <a href="#">after deductible</a>	Includes physical therapy, speech therapy, and occupational therapy.

[\* 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% <a href="#">after deductible</a>	50% <a href="#">after deductible</a>	Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Skilled nursing care</a>	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% <a href="#">after deductible</a>	50% <a href="#">after deductible</a>	Requires <a href="#">preauthorization</a>
	<a href="#">Durable medical equipment</a>	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% <a href="#">after deductible</a>	50% <a href="#">after deductible</a>	Some services require <a href="#">preauthorization</a> . Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	Enhanced Tier: 10% after <a href="#">deductible</a> ; Core Tier: 30% <a href="#">after deductible</a>	50% <a href="#">after deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service.
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally 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>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Glasses, except after cataract surgery</li> <li>• Weight loss programs</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>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing – Max 240 Hours</li> <li>• Routine foot care, except for those with a metabolic, neurological, or peripheral-vascular disease.</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>• Acupuncture (if prescribed for rehabilitation purposes)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment limited to \$10,000 lifetime maximum in combination with the Adoption Policy</li> </ul>

[\* 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](http://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](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 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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$550
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$550
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$1,205
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1855</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>	\$550
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$550
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$650</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>	\$550
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$550
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$850</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: 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.

