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?	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	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 $4,500 individual / $8,250 family; for out-of-network providers $6,750 individual / $12,750 family	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. ***For Prescription out-of-pocket information, see below "If you need Drugs."***
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. $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.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Enhanced Tier $20 copay/visit Core Tier: $30 copay/visit	50% after deductible	None
	Specialist visit	Enhanced Tier $40 copay/visit Core Tier: $45 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	$250 copay per test, then 50% after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs Core Tier and out-of-network - $10 minimum	Enhanced Tier: $10 copay/retail $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). Maintenance Drugs are required to be filled through WellSpan Pharmacies. Some prescription drugs require preauthorization by OptumRx. Non-payment penalty for non-compliance. If a generic is available, the cost would be the copay or coinsurance plus any amount over the generic cost. Some injectable and other drugs require preauthorization (see http://hr.wellspan. org) or call WellSpan Population Health Services).
	Preferred brand drugs Core Tier and out-of-network - $40 minimum	Enhanced Tier: $40 copay/retail $80 copay/100 day or mail Core Tier: 35% coinsurance/retail	35% coinsurance/retail	
	Non-preferred brand drugs Core Tier and out-of-network - $65 minimum	Enhanced Tier: $65 copay/retail; $130 copay/100 day or mail; Core Tier: 50% coinsurance/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 $3,000 individual / $5,250 family; for out-of-network providers $10,250 individual / $20,250 family	Specialty drugs 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"**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible	$250 copay per procedure, 50% after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible	50% after deductible	50% coinsurance for anesthesia.
If you need immediate medical attention	Emergency room care	$200 copay		Facility room charge not covered for non-emergency
	Emergency medical transportation	0% copay or coinsurance		None
	Urgent care	Enhanced Tier: $30 Primary Care, $60 copay Specialist; 0% after deductible. Core Tier: $50 copay Primary Care, $80 copay Specialist;30% after deductible	50% after deductible	If you use WellSpan Online Urgency Care, there is no copayment.
If you have a hospital stay	Facility fee (e.g., hospital room)	Enhanced Tier: 10% after deductible, Core Tier: 30% after deductible	$250 copay per admission; 30% after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	Enhanced Tier:10% after deductible, Core Tier: 20% after deductible	30% after deductible	30% after deductible for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Enhanced Tier: $20 copay no deductible, Core Tier: $30 copay no 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: $40 copay Core Tier: $45 copay	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	30% 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Enhanced Tier: 10% after deductible; Core Tier: 30% after deductible	50% after deductible	Includes physical therapy, speech therapy, and occupational therapy.
	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 you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
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)
- Private Duty Nursing – Max 240 Hours
- 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
- Weight loss programs
- Infertility treatment limited to $10,000 lifetime maximum in combination with the Adoption Policy

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].]

About these Coverage Examples:

- **The plan's overall deductible** **$550**
- **Specialist copayment** **$40**
- **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)*

- **The plan's overall deductible** **$550**
- **Specialist copayment** **$40**
- **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)*

- **The plan's overall deductible** **$550**
- **Specialist copayment** **$40**
- **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)*