




The is only a Summary of Benefits and Coverage (SBC). If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://hr.wellspaneap.org>, or by calling (717) 851-5959. You can also contact the WellSpan Employee Assistance Program (EAP) at (800) 673-2514.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See page 2 for your costs for services.
Are there services covered before you meet your deductible ?	No	You do not have to meet deductibles for specific services but see page 2 for your costs for services.
Are there other deductibles for specific services?	No	This plan pays covered services at 100%.
What is the out-of-pocket limit for this plan ?	\$0	Not Applicable as there is no out-of-pocket limit on this plan.
What is not included in the out-of-pocket limit ?	\$0	Not Applicable as there is no out-of-pocket limit on this plan.
Will you pay less if you use a network provider ?	Yes. For a list of participating providers, go to www.wellspan.org/eap or call (800) 673-2514	If you use a participating doctor or other health care provider , this plan will pay some or all the costs of covered services. Plans use the term in-network, preferred , or participating for providers in their network . See page 2 for how this plan pays different kinds of providers .
Do you need a referral to see a specialist ?	No.	Some of the services this plan does not cover are listed on page 2. See your policy or plan document for additional information about excluded services.

 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 Your Costs	Out-of-Network Provider Your costs	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health Outpatient services	No Charge Services covered at 100%	Not covered	The EAP covers up to 6 in-person and/or tele-health counseling visits, per family, each calendar year (includes substance abuse disorder outpatient visits)
	Mental/Behavioral Health Inpatient services	Not covered	Not covered	None
	Substance use disorder Outpatient services	No Charge Services covered at 100%	Not covered	The EAP covers up to 6 in-person and/or tele-health counseling visits, per family, each calendar year (includes substance abuse disorder outpatient visits)
	Substance use disorder Inpatient services	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 .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Cosmetic surgery • Court-ordered evaluations • Dental care (Adult & Child) • Department of Transportation evaluations 	<ul style="list-style-type: none"> • Fitness for duty evaluations • Hearing aides • Infertility treatment • Long-term care • Medication check visits • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private Duty Nursing • Psychiatrist visits • Routine eye care (Adult & Child) • Routine foot care • Substance use disorder Intensive Outpatient Program (IOP) services • Weight loss programs

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

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

assistance, contact: (717) 851-3332.

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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