WELLSPAN HEALTH

Population Health Services

Guide to Your Medical Benefits

Plan Document and Summary Plan Description

WellSpan Plus Medical Health Plan

Effective January 2024

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WellSpan Plus Schedule of Benefits – APPENDIX 1

Below is the Schedule of Benefits. See the section "The WellSpan Plus Medical Plan Option" for more detailed information about how the WellSpan Plus Plan Option works, the ***networks*** available to you, and information about what is covered or not covered under this Option.

	ENHANCED TIER WellSpan Provider Network (includes other Select Providers	**CORE TIER** Capital Blue Cross	**OUT-OF-NETWORK**
MEDICAL DEDUCTIBLE PER CALENDAR YEAR			
Per Covered Person	$300	$450	$900
Deductibles do not accumulate across Tiers.			
INJECTABLE DRUG DEDUCTIBLE PER CALENDAR YEAR			
Per Covered Person	$150		$150
Deductible accumulates across Enhanced Tier and Core Tier only			
OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR			
Per Covered Person	$2,750		$10,250
Per Family Unit	$4,750		$20,250
Out-of-Pocket maximums accumulate across Enhanced and Core Tiers only. Maximum includes Medical and Behavioral Health deductibles, co-insurance, and co-payments. Pre-certification penalties, non-covered services, amounts over the *Plan Allowance,* etc. do not count toward the out-of-pocket maximum.			
TYPE OF EXPENSE	**ENHANCED TIER** WellSpan Provider Network (includes other Select Providers)	**CORE TIER** Capital Blue Cross	**OUT-OF-NETWORK**
Acupuncture. Benefits include charges for acupuncture used to induce surgical anesthesia or for therapeutic treatment for a medical condition.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
	Maximum of $500 per ***calendar year***		

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Ambulance Services. Benefits for the following land/air ambulance services are covered: • Land ambulance services (for ***emergencies***) from the place of the emergency to the nearest hospital or facility; or • Air ambulance services are covered when the point of pick-up is inaccessible by land vehicles; or great distances or other obstacles are involved in getting the person to the nearest hospital with appropriate facilities and speedy admission is essential.	100% with no deductible	100% with no deductible	100% with no deductible; subject to the ***Plan Allowance***
Ambulatory (Outpatient) Surgical Facility (not in a physician's office.) **NOTE:** Services may require ***pre-certification***!	95% after the deductible	$200 co-payment, then 80% after the deductible	$250 co- payment, then 50% after the deductible subject to the ***Plan Allowance***
Anesthesia. Benefits are available when administered in connection with a covered surgical procedure and given by a physician (other than the operating surgeon) or by a Certified Registered Nurse Anesthetist.	95% after the deductible	95% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Biofeedback. Benefits include ***medically necessary*** biofeedback.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Birthing Center. **NOTE:** Services may require ***precertification*!**	95% after the deductible	$200 co-payment, then 80% after the deductible	$250 co-payment, then 70% after the deductible subject to the ***Plan Allowance***
Cardiac Rehabilitation. Cardiac rehabilitation must be ***medically necessary*** and prescribed by your ***physician***.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***

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TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes Other Select	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Chemotherapy. The cost of the injectable antineoplastic agent is covered under the medical benefits when administered where dispensed.	95% after the deductible The $150 injectable drug deductible may apply	95% after the deductible The $150 injectable drug deductible may apply	50% after the deductible subject to the ***Plan Allowance*** The $150 injectable drug deductible may apply
Chiropractic Care. ***Covered charges*** include: • Initial consultation • Work-up; and • X-rays and treatment.	$20 co-payment, then 100% for office visit or manipulation with no deductible; 95% after the deductible for other ***covered services***	$30 co-payment, then 100% for office visit or manipulation with no Deductible; 80% after the deductible for other ***covered services***	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 24 visits per ***calendar year***		
Cleft Palate and Cleft Lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close and cleft lip is defined as a birth deformity in which the lip fails to close. Benefits include the following expenses: • Oral and facial surgery surgical management and follow-up care • Speech therapy • Otolaryngology treatment • Audiological assessments and treatment • ***Medically necessary*** orthodontic treatment directly related to a diagnosis of cleft palate or cleft lip; • ***Medically necessary*** prosthodontic treatment directly related to a diagnosis of cleft palate or cleft lip; and • Prosthetic treatment such as obturators, speech appliances, and feeding appliances. **NOTE**: Services may require ***pre-certification!***	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to the ***Plan Allowance*** Benefits will depend upon the type of service you receive – for example: a ***physician's*** office visit, surgery, or diagnostic tests.
Contact Lenses and Glasses. ***Covered charges*** include one (1) pair of eyeglasses with standard frames or one (1) set of contact lenses after cataract surgery.	$20 co-payment, then 100% for office visit; 95% after the deductible for other ***covered services***	$30 co-payment, then 100% for office visit with no deductible; 80% after the deductible for other ***covered services***	50% after the deductible subject to the ***Plan Allowance***

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Contact Lenses and Glasses. ***Covered charges*** include one (1) pair of eyeglasses with standard frames or one (1) set of contact lenses after cataract surgery.	$20 co-payment, then 100% for office visit; 95% after the deductible for other ***covered services***	$30 co-payment, then 100% for office visit with no deductible; 80% after the deductible for other ***covered services***	50% after the deductible subject to the ***Plan Allowance***
Contraceptive Management and Family Planning Services for Men. Benefits include ***physician*** services and surgery. See the **Preventive Care** section for benefits related to contraceptive management and family planning for women. **NOTE:** Services may require ***precertification***!	95% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit or surgery.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit or surgery.	50% after the deductible subject to the ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit or surgery.
CT Scan (Outpatient) Services (Technical Component). **NOTE:** Services may require ***precertification***!	95% after the deductible	$250 co-payment, then 80% after the deductible	$250 co-payment, then 50% after the deductible subject to the ***Plan Allowance***
Dental Services. Coverage includes dental services provided by a physician or dentist only when services begin within 18 months of an accidental injury to the jaw, sound natural teeth, gums, alveolar processes, or face. **NOTE:** Services may require ***pre-certification***!	95% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to the ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.
Diabetes Education. Benefits include diabetes self-management educational programs and consultations.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Diagnostic Services (Technical Component). Benefits for services from ***facilities*** or ***physicians*** that include charges to perform diagnostic tests. **NOTE:** Services may require ***pre-certification***!	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Diagnostic Services (Professional Component). **NOTE:** Services may require ***pre-certification***!	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Dietary Counseling. This benefit is limited to ***medically necessary*** dietary counseling when it is a primary treatment option for an underlying ***sickness*** or condition.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Durable Medical Equipment. Benefits include the rental, and, in some cases, the purchase of ***durable medical equipment*** (***DME***) and surgical equipment when it is prescribed by a ***provider*** and required for therapeutic use. **NOTE:** Services may require ***pre-certification***!	95% after the deductible For Insulin Pumps, the benefit is 100%; deductible waived at this tier	80% after the deductible For insulin Pumps, the benefit is 100%; deductible waived at this tier.	50% after the deductible subject to the ***Plan Allowance***
Emergency Department Physicians. Coverage includes charges from a ***physician*** in the Emergency Department.	100% with no deductible	100% with no deductible	100% with no deductible subject to the ***Plan Allowance***

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TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK

Emergency Department Services. Coverage is included for these services:
• ***Emergency*** services, including ***facility*** and ***professional provider*** services and supplies for the initial treatment of traumatic bodily injuries resulting from an accident; and
• ***Emergency*** services, including ***facility*** and ***professional provider*** services and supplies for the treatment of an acute medical condition that manifests itself by acute symptoms (including severe pain) of sufficient severity that the absence of immediate medical attention could reasonably result in:
  • Placing the patient's health in jeopardy;
  • Causing other serious medical consequences;
  • Causing serious impairment to bodily functions; and
  • Causing serious dysfunction of any bodily organ or part.
	$200 co-payment, then 100% with no deductible	$200 co-payment, then 100% with no deductible	$200 co-payment, then 100% with no deductible subject to the ***Plan Allowance***

	The co-payment is *waived* if admitted as an inpatient or observation level of care. **The Emergency Department room charge is not covered for non-emergency use of the Emergency Department.** **Should a prudent layperson, who possesses an average knowledge of health and medicine, believe a serious medical condition exists; the emergency department visit is justified.**		
Hearing Aids and Associated Services.	$25 co-payment, then 100% for office visit with no deductible, then 95% after the deductible for other ***covered services***	$35 co-payment, then 100% for office visit with no deductible; 80% after the deductible for other ***covered services***	50% after the deductible subject to the ***Plan Allowance***
Home Health Care Services. ***Home health care*** services and supplies are covered when prescribed by a ***physician***. ***Covered services*** include: • Part-time or intermittent skilled nursing care by a ***nurse;*** • Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services; • Physical, respiratory, occupational, and speech therapy; • Medical and surgical supplies; • Infusion therapy; • Oxygen and its administration; and, • Medical social service consultations. **NOTE:** Services may require ***pre-certification***!	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 120 visits per ***calendar year***		

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes Other Select providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Hospice Care (Inpatient and Home). ***Hospice care services and supplies*** are covered for terminally ill patients with a life expectancy of six months or less when care is ***medically necessary***. ***Covered services*** include: • ***Inpatient*** or ***outpatient*** care; • Nutrition counseling and special meals; • Part-time nursing; • Short-term respite care; • Homemaker services; • Physical and chemical therapy; and, • Bereavement counseling for a ***spouse***, and/or children for a period of six months after the death – up to a combined maximum of six visits. **NOTE:** Services may require ***pre-certification***!	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Hospital Services (Inpatient). Benefits cover semi-private room and board expenses, including medical and educational services and supplies furnished by the ***hospital***. **NOTE:** Services may require ***pre-certification***!	95% after the deductible	$200 co-payment per admission, then 80% after the deductible	$250 co-payment per admission, then 70% after the deductible subject to the ***Plan Allowance***
Immunizations for Adults and Children Recommended by the Centers for Disease Control (CDC) and that are not included in the preventive benefits as required by the Affordable Care Act (ACA).	95% after the deductible	80% after the deductible	50% after the deductible subject to the Plan Allowance

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TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes Other Select providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Infertility – Treatment and Assisted Reproduction Services in combination with the Adoption Policy. **NOTE:** Injectable ***prescription drugs*** are subject to the annual $150 injectable drug deductible. Services may require ***precertification!***	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to ***Plan Allowance*** Benefits will depend upon the type of service you receive – for example: a ***physician's*** office visit, surgery, or diagnostic tests.
	Maximum of $10,000 per lifetime combined with Adoption Policy (Refer to WellSpan Health Adoption Policy)		
Infertility - Diagnostic Services. Coverage includes benefits for the diagnosis of infertility. **NOTE:** Services may require ***pre-certification!***	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery or diagnostic tests.
Inpatient Hospital Visits by Physicians.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
	Emergency inpatient services (through an ED) from an out-of-network provider or facility are treated at the Enhanced Tier (Tier 1) level.		
Mastectomy Services. Benefits cover ***reconstructive surgery***, prosthesis, and treatment of the physical complications during all stages of a mastectomy. **NOTE:** Services may require ***pre-certification***!	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Maternity Services. Coverage is available for ***pregnancy*** of ***employees***, ***spouses*** of ***employees***, and ***dependent*** daughters. **NOTE:** Services may require ***pre-certification***! *****Doula services covered effective 1/1/2024. Please see the "What is Covered" section of the Plan Document*****	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after deductible subject to ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.
MENTAL HEALTH SERVICES.	***Mental health*** **benefits are provided through Quest Behavioral Health. See the section "Mental Health and Substance Use Disorder Benefits" for detailed information about *mental health* benefits.**		
MRA/MRI Scan (Outpatient) Services (Technical Component). **NOTE:** Services may require ***pre- certification***!	95% after the deductible	$250 co-payment, then 80% after the deductible	$250 co-payment, then 50% after the deductible subject to the ***Plan Allowance***
Newborn Care. ***Physician's*** charges for circumcision of a newborn male child and for ***hospital*** visits to newborn children are covered.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Nursery Room Charges.	95% after the deductible	$200 co-payment, then 80% after the deductible	$250 co-payment, then 70% after the deductible subject to the ***Plan Allowance***
Nutrition Therapy. Benefits are available for nutrition therapy. These services include: • Enteral therapy (i.e., by feeding tube) and parenteral therapy (i.e., by intravenous administration limited to medically necessary formula when ordered by a physician where the member has either (a) a non-function or disease of the structures that normally permit food to reach the small bowel; or (b) disease of the small bowel that impairs digestion and absorption of an oral diet, either of which requires enteral or parenteral feedings to provide sufficient nutrients to maintain weight ***Continued on next page***	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Nutrition Therapy continued from previous page. and strength appropriate for the member's overall health status. Metabolic formulas limited to ***medically necessary formulas*** for inherited metabolic disorders when ordered, in writing, by a ***physician.*** Lactose intolerance without a diagnosis of galactosemia is not considered to be an inherited metabolic disorder under the ***Plan.*** Metabolic formulas must be: • Formulated to be consumed under the direction of a ***physician;*** • Processed or formulated to be deficient in one or more of the nutrients present in typical food stuffs; • Administered for the medical and nutritional management of a patient with limited capacity to metabolize food stuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and • Essential to the patient's optimal growth, health, and metabolic homeostasis. Coverage is not available for any of the following: • Metabolic formulas for any medical condition other than for inherited disorders as defined above; • Natural foods that are naturally low in protein and/or galactose; • Spices/flavorings; and • Foods and/or formulas available to any person, even a person with an inherited metabolic disorder as defined above, which may be purchased without a prescription and/or that, do not require supervision by a ***physician.***	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Obesity. Care related to a diagnosis of ***obesity*** are covered. This could include: • ***Physician*** services; • Diagnostic tests; • Prescription generic medications; • Dietary counseling; and • Surgery. Commercial weight loss programs, non-prescription items, and fitness center memberships are not covered. Also, the patient must meet the definition of ***obesity*** (see the "Terms You Should Know" section later in this guide). Benefits for bariatric surgery are only available when performed in a ***facility*** recognized by a national medical society who offers accreditation for such surgery. Surgery must be performed by surgeons who are certified through nationally recognized medical societies who offer bariatric surgery certification programs. **NOTE:** Services may require ***pre-certification***!	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.
Occupational Therapy. Coverage includes treatment for a physically disabled person by means of constructive activities designed to restore the person's ability to satisfactorily perform the ordinary tasks of daily living.	$10 co-payment, then 95% with no deductible for office visit	$20 co-payment, then 90% with no deductible for office visit	50% after the deductible subject to the ***Plan Allowance***
Oral Surgery. Charges for ***injury*** to or care of the mouth, teeth, gums, and alveolar processes will be covered. **NOTE:** Services may require ***pre- certification***!	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to ***Plan Allowance.*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.

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TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Orthotic Devices (Orthosis). Charges for ***medically necessary*** orthotic devices, including custom-molded (but not ***over-the-counter***) foot orthoses, are covered. Replacements will be covered only if it is shown that: • It is needed due to a change in the physical condition of the patient to make the original device no longer functional; • It is needed due to normal wear and tear; or • It is likely to cost less to buy a replacement than to repair the existing device. Charges for repair or ***medically necessary*** replacement of an orthotic device will be considered a ***covered charge***, except when such repairs or replacements are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for devices when under warranty from the manufacturer. Orthopedic shoes are not covered unless they are part of a leg brace. **NOTE:** Services may require ***pre-certification***!	95% after the deductible	95% after the deductible	50% after the deductible subject to the ***Plan Allowance***
PET Scan (Outpatient) Services (Technical Component). **NOTE:** Services may require ***pre-certification***!	95% after the deductible	$250 co-payment, then 80% after the deductible	$250 co-payment, then 50% after the deductible subject to the ***Plan Allowance***
Physical Therapy. Coverage includes treatment by physical means, including: • Hydrotherapy, heat, or similar modalities • Physical agents • Bio-mechanical and neuro-physical principals; and • Devices to relive pain, restore maximum function lost or impaired, and prevent disability or loss of a body part.	$0 co-payment, then 95% with no deductible	$20 co-payment, then 90% with no deductible	50% after the deductible subject to the ***Plan Allowance***
Physician Visits with a Primary Care Physician (PCP). A PCP includes Internal Medicine, Family Practice, General Practice, and General Pediatrics	$10 co-payment, then 100% for office visit with no deductible; 95% all other covered services after deductible	$25 co-payment, then 100% for office visit with no deductible; 80% all other covered services after deductible	50% after the deductible subject to the ***Plan Allowance***
Physician Visits with a Specialist. A Specialist is a physician who is not a PCP.	$30 co-payment 100% for office visit with no deductible; 95% all other covered services after deductible	$40 co-payment, then 100% for office visit with no deductible; 80% all other covered services after deductible	50% after the deductible subject to the ***Plan Allowance***

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Podiatry Services. Surgical podiatry services include: • Incision and drainage of infected foot tissues and toenails of the foot • Removal of lesions (not including corns or calluses) • Treatment of fractures, deformities, and dislocations of bones of the foot; and • ***Medically necessary*** foot care for ***covered persons*** with metabolic, neurological, or peripheral-vascular disease. Podiatry, or foot care, services are not covered when those services and procedures are considered to be in the realm of self-care, such as: • Clipping, trimming, shaving, paring or nonsurgical care of toenails, corns, and calluses • Other hygienic and preventive maintenance care in the realm of self-care, such as cleaning the feet and the use of skin creams; and • Any services performed in the absence of localized ***sickness***, ***injury***, or symptoms involving the foot. **NOTE:** Services may require ***pre-certification!***	95% after the deductible Benefits will depend upon the type of service you receive, - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to the ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.
PRESCRIPTION DRUGS – BENEFIT MANAGER (PBM) PROGRAM.	***Prescription drug*** **benefits are provided through the PBM. See the section "Prescription Drug Benefits" for detailed information about** ***prescription drug*** **benefits**		

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Prescription Drugs Covered Under the Medical Benefits. Injectable ***prescription drugs***, that require administration by your ***provider*** can be reimbursed through either the medical or ***prescription drug*** benefits, but not through both. Insulin and other self-administered drugs are only covered under the ***prescription drug*** benefits. Those supplies necessary to administer self-injectable ***prescription drugs***, can only be reimbursed under the ***prescription drug*** coverage. All ***prescription drugs*** that are administered in the place where they are dispensed, such as in the Emergency Department, a ***physician's*** office, a place providing urgent care, for oncology treatment, or as part of an ***inpatient hospital*** admission will be covered under the medical benefits. Some injectables must be obtained through the prescription ***plan*** or the WellSpan Pharmacies. ***Prescription drugs*** dispensed, but not administered, such as "take home" drugs, are not covered under the medical or ***prescription drug*** benefits. **NOTE:** Certain injectable ***prescription drugs*** must be ***pre-certified***!	95% after the deductible **The $150 injectable drug deductible, including drugs given by infusion, may apply**	80% after the deductible **The $150 injectable drug deductible, including drugs given by infusion, may apply**	50% after the deductible subject to the ***Plan Allowance*** **The $150 injectable drug deductible, including drugs given by infusion, may apply**
Private Duty Nursing Care. Benefits are available for private duty nursing services, defined as skilled nursing care in the home by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) whose purpose is to assess, monitor, and provide skilled nursing care in the home on an hourly basis. **NOTE:** Services require ***precertification***!	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 240 hours per ***calendar year***		

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Prosthetic Devices. Coverage includes prosthetic devices (other than dental) to replace all or part of an absent body part, including contiguous tissue, or to replace all or part of the function of a permanently inoperative or malfunctioning body part. A replacement device will be covered only if it is shown that: • It is needed due to a change in the physical condition of the patient to make the original device no longer functional; • It is needed due to normal wear and tear as determined by the manufacturer and the ***Plan***; or • It is likely to cost less to buy a replacement than to repair the existing device. Charges for repair or ***medically necessary*** replacement of a prosthetic device will be considered a ***covered charge***, except when such repairs or replacement are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for devices when under warranty from the manufacturer. **NOTE:** Services may require ***pre-certification***!	95% after the deductible	95% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Radiation Therapy.	95% after the deductible	95% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Renal Dialysis. Benefits are provided for the treatment of acute renal failure or chronic irreversible renal insufficiency through the removal of waste materials from the body, including, hemodialysis and peritoneal dialysis.	95% after the deductible	80% after the deductible	Not Covered
Respiratory Therapy.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Second Surgical Opinion. A third opinion is also covered if the second opinion disagrees with the first.	$30 co-payment, then 100% for office visit with no deductible; 95% other covered services after deductible	$40 co-payment, then 100% for office visit with no deductible; 80% other covered services after deductible	50% after the deductible subject to the ***Plan Allowance***
Skilled Nursing Facility (Extended Care Facility). Benefits include ***inpatient skilled nursing facility*** services when you need skilled nursing care, but do not need the level of care provided by a ***hospital***. **NOTE:** Services require ***pre-certification***!	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 120 days per ***calendar year***		

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Speech Therapy. The treatment for the correction of a speech impairment resulting from ***sickness***, surgery, ***injury***, congenital or developmental anomalies, or previous therapeutic processes is covered.	$10 co-payment, then 95% with no deductible for office visit	$20 co-payment, then 90% with no deductible for office visit	50% after the deductible subject to the ***Plan Allowance***
SUBSTANCE USE DISORDER SERVICES	***Substance Use Disorder*** **benefits are provided through Quest Behavioral Health. See the section "Mental Health and Substance Use Disorder Benefits" for detailed information about *substance use disorder* benefits.**		
Supplies & Catheters. Benefits are available for ***medically necessary*** medical supplies and catheters, but not common first aid supplies. (Colostomy, ileostomy, respiratory therapy supplies are covered under either the ***prescription drug*** benefits or the medical benefits. Insulin syringes and diabetes supplies are covered only under the ***prescription drug*** benefits) **NOTE**: Services may require ***pre-certification!***	95% with no deductible	95% with no deductible	50% after the deductible subject to the ***Plan Allowance***
Surgical Procedures (Inpatient, Outpatient, and Office). ***Emergency*** and elective. **NOTE:** Services may require ***pre-certification***!	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Surgical Dressings.	95% after the deductible	80% after the deductible	50% after the deductible subject to the ***Plan Allowance***
Temporomandibular Joint Dysfunction (TMJ) Services. Coverage is included for services related to a diagnosis of ***temporomandibular joint dysfunction*** and myofascial pain dysfunction. **NOTE:** Services may require ***pre-certification***!	95% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.
Therapeutic Shoes and Inserts. Benefits are provided for molded or depth-inlay shoes and custom-molded shoe inserts for the prevention and treatment of foot complications associated with diabetes or neuropathies related to other conditions. The footwear and associated inserts must be ***medically necessary***, be prescribed by a ***physician*** or other ***provider***, and be fitted and furnished by a podiatrist, pedorthist, orthotist, or prosthetist.	95% with no deductible	95% with no deductible	50% after the deductible subject to the ***Plan Allowance***

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Transplant Services. Benefits cover human-to-human organ or tissue transplants. Only those transplants that are considered to be ***medically necessary*** and not ***experimental*** or ***investigational*** will be covered under this ***Plan***. If you or your covered ***dependent*** is the donor, expenses are covered the same as for any other ***sickness***. Benefits will be available for the donor, if not a ***covered person*** under this ***Plan***, as long as you or your ***dependent's*** benefits have not been exhausted and as long as the donor's expenses are not covered under another group health plan. Covered expenses will be paid for each transplant procedure that is completed, including: • Organ or tissue procurement from a cadaver, including the removal, preservation, and transportation of the donated part; • Services and supplies furnished by the ***Facility;*** • Treatment and surgery by a ***professional provider;*** • Drug therapy treatment to prevent rejection of the transplanted organ or tissue; and • Surgical, storage, and transportation costs directly related to the procurement of an organ or tissue. **NOTE:** Services may require ***pre-certification***!	95% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	80% after the deductible Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.	50% after the deductible subject to ***Plan Allowance*** Benefits will depend upon the type of service you receive - for example: a ***physician's*** office visit, surgery, or diagnostic tests.
Urgent Care Services, Walk-In Clinics, Retail Clinics. Coverage is available for charges received in an urgent care center or a ***facility*** that sees patients for non-***emergency***, yet necessary, care. These ***facilities*** usually see patients for unscheduled walk-in care that is not through a ***hospital's*** Emergency Department. ***Prescription drugs*** that are dispensed, but not administered, are not covered under the medical or ***prescription drug*** benefits.	$25 co-payment, then 100% for office visit with PCP $50 co-payment, then 100% for office visit with a Specialist 95% after the deductible for all other ***covered services***	$45 co-payment, then 100% for office visit with a PCP $60 co-payment, then 100% for office visit with a Specialist 80% after the deductible for other ***covered services***	50% after the deductible subject to the ***Plan Allowance***
WellSpan Virtual On-demand Care. On-demand healthcare is available 24/7 using a smartphone, tablet or personal computer with a webcam and microphone for non-emergency, yet necessary, care.	$0 co-payment with no deductible	Not available.	Not Available.
Vision Therapy. Treatment involving non-surgical methods aimed at improving visual skills resulting from binocular impairments is covered.	$10 co-payment, then 95% with no deductible for office visit	$20 co-payment, then 90% with no deductible for office visit	50% after the deductible subject to the ***Plan Allowance***

Preventative Services **The Plan covers certain preventative services as required by the federal Affordable Care Act (ACA). For more information about Preventative Services covered under the Plan, see the section "Preventative Services" under the "What is Covered" heading. Out-of-network benefits are only considered at 100% if there is no network provider who can reasonably provide the service**			
TYPE OF EXPENSE	**ENHANCED TIER** **WellSpan Provider Network (includes other Select Providers)**	**CORE TIER** **Capital Blue Cross**	**OUT-OF-NETWORK**
Adult and Women's Preventive Visits. Includes preventive office visits for adults age 19+ and gynecological visits for all women. Visit could include blood pressure screening, skin cancer counseling and intimate partner violence screening. Based on ***medical necessity.***	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Abdominal Screening Aortic Aneurysm Ultrasound.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 screening test, per ***lifetime***, between ages 65 and 75		
Alcohol/Drug Misuse Screening and Behavioral Counseling in a Primary Care Setting.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 visit per ***calendar year***		
Maternity Screening Tests. Based on ***Medical necessity*** Limited to: Anemia, Bacteriuria, Hepatitis B, Rh incompatibility.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Counseling for BRCA Screening and BRCA Testing. Based on ***medical necessity.***	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Counseling for Breast Cancer Preventive Medication. Based on ***medical necessity.***	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Screening Mammography for Women.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 screening test per ***calendar year***, age 40+		
Lung Cancer Screening. Low dose CT for those who smoke or have quit smoking in the past 15 years.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 test per ***calendar year***, between ages 55 and 80		

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	Out-of-Network
Cervical Cancer Screening in Women.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 screening test per ***calendar year***		
Screening Tests for Children and Adults. Based on ***Medical necessity.*** Limited to: Chlamydia, Hepatitis C, Hepatitis B, Cholesterol, Glucose, Gonorrhea, HIV, Syphilis.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Screening for Colon Cancer - Blood Occult.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 screening test per ***calendar year***, age 45+		
Screening for Colon Cancer – Sigmoidoscopy.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 screening procedure every 5 ***calendar years***, age 45+		
Screening for Colon Cancer – Cologuard.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 screening procedure every 3 ***calendar years***, age 45+		
Screening for Colon Cancer – Colonoscopy.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 screening procedure every 10 ***calendar years***, age 45+		
Depression Screening in Adults and Major Depressive Screening for Children and Adolescents. Based on ***Medical necessity.***	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Healthy Diet Counseling for Adults. Based on ***Medical necessity.***	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Limited to age 19+		
Sexually Transmitted Infections Screening/Counseling in Children and Adults.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum 1 visit per ***calendar year***		
Obesity Screening in Children and Adults.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 visit per ***calendar year***		
Screening for Osteoporosis. Based on ***Medical necessity.***	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 screening test every 2 ***calendar years***		
Fall Prevention Physical Therapy. Based on ***Medical necessity.***	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Limited to age 65+		

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Supplements. Requires a ***Physician's*** Prescription or Letter of ***Medical necessity***. Limited to: Aspirin to prevent cardiovascular disease or for preeclampsia prevention, Folic Acid for women capable of becoming pregnant, Vitamin D for those age 65+ at risk for falls.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Tobacco Use and Tobacco-Caused Disease Counseling and Interventions. Based on ***Medical necessity*** could include ***physician*** visits, tobacco cessation classes, and cessation aids. Requires ***physician*** prescription or Letter of Medical Necessity for cessation aids submitted through the medical plan (see the Prescription Drug Plan for items covered there).	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Screening for Gestational Diabetes.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 2 screening tests per ***calendar year***		
Screening for Human Papillomavirus (HPV) for Women.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 screening test every 3 ***calendar years***, age 30+		
Counseling for Human Immune-Deficiency virus (HIV) for Women.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 visit per **calendar year**		
Screening and Counseling for Interpersonal and Domestic Violence for Women.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Breastfeeding Support, Supplies, and Counseling for Women. Lactation support, during pregnancy and/or in postpartum period and costs for breastfeeding equipment in conjunction with each birth. Breast pumps limited to rentals (up to the purchase price) and pumps purchased through a ***hospital, durable medical equipment***/medical supplier, ***physician's*** office, or ***pharmacy***. Charges limited to items deemed to be ***medically necessary***; convenience items or upgrades are not covered.	100%	100%	100% up to **$500 maximum** subject to the ***Plan Allowance***
Prenatal Visit with a Pediatrician.	100%	100%	50% after the deductible subject to the ***Plan Allowance***

TYPE OF EXPENSE	ENHANCED TIER WellSpan Provider Network (includes other Select Providers)	CORE TIER Capital Blue Cross	OUT-OF-NETWORK
Contraceptive Methods and Counseling for Women. All FDA approved, and ***physician*** prescribed contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. Requires ***Physician*** Prescription or Letter of Medical Necessity for contraceptives submitted through the medical plan (see the Prescription Drug benefits for contraceptives covered there).	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Preventive Immunizations for Adults and Children. Limited to those recommended by the Advisory Committee on Immunization Practices (ACIP) and included in the Affordable Care Act (ACA) as a preventive service.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Child Preventive Visits. Visit could include blood pressure screening, measurements, anticipatory guidance, skin cancer counseling and intimate partner violence screening.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 12 visits from birth through age 2 Maximum of 1 visit per ***calendar year***, age 3 through 18		
Newborn Services. Limited to: Gonorrhea prophylactic medication, Hearing Loss screening, Hemoglobinopathies screening, Hypothyroidism screening, PKU screening, Vision screening, Newborn Metabolic/Hemoglobin screening.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
Hearing Screening in a Primary Care Setting.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 screening test per ***calendar year***, birth through age 21		
Vision Screening in a Primary Care Setting.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 screening test per ***calendar year***, birth through age 21		
Oral Health Screening in a Primary Care Setting.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 8 screenings, age 6 months through age 6		
Screening Tests for Children. Based on ***medical necessity.*** Limited to: Hematocrit or Hemoglobin, Lead screening, Tuberculin test.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Limited through age 21		
Developmental and Autism Screening in a Primary Care Setting.	100%	100%	50% after the deductible subject to the ***Plan Allowance***
	Maximum of 1 screening per ***calendar year***, birth through age 21		

Prescription Drug Schedule of Benefits – APPENDIX 2

TYPE OF EXPENSE	ENHANCED TIER NETWORK BENEFITS WellSpan Health Pharmacy	CORE TIER NETWORK BENEFITS Prescription Benefit Manager	OUT-OF-NETWORK
OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR			
Per Covered Person	$3,000		$10,250
Per Family Unit	$5,250		$20,250
Only Enhanced Tier and Core Tier Prescription Drug co-payments and coinsurance count toward this limit. Once met, the Plan pays 100% coinsurance of covered charges for the remainder of the Plan Year for Enhanced Tier & Core Tier			

TYPE OF EXPENSE	ENHANCED TIER NETWORK BENEFITS WellSpan Health Pharmacy	CORE TIER NETWORK BENEFITS Prescription Benefit Manager	OUT-OF-NETWORK
RETAIL (UP TO 34-DAY SUPPLY) **All Specialty Drugs are only covered if obtained from WellSpan Pharmacy**** **(HIV and Transplant drugs can be obtained at any Pharmacy)** **Continuous Glucose Monitors are only covered if obtained from WellSpan Pharmacies** **Specialty Drugs are limited to a 30-day fill.** **When a *generic* is available, you will be responsible for any amount over the *generic* drug cost, even if the prescription states "dispense as written" or "brand medically necessary."**			
Generic Drugs	$10 co-payment, then 100%	20% with a $10 minimum co-insurance, then 100%	20% with a $10 minimum co-insurance, then 100%
Brand-Name Formulary Drugs	$35 co-payment, then 100%	35% with a $35 minimum co-insurance, then 100%	35% with a $35 minimum co-insurance, then 100%
Brand-Name Non - Formulary Drugs	$60 co-payment, then 100%	50% with a $60 minimum co-insurance, then 100%	50% with a $60 minimum co-insurance, then 100%
Specialty Drugs	20% with a $150 maximum	Not Covered**	Not Covered**
RETAIL (UP TO 100-DAY SUPPLY)*** **Only available at a WellSpan Pharmacy. Specialty Drugs are limited to a 30-day fill.** **When a *generic* is available, you will be responsible for any amount over the *generic* drug cost, even if the prescription states "dispense as written" or "brand medically necessary."**			
Generic Drugs	$20 co-payment, then 100%	Not Covered	Not Covered
Brand-Name Formulary Drugs	$70 co-payment, then 100%	Not Covered	Not Covered
Brand-Name Non-Formulary Drugs	$120 co-payment, then 100%	Not covered	Not Covered

TYPE OF EXPENSE	ENHANCED TIER NETWORK BENEFITS WellSpan Health Pharmacy	CORE TIER NETWORK BENEFITS Prescription Benefit Manager	OUT-OF-NETWORK
WELLSPAN PHARMACY MAIL ORDER (UP TO 100-DAY SUPPLY)* Maintenance drugs are required to be filled through WellSpan Pharmacies*** When a *generic* is available, you will be responsible for any amount over the *generic* drug cost, even if the prescription states "dispense as written" or "brand medically necessary."			
Generic Drugs	$20 co-payment, then 100%	Not Covered	Not Covered
Brand-Name Formulary Drugs	$70 co-payment, then 100%	Not Covered	Not Covered
Brand-Name Non-Formulary Drugs	$120 co-payment, then 100%	Not Covered	Not Covered
PREVENTATIVE DRUGS* Subject to Change based on Regulatory updates* Requires a *Physician's* prescription (Limited to 34-day supply) Certain medications are required to be covered with a zero co-payment. The Plan follows the Centers for Disease Control and Prevention (CDC)			
Pediatric Fluoride	$0 co-payment	$0 co-payment	50% with a $50 minimum co-insurance, then 100%
Tamoxifen and Raloxifene* Breast cancer preventive medication	$0 co-payment	$0 co-payment	50% with a $50 minimum co-insurance, then 100%
Generic Tobacco Cessation Drugs and Aids* *Brand-name formulary* or *brand name non-formulary* if a *generic* does not exist or the *generic* would be medically inadvisable according to the prescribing *physician*	$0 co-payment	$0 co-payment	50% with a $50 minimum co-insurance, then 100%
Contraceptives Drugs and Devices*	$0 co-payment Generic Only (Follow above schedule for anything other than generic.)	$0 co-payment Generic Only (Follow above schedule for anything other than generic.)	50% with a $50 minimum co-insurance, then 100%
Preventative Immunizations for Adults and Children	$0 co-payment	$0 co-payment	50% with a $50 minimum co-insurance, then 100%

*Capital Rx cannot process some drugs, devices, or aids - or cannot process it with a $0 co- payment. In those cases, a *claim* for an item or a *claim* for the *Plan's* Prescription Drug Plan co-payment/coinsurance must be submitted to the Medical Plan along with a *physician* prescription. See the section Covered Prescription Drugs for more information about this *Plan* benefit.

**If WellSpan Pharmacy cannot provide the needed specialty medication, they will assist you with transitioning the medication to another specialty pharmacy.

***The Plan will allow two (2) refills of up to 34 days at any pharmacy in order to assist in transitioning to WellSpan Pharmacies.**

Behavioral Health Schedule of Benefits – APPENDIX 3

	WellSpan Provider Network	Quest Network	OUT-OF-NETWORK
BEHAVIORAL HEALTH DEDUCTIBLE, PER CALENDAR YEAR:			
Per Covered Person	$300	$450	$900
Deductibles do not accumulate across tiers.			
OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR:			
Per Covered Person	$2,750		$10,250
Per Family Unit	$4,750		$20,250
Out-of-pockets accumulate across the WellSpan Network and Quest Network Tiers only. ***Pre-certification* penalties, non-*covered services*, amounts over the *Plan Allowance*, etc. do not count toward the out-of-pocket maximum.** **Maximum includes Medical and Behavioral Health deductibles, co-insurance, and co-payments.**			
BEHAVIORAL HEALTH BENEFITS			
Autism Spectrum Disorder. **Services may require ***pre-certification.***	$10 co-payment per day, then 100% with no deductible	$25 co-payment per day, then 100% with no deductible	50% after the deductible, subject to the ***Plan Allowance***
Biofeedback. A therapeutic modality performed by a licensed provider that uses a special machine to help clients become more aware of certain biological functions (e.g., muscle tension, temperature, etc.)	95% after the deductible	80% after the deductible	50% after the deductible, subject to the ***Plan Allowance***
Electroconvulsive Therapy. Benefits include treatment that electrically induces seizures for the treatment of certain behavioral health disorders that have not responded well to medications and psychotherapy. ****Services may require ***pre-certification.***	95% after the deductible	80% after the deductible	50% after the deductible, subject to the ***Plan Allowance***

TYPE OF EXPENSE	WellSpan Provider Network	Quest Network	OUT-OF-NETWORK
Emergency/Crisis Evaluation. Benefits for *emergency* treatment related to a behavioral health disorder are covered.	$200 co-payment, then 100% with no deductible	$200 co-payment, then 100% with no deductible	ER: You pay $200 with no deductible/Plan pays 100% Non-Emergency: After deductible Plan pays 50%/You pay 50%
	The co-payment is *waived* if admitted as an inpatient or observation level of care. **Should a prudent layperson, who possesses an average knowledge of health and medicine, believe a serious medical condition exists; the emergency department visit is justified.**		
Inpatient. The benefits cover inpatient stays for the treatment of mental health or chemical dependency in a hospital or appropriate facility that includes 24-hour care. **Services may require ***pre-certification.***	95% after the deductible	$200 per-admission copayment, then 80% after the deductible	$250 per-admission co-payment, then 70% after the deductible, subject to the ***Plan Allowance***
	Emergency inpatient services (through an ED) from an out-of-network provider or facility are treated at the WellSpan Provider Network (Tier 1) level.		
Intensive Outpatient (IOP). This program can be a step-down treatment from a higher or more restrictive level of care or can be an appropriate level of care to provide intensive intervention. **Services may require ***pre-certification.***	95% after the deductible	$200 per-admission copayment, then 80% after the deductible	$250 per-admission co-payment, then 70% after the deductible, subject to the ***Plan Allowance***
Outpatient. Your coverage includes benefits for behavioral health *outpatient* visits from an eligible behavioral health *provider*. Telehealth visits via a HIPAA compliant audio video platform, or telephonic when clinically appropriate and video is not possible, may also be covered by the Plan when such visits meet the definition of ***medical necessity***.	$10 co-payment, then 100% with no deductible	$25 co-payment, then 100% with no deductible	50% after the deductible, subject to the ***Plan Allowance***
Outpatient Psychological Testing. Psychological testing is a covered charge when needed to aid in the evaluation of an individual with emotional, psychiatric, or personality disorders. (Excludes educational, vocational, and learning disability testing). **Services may require ***pre-certification.***	95% after the deductible	80% after the deductible	50% after the deductible, subject to the ***Plan Allowance***

TYPE OF EXPENSE	WellSpan Provider Network	Quest Network	OUT-OF-NETWORK
Partial Hospitalization (PHP). Partial hospitalization is designed to increase or sustain the highest level of functioning and promote movement to the least restrictive level of care. **Services may require ***pre-certification.***	95% after the deductible	$200 per-admission copayment, then 80% after the deductible	$250 per-admission co-payment, then 70% after the deductible, subject to the ***Plan Allowance***
Professional Services (*Inpatient*). *Physician* services while in observation or during an *inpatient* admission.	95% after the deductible	80% after the deductible	50% after the deductible, subject to the ***Plan Allowance***
Residential Treatment. A structured sub-acute facility-based program and stable living environment that delivers 24-hour/7-day assessment, diagnostic services, and active behavioral health treatment. **Services may require ***pre-certification.***	95% after the deductible	80% after the deductible	50% after the deductible, subject to the ***Plan Allowance***
	Maximum of 120 days per ***calendar year***		
Transcranial Magnetic Stimulation (TMS). A noninvasive technique to apply brief magnetic pulses to the brain. **Services may require ***pre-certification.***	95% after the deductible	80% after the deductible	50% after the deductible, subject to the ***Plan Allowance***
Medication Management (post-administration)	$30 copayment (no deductible)	$40 copayment (no deductible)	50% after the deductible, subject to the ***Plan Allowance***

About the WellSpan Medical Plan Option

WellSpan is a comprehensive Medical Plan Option (the "Plan") that provides you and your family with the flexibility to use healthcare providers from multiple networks. The benefit level you receive for each service will depend on which network your provider participates in. Or – you may receive care from providers that do not participate in a network.

- Enhanced Tier - WellSpan Provider Network. Includes WellSpan providers and facilities as well as other select providers.
- Core Tier - Capital Blue Cross** (CBC) Network. Includes a nationwide network of providers and facilities.
- Out-of-Network - Includes those providers and facilities who do not participate in the Enhanced or Core networks.

Capital Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

Before most benefits are paid, you and your family are responsible for an individual deductible. Amounts applied to the Enhanced Tier or Core Tier deductible are not credited under the Out-of-Network deductible; each Tier deductible must be met separately.

The WellSpan Medical Plan Option also includes an out-of-pocket maximum under Enhanced, Core, and Out-of-Network Tiers. This means the amount you pay out of pocket is limited. Once the out-of-pocket has been reached, the Plan will pay 100% of allowable charges for the remainder of the calendar year. There is a family out-of-pocket under Enhanced and Core Tiers. Amounts can be contributed by any number of family members – however, one family member may not add more than the individual out-of-pocket toward the family limit. There is no family out-of-pocket maximum under Out-of-Network. Your out-of-pocket amounts accumulate together across the Enhanced and Core Tiers only.

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It is important to understand that a network provider may not be available for each type of service or in each benefit Tier. WellSpan Provider Network providers may need to use Core Tier or Out-of-Network providers for some services. Benefit levels will be determined by the network in which your provider participates. Visit the WellSpan Population Health Services website www.wellspanpophealth.com to search for a network provider or contact WellSpan Population Health Services at (800) 842-1768 or (717) 851-6800 for assistance.

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The WellSpan Medical Plan

Most employees of WellSpan Health are eligible to receive health care coverage as part of their compensation package. The plan option that you, as an employee, and your dependents choose may depend on where you work, your employment status, which medical providers you see – or the type of coverage that works best for you and your family. While WellSpan Health offers different options for coverage, they both fall under one group health plan umbrella, known as the WellSpan Medical Plan (the "Plan").

During your service as a WellSpan employee, you may have the option to switch your plan option from year to year to accommodate changes in your employment, your family or where you live. Both plan options have different benefits, such as deductibles, coinsurance, but both include mental health and substance use disorder, and prescription drug benefits.

The WellSpan Health Plan Option will comply, always, in good faith, with federal regulations including the Patient Protection and Affordable Care Act (the Affordable Care Act "ACA"). If modifications are issued with respect to the federal regulations or the ACA, the Plan will incorporate these changes, effective as soon as practical after it occurs.

About this Plan Document and Summary Plan Description

This Guide to your Medical Benefits is meant to be informative and easy to understand. It provides you with information about how your medical, behavioral health and prescription drug benefits work so you can use them most effectively. This guide functions as the Plan Document and Summary Plan Description – or "SPD". By law, SPDs are required for certain benefits. As a covered person under the Plan, you are entitled to certain rights under the Employee Retirement Income Security Act (ERISA) of 1974 as amended, as described in the "Administrative Information" section of this guide.

WellSpan Health reserves the right to change, amend, or terminate any or all the Plan options within the WellSpan Medical Plan at any time. This Plan Document/Summary Plan Description is not a contract of employment and participation in any of the Plan options does not guarantee employment.

This "Introduction to Your Medical Benefits" section of your guide provides general information about the Plan. The next section – "Participating in the Medical Plan Option" – provides important information on how to participate in the Plan, including information on eligibility and coverage. Next, you'll find a section which describes the specific benefits and coverage levels provided under the WellSpan option. The following sections, "Prescription Drug Benefits" and "Mental Health and Substance Use Disorder Benefits" describe those benefits. In the next section, "Administrative Information", you will find important information about all the WellSpan Medical Plan benefits. The last section, "Terms You Should Know", includes definitions to important terms found in this guide and which appear throughout this guide.

Please take a few moments to read through this guide and become familiar with your coverage. You should review your options carefully and choose the medical plan option that's best for you and your family.

Important Information

Reading this SPD is a good way to understand your benefits. Understanding your benefits helps you and your family to make good decisions regarding your health care and out-of-pocket costs. Throughout this SPD, information that is especially important will be show outlined in Red Asterisks.

If you need TTY Assistance or special assistance, including accommodations for members with disabilities or limited English proficiency, please call the Interpreter line at 800-643-2255; or TDD/TTY at 800-654-5984 to receive assistance free of charge.

Important Phone Numbers and Web Sites

- **WellSpan Benefits**
  www.wellspanbenefits.org
- **WellSpan Population Health Services**
  (800) 842-1768 or (717) 851-6800
  www.wellspanpophealth.com
  email: pophealthbenefits@wellspan.org
- **Quest Behavioral Health Services**
  (800)364-6352
  www.questbh.com
  email: membership@questbh.com
- **WellSpan Health("My WellSpan Benefits")**
  https://hr.wellspan.org
- **Capital RX (Prescription Benefits Manager)**
  (844)306-5008
  https://www.cap-rx.com
- **Interpreter line**
  (800) 643-2255
- **TDD/TTY**
  (800) 654-5984

Your Eligibility

You become eligible to enroll for coverage as follows:

- Full-time regular employees – coverage begins the first day of the month following the first day of active service, provided you make your required contribution. Otherwise, coverage becomes effective on the first day of the second month following the first day of active service.

- Part-time employees, PRN employees, and per diem employees – coverage begins the first day of the month following the first day of active services provided you make the required contribution. Otherwise, coverage becomes effective on the first day of the second month following the first day of active service.

For information on how to enroll, see the heading "Enrolling for Coverage".

Your Dependents' Eligibility

You may cover yourself, yourself, and your spouse, yourself, and your child(ren) or you and your entire family. These family members are called dependents. Your eligible dependents include:

- Your spouse.
- The following children of yours:
  - Newborn children.
  - Stepchildren.
  - Children legally placed for adoption.
  - Legally adopted children
  - Children for whom the employee or the employee's spouse is the child's legal guardian
  - Children awarded coverage pursuant to an order of court.

  The spouse of your dependent child, or the children of your dependent child, are not eligible to be covered under this Plan.
- Coverage ends:
  - On the last day of the month in which they reach age 26; or
  - Up to any age if physically or mentally disabled before age 26. They must be:
    - Incapable of self-sustaining employment because of mental or physical disability, which can be expected to be of long-term or indefinite duration; and
    - Age 26 and older, must be claimed as a "dependent" for federal tax purposes by the employee, or spouse.

Both tests must be met to continue your child's eligibility under the Plan. If they child is, at any point, no longer disabled after their 26th birthday, they will thereafter be ineligible as a covered dependent even if a subsequent disability is a recurrence of a prior condition. The Plan Administrator may require initial and subsequent proof of the child's disability and dependency (but not more than once per year).

An eligible child may be your natural child, legally adopted child, stepchild, child who is the subject of a court order directed to you, or a child for whom you are the legal guardian (until age 26 or guardianship ends). In addition, any child named in a "qualified medical child support order" will be covered under the Plan.

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A newborn child will be covered under the Plan for the first 31 days following birth. If you wish to continue your baby's coverage after 31 days, you will need to enroll your child during this 31-day period. For more information on how to enroll your dependents, see the heading "Enrolling for Coverage".

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At any time, the Plan may require proof that a spouse, or dependent child qualifies or continues to qualify as a dependent as defined by the Plan.

Enrolling for Coverage

You will need to enroll for your medical coverage. When you are first hired or when you experience a qualified life event, such as becoming eligible for benefits due to a job status change, you should process the appropriate life event using Oracle. You should complete this process within 31-days of your employment start date or qualified life event. Once enrolled, you may only change your level of coverage and/or change your medical option as explained above.

You may choose from the following coverage levels:

- You only
- You and your spouse
- You and your child(ren); or
- You and your family.

Open Enrollment Period

You can change your coverage selections during the open enrollment period. Your changes will take effect the following January 1st. Human Resources will notify you of the open enrollment period.

Qualified Medical Child Support Order (QMCSO)

A qualified medical support order (QMCSO) means any judgement, decree, or order (including approval or settlement agreement) issued by a court of competent jurisdiction or issued through an administrative process established under state law and which has the force and effect of law under applicable state law.

A QMCSO is a court order that creates or recognizes the right of a child (called an "alternate recipient" in the law) to receive health care benefits under your Plan. To be considered a QMCSO, the qualified medical child support order must clearly specify the following information:

- Your last known mailing address and the name and address of each child covered by the order.
- A description of the type of coverage to be provided by the Plan for each child, or the
- manner in which the type of coverage is to be determined.
- The period to which the order applies; and
- Each benefit plan to which the order applies.

The Plan Administrator is responsible for establishing reasonable, written procedures for determining if the court order is a QMCSO. You may request, free of charge, copies of these written procedures. The Plan Administrator must notify you and the child that a court order has been received and within a reasonable time inform you and the child whether or not the court order is a QMCSO. If the court order is determined to be a QMCSO, the child is an "alternate recipient" and is considered to be covered by the Plan. Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the child, the child's custodial parent, or another designated representative – or if the benefits are assigned, to the provider of care.

The court order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan. If a state has paid for medical services for the child under Medicaid for which the Plan was liable, the state may seek to recover those amounts paid from the Plan.

Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with certain special enrollment rights pertaining to your health care coverage. If you decline enrollment for yourself or your dependents (including your spouse) because of other health coverage (such as coverage through another employer), you may in the future be able to enroll yourself, your spouse, or your child(ren) in the WellSpan Health-sponsored coverage, provided that you request enrollment within 31 days after the other coverage ends. You must request this enrollment in writing.

In the case of a birth, marriage, adoption, or placement for adoption, there may be a right to enroll in the Plan. These requests must also be made within 31 days after the birth, marriage, adoption, or placement for adoption. You must provide documentation of the event.

If you or your dependents are entitled to a special enrollment, you are allowed to enroll in all available benefit options and to switch to another option if your spouse or child(ren) have special enrollment rights.

Special Enrollment Periods

If you or your dependents (spouse or child) are eligible, but not enrolled in this Plan, you may be able to enroll if you experience a loss of eligibility for other coverage due to the following reasons:

- You or your dependents were covered under another group health plan, or had health coverage at the time coverage under this Plan was previously offered (either initially or during an open enrollment period); and
- If required by the WellSpan Medical Plan, you stated in writing at the time that this coverage was offered that the other health coverage was the reason for declining enrollment; and/or
- You or your dependents lose eligibility for Medicaid or State Children's Health Insurance Program (CHIP) or obtained eligibility for a state premium assistance subsidy under these two programs.
- You or your dependents, who lost coverage, were under COBRA continuation coverage and the COBRA coverage was exhausted, or you or your dependent had non-COBRA coverage and either the coverage was terminated as a result of loss or eligibility or because employer contributions towards the coverage were terminated; and
- You or your dependents requested enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA or the termination of non-COBRA coverage due to a loss of eligibility or termination of employer contributions. Coverage will begin on the first day of the month beginning after the date of the completed request for enrollment is received (and you make your required contribution).

For special enrollment purposes, a loss of eligibility occurs if:

- You or your dependents had a loss of eligibility due to the other plan no longer offering benefits to a class of similarly situated individuals (for example, part-time employees)
- You or your dependents had a loss of eligibility for Medicaid or a State Children's Health Insurance Program (CHIP) or obtained eligibility for a state premium assistance subsidy under these two programs (contact your state's Medicaid or CHIP office to see if premium assistance is available). You or your dependents have 50 days to request enrollment after the loss of Medicaid or CHIP coverage. This request for enrollment must be in writing
- You or your dependents had a loss of eligibility when individual coverage is through an HMO, or other arrangement, that does not provide benefits to persons who no longer reside, live, or work in the plan's service area (regardless, if this is your or your dependents' choice) and no other benefit package is available; or
- You or your dependents had a loss of eligibility when group coverage is through an HMO, or other arrangement, that does not provide benefits to persons who no longer reside, live, or work in the plan's service area (regardless, if this is your or your dependents' choice) and no other benefit package is available.

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There is no special enrollment right if you, your child(ren), or spouse lost the other coverage because required COBRA premiums or plan contributions were not made.

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Your dependents may have a special enrollment right if:

- ❖ You are a participant under this Plan (or have met the waiting period and are eligible to be enrolled under the Plan). If you failed to enroll during a previous enrollment period, this special enrollment right may not apply; or
- ❖ A person becomes your dependent through marriage, birth, adoption, or placement for adoption.

Your spouse or dependent child may then be enrolled under this Plan. In the case of birth or adoption of a child, your spouse may be enrolled if the spouse is otherwise eligible for coverage. If you are not enrolled at the time of the event, you must enroll under this special enrollment period in order for your dependents to enroll.

Change in the Family Status

In addition to making changes during the open enrollment or special enrollment periods, you (or your covered dependents) can also change your benefit elections after a qualified status change. Status changes include:

- ❖ Your marriage, divorce, legal separation (where recognized), or annulment
- ❖ The birth, adoption, placement for adoption, or appointment of legal guardianship of your child
- ❖ Your death
- ❖ The death of your spouse or dependent child
- ❖ Your spouse or dependent child losing or gaining other coverage
- ❖ A change in your (or your dependent's) employment status due to a switch between full-time and part-time or an unpaid leave of absence
- ❖ A significant change in cost or coverage under a health plan
- ❖ An open enrollment for your spouse's benefit plans (all benefit changes you make must be consistent with the offerings in your spouse's plans)
- ❖ A mid-year plan offering through your spouse's employer (all benefit changes you make must be consistent with the offerings in your spouse's plans)
- ❖ A change in your dependent's eligibility (for example, due to being over the age limit)
- ❖ A change in your (or your dependent's) place of residence or worksite
- ❖ Your requirement to coverage your dependent according to a qualified medical support order or change in legal custody (this does not include coverage you may be required to provide for your divorced spouse – COBRA coverage may be available in that circumstance – or coverage of a dependent unless it is through a qualified medical support order)
- ❖ Your (or your dependent's) eligibility for COBRA
- ❖ Your (or your dependent's) eligibility for Medicare or Medicaid (you may change the current election for the eligible person only); or
- ❖ Any other event that qualifies as a life status change under the Internal Revenue Code (with the approval of the Plan Administrator)

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You will need to change your elections within 31 days of your change in status. You must also provide documentation of the change in status when you request a change in your coverage.

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Any changes you make in your coverage must be consistent with your status change. If you don't change your coverage within 31 days, you will have to wait until next open enrollment period to make new elections.

When Coverage Begins

The date your coverage begins depends on when you become eligible and enroll, as explained in the chart below.

If this is your situation:	You and/or your dependents' coverage will begin:
You are a new full-time, part-time, PRN, or diem employee and you enroll within 31 days of your employment date.	On the first day of the month following your first day of work,
You enroll during open enrollment	On the following January 1st.
Your coverage changes due to a change in family status, employment status or special enrollment right.	On the first day of the month after your qualified life event. Coverage for dependents acquired through birth, adoption or placement for adoption begins on the date of birth, adoption or placement for adoption and continues for 31 days. You will need to notify Human Resources during this time if you want to continue coverage.

About Cost

You and WellSpan Health share the cost of your group health coverage. Your share of the cost is paid with pre-tax dollars. By using pre-tax dollars, your contributions are deducted from your pay before federal, state, and local taxes are calculated, so you pay less in taxes. This pre-tax feature is not available for certain PRN, part-time or per diem positions. You will receive cost information when you are first hired and at each open enrollment period. Or you may contact Human Resources for specific cost information.

Situations Affecting your Medical Coverage

Employees on Military Leave

Employees going into or returning from military services will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). The maximum period of

coverage of the employee and their covered dependents under such an election will be the lesser of:

- The 24-month period beginning on the date on which the employee's absence begins; or
- The day after the date on which the employee fails to apply for a return to a position of employment, as determined by USERRA.

An employee who elects to continue coverage under this section will be subject to the WellSpan Health Leave of Absence Policy.

An employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Plan upon re-employment. Upon re-employment and reinstatement of coverage no new exclusions or waiting period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. These rights apply only to employees and their covered spouse or dependents covered under the Plan before leaving for military services.

If You Are on a Leave of Absence

If you are on a WellSpan Health - approved leave of absence – such as a family or medical leave – you may continue your medical coverage by paying your share of the cost, as defined in the WellSpan Health Leave of Absence Policy. If you do not return to work after your approved leave of absence is over, you may be able to continue medical coverage for yourself and your covered dependents through a federal law called COBRA. See the heading "Continuation of Coverage Under COBRA" later in this section for specific information. Remember, there are time limits within which you must contact the Plan when certain COBRA qualifying events occur. When you and/or a dependent changes enrollment status, such as:

- Changing status from a dependent to an employee,
- Changing status from an employee to a dependent, or
- Being rehired by WellSpan Health

The Plan will be guided by the following rules:

- When coverage is continued (including COBRA coverage) after an enrollment status event and coverage has been continuous, credit will be given for applicable deductibles and amounts applied to benefit maximums.
- When coverage is resumed, and less than 6 months have passed since coverage terminated under the Plan, credit will be given for applicable deductibles and amounts applied to benefit maximums.
- When coverage under the Plan is resumed after a period of 6 months, it will be treated as "new

coverage." This means that you or our dependents will be required to satisfy all eligibility and enrollment requirements and no credit will be given for deductibles or amounts applied to benefit maximums.

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If you or your dependent lose eligibility or waive coverage under this Plan, while you continue to be an active employee, then later regain eligibility or elect coverage, re-enrollment will not be considered an enrollment status even subject to the Plan rules explained above. In these cases, credit will be given for applicable deductibles and amounts applied to benefit maximums, regardless of the time between enrollment periods.

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If You Become Disabled

If you become disabled, your medical coverage will continue as defined in the WellSpan Health Leave of Absence Policy. You may be responsible for paying a portion or the entire cost of the coverage. Contact the Human Resources Department for details. If you do not return to work, you may be able to continue medical coverage for yourself and your covered spouse or dependent child(ren) through a federal law called COBRA. See the heading "Continuation of Coverage Under COBRA" later in this section for specific information. Remember, there are time limits within which you must contact the Plan when certain COBRA qualifying events occur.

If You Die

If you die while an active employee, your covered dependents may continue medical coverage through a federal law called COBRA. See the heading "Continuation of Coverage under COBRA" later in this section for specific information.

When Coverage Ends

When Your Coverage Ends

Your medical coverage ends on the earliest of the following events:

- The day the Plan is terminated
- The last day of the month in which your active employment ends
- The last day of the month in which you are no longer eligible for coverage under the
- Plan. The last day of the month of an approved leave, if you do not return to work at the end of the leave; or

- The last day of the month in which your last contribution for coverage is received.

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Under certain circumstances, you may continue your medical coverage. See "Situations Affecting Your Health Care Coverage" earlier in this section for additional information.

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When Your Dependents' Coverage Ends

Your covered dependents' coverage will end on the earliest of the following events:

- The day the Plan is terminated
- The day dependent coverage is terminated under the
- Plan The day your coverage ends
- The last day of the month in which you die while an active employee
- The last day of the month in which they are no longer eligible for coverage as a dependent, or
- The last day of the month in which the last contribution for coverage is received.

If Your Employment Ends

If your employment with WellSpan Health ends, you may be able to continue the coverage outlined in this guide, for yourself, spouse, or dependent child(ren) through a federal law called COBRA. See the heading "Continuation of Coverage Under COBRA" later in this section for specific information.

Coordination of Benefits (C.O.B.)

If you or your covered dependents have additional medical coverage through another health care plan – such as another employer's medical plan or Medicare – your benefits through that plan will be coordinated with your WellSpan Medical Plan. Be sure to indicate if you have additional coverage when you enroll and when you file any claim forms.

All claims are subject to Coordination of Benefits other than WellSpan online urgent care. WellSpan online urgent care is only covered under the WellSpan Plus Plan option.

How Coordination of Benefits Works

This Plan will always pay either its regular benefits or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed the amount that this Plan would have paid in the absence of the other coverage. Be sure to indicate if you have additional coverage when you enroll or when you file any claim forms.

If this Plan is primary, it will provide the scheduled amount of benefits. If this Plan is secondary, it will pay the difference between the amount your other plan paid and the charge for the covered service – up to the amount this Plan would have paid if it were primary. In no case will this Plan pay more than its scheduled amount of benefits.

Reimbursement is limited to the "allowable expenses" under this Plan. This means those charges which the Plan normally considers eligible for benefits for you or your dependents, and not expenses this Plan excludes, even if the primary carrier considers it to be an eligible expense under that plan.

When this Plan is secondary, allowable expenses will not include any amount that is not payable by the primary plan as a result of a contract between the primary plan and a medical provider when that provider agrees to accept a reduced payment and not bill the patient. Additionally, allowable expenses do not include charges for services provided to an HMO participant by a medical provider that is not a member of that HMO, unless the patient was authorized by the HMO to receive treatment outside of the HMO. Lastly, allowable expenses will not include charges refused by another plan as a penalty assessed because of non-compliance with the plan's rules.

See this example of how C.O.B. is calculated under the Plan when we are secondary:

Primary plan allowed:	$131.00
Primary plan paid:	$111.00
Primary plan co-payment (patient responsibility)	$20.00
IF we had been primary, we would have paid:	$118.00
Since we are secondary, we would pay:	$ 7.00 (the difference between $118.00 and what the primary paid of $111.00)
Patient responsibility:	$13.00

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If you submit a secondary claim for benefits and no benefits are paid, any visit or quantity limitations will be applied.

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Benefit Determination Order

The rules establishing the order of benefits determination are as follows. If your situation is not explained below, contact WellSpan Population Health Services for more information.

- A plan that does not contain a coordination of benefits provision or similar provision will be primary before benefits under this Plan.
- The benefits of a plan which covers an employee as primary will be determined before the benefits of the plan that covers the person as a spouse (or secondarily). For example, when both plans have a C.O.B. provision, this is how the primary plan is determined.

If you are:	And the second plan is provided by the:	And expenses are for the :	Then the WellSpan Medical Plan is:
Spouse	WellSpan Health Employee	Spouse	Secondary

- The benefits of a plan which covers an employee will be determined before the benefits of the plan that covers the person as a dependent child (or secondarily).

For example, when both plans have a C.O.B. provision, this is how the primary plan is determined for an employee and spouse.

If you are:	And the second plan is provided by the:	And expenses are for the:	Then the WellSpan Medical Plan is:
Adult Dependent Child	Adult Dependent Child's Employer	Adult Dependent Child	Secondary

- ❖ The benefits of a plan which covers a spouse will be determined before the benefits of the plan that covers the person as a dependent child (or secondarily). For example, when both plans have a C.O.B. provision, this is how the primary plan is determined.

If you are:	And the second plan is provided by the:	And expenses are for the:	Then the WellSpan Medical Plan is:
Adult Dependent Child	Adult Dependent Child's Spouse	Adult Dependent Child	Secondary

- ❖ For dependent children whose parents are married or living together (whether or not they have ever been married) the following benefit determination order will be used:

  - The plan benefits of the parent whose birthday falls earlier in the calendar year (only month and date) will be primary.
  - If both parents have the same birthday, the plan that covered the parent longer will be primary.
  - If the other plan determines the order of benefits based on the gender of the parent, instead of using the parent's birthdays, this Plan will also use the gender rule to determine which plan is primary.

- ❖ For dependent children whose parents are separated or divorced or are not living together (whether or not they have ever been married) the following benefit determination order will be used:

  - If a court decree exists stating that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the same benefit determination rules will apply as those for parents who are married or living together.
  - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan.
  - If there is no court decree stating which parent has responsibility for the dependent child's

health care expenses or health care coverage, the order of benefits are as follows:

- The plan covering the custodial parent OR The plan covering the biological parent/legal guardian whose birthday falls earlier in the calendar year (only month and date)
- The plan covering the custodial parent's spouse OR The plan covering the spouse of the biological parent/legal guardian whose birthday falls earlier in the calendar year (only month and date)
- The plan covering the non-custodial parent OR The plan covering the other biological parent/legal guardian; and then
- The plan covering the non-custodial parent's spouse OR The plan covering the spouse of the other biological parent/legal guardian.

❖ For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined, as applicable, as if those individuals were parents of the child.

- The plan that covers a person as an active employee (who is neither laid off nor retired or as a dependent of an active employee) is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- If a person whose coverage is provided through COBRA continuation coverage or under a right of continuation due to state or federal law is covered under another plan, the plan covering the person as an employee, subscriber, or retiree or covering the person as a dependent of an employee, subscriber, or retiree is the primary plan and the plan covering the person under the continuation coverage is the secondary plan.
- If a plan contains order of benefit determination rules that declares that plan to be excess or always secondary to all other plans, this Plan will coordinate benefits as follows:
  - If this Plan determines itself to be primary based on its C.O.B. rules, it will provide benefits on a primary basis.
  - If this Plan determines itself to be secondary based on its C.O.B. rules, it will provide benefits first, but the amount of benefits payable will be determined as if this Plan were the secondary plan.
  - When a primary plan that is designed to provide a secondary level of benefits when this Plan is secondary, this Plan will determine its secondary liability as if the primary plan has provided a primary level of benefits. This Plan will calculate its secondary liability by reducing benefits by the amount it would have paid had it been primary.
- If the person has Medicare due to age or disability, this Plan will pay primary, secondary, or last to the extent stated in Federal Law.

- If you have elected Medicare Part D, the WellSpan Plan is primary. If it is determined that you utilized your Part D plan and Medicare demands repayment, you will be responsible to reimburse the Plan.

Automobile Benefits

The WellSpan Medical Plan is not to be elected as a primary coverage in lieu of automobile benefits. This Plan will always be considered the secondary carrier regardless of the individual's election under the automobile policy.

Right to Receive or Release Necessary Information

To administer C.O.B., this plan may give or obtain information from another carrier, insurer, or from any other organization or person to the extent permitted by law. In many situations, this

information may be given or obtained without the consent or notice to any person. You and/or your dependents are required to give this Plan the information it asks for about any other plans and their payments.

Right of Recovery

If this Plan pays benefits that should be paid by another benefit plan, this Plan may recover the amount paid from the other benefit plan or from you.

If this Plan pays benefits that are later found to be greater than the allowable expense, this Plan may recover the amount of the overpayment from the provider or covered person that it was paid.

When the Plan May Recover Payment (Subrogation)

WHEN THIS PROVISION APPLIES: If you, your spouse, one of your dependents, or anyone who receives benefits under this Plan becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan which total in excess of $5,000 are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to

reimburse the Plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. An employee or covered person may choose any attorney; however, that attorney must agree not to assert the Common Funds or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial, or other sufficiency. If the injury person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The employee or covered person agrees to sign any documents requested by the Plan including but not limited to, reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Accident-related claims will be denied until the original subrogation questionnaire and

agreement is executed and returned to the Plan. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the employee or covered person and their attorney, if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by the employee or covered person and not the Plan.

The employee or covered person agrees to take no action that in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan administrator has sole discretion to interpret the terms of this provision in its entirely and reserves the right to make changes, as it deems necessary.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

Continuation of Coverage Under COBRA

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WellSpan Population Health Services administers COBRA continuation coverage for WellSpan Health. Questions about COBRA continuation coverage and payments for COBRA coverage can be directed to the COBRA Department at P.O. Box 2347, York, PA 17405 or by calling (717) 851-6862 or toll-free at (800) 842-1768

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The Cobra Continuation Coverage Option

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their families the opportunity to temporarily extend their health coverage (continuation coverage) at group rates in certain instances (COBRA qualifying events) when coverage under the Plan would otherwise end. This notice summarizes your rights and obligations under the continuation of coverage provision of the law. Both you and your spouse should take the time to read this notice carefully.

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The Plan Administrator is WellSpan Health. The Plan Administrator is responsible for COBRA continuation coverage management and can be contacted at the WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402 or

(717) 851-5959.

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COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you or your dependents choose continuation coverage, WellSpan Health will provide you with the same coverage provided to active employees and their family members under its Plan. This means that if the coverage for active employees and their family members is modified, your continuation coverage will also be modified. You may only continue coverage in plan options you had when COBRA rights began, not add

coverage in other plan options. If no coverage existed immediately prior to the qualifying events listed below, no COBRA continuation coverage is available.

For example, if you had medical and dental coverage while an active employee, when you have a qualifying event for COBRA, you may only choose to continue medical, dental or both types of coverage, but not add coverage – such as vision. You may be able to change coverage under COBRA under certain circumstances, such as when you experience a family status change or during open enrollment.

COBRA Qualifying Events

If you are an employee and covered by the WellSpan Medical Plan, you will become a qualified beneficiary if you lose your medical coverage because of either one of the following qualifying events occur:

- Termination of your employment for any reason other than for your gross misconduct; or
- Reduction of your hours of employment

A spouse will become a qualified beneficiary if you lose your medical coverage because any of the following qualifying events occur:

- You die
- Your hours of employment are reduced
- Your employment ends for any reason other than for their gross misconduct; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose medical coverage because any of the following qualifying events occur:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee's employment ends for any reason other than for their gross misconduct; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Your Employer's Responsibility Under COBRA

The WellSpan Medical Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the plan Administrator of the qualifying event within 30 days of any of these events:

- The end of employment or reduction of hours of employment
- Death of the employee, or
- Commencement of a proceeding in bankruptcy with respect to the employer, or
- Entitlement (which means enrollment) of the employee to Medicare (Part A, Part B, or both).

Your Responsibility Under COBRA

You must notify the Plan Administrator of these other qualifying events:

- Divorce or legal separation (where recognized) of the employee or spouse; or
- A dependent child's losing eligibility for coverage as a dependent child.

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You are required to notify the Plan Administrator within 60 days after the qualifying event occurs. Notice must be given to the Employee Benefits, Human Resources Department. Notice may be provided by e-mail, letter (certified mail, return receipt requested) or in person at the WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402.

If you fail to provide the notice within the 60-day period, the spouse or child's coverage will cease at the end of the month in which the divorce, legal separation (where recognized), or the child's loss of eligibility status occurs, and coverage cannot be continued under COBRA.

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When coverage is lost due to the reasons set forth below, you must provide documentation as shown beside each reason:

- Death of an employee – death certificate; or
- Legal separation (where recognized) or divorce – copy of legal separation papers or divorce decree.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost.

Newly Acquired Dependents

A qualified beneficiary may elect coverage for a dependent acquired during COBRA continuation coverage. All enrollment requirements that apply to dependents of active employees apply to dependents acquired by qualified beneficiaries during COBRA continuation coverage.

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Notice must be given to the Employee Benefits, Human Resources Department within 31 days or during open enrollment. Notice may be provided by e-mail, letter (certified mail, return receipt requested) or in person at the WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402

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With one exception, newly acquired dependents are not considered to be qualified beneficiaries. Their coverage will end when the qualified beneficiary's coverage ends and will not be extended if the qualified beneficiary experiences a second qualifying event. However, if the former employee adds a newborn child, an adopted child, or has a child placed for adoption while covered under COBRA continuation coverage, that child will be considered a qualified beneficiary.

Adding a newly acquired dependent may cause an increase in the amount you must pay for COBRA continuation coverage.

Length of Continuation Coverage

You and your qualified dependents may elect to continue medical coverage for up to 18 months, if group coverage ends because:

- Your employment is terminated (voluntarily or involuntarily), except if your employment is terminated due to gross misconduct; or
- Your employment hours are reduced.

Your spouse may extend or individually elect medical coverage for up to 36 months if group coverage ends due to:

- Your death; or
- Divorce or legal separation (where recognized); or

Your eligible dependent children may individually elect medical continuation coverage for up to 36 months if they lose their dependent eligibility because:

- ❖ Of your death; or
- ❖ They no longer qualify as dependents under the Plan. See the heading "Your Dependent's Eligibility" for information about eligible dependents.

Medical coverage may be continued under any one of these qualifying events without proof of good health.

Special Rules for Disabled Qualified Beneficiaries

If all of the following conditions are met:

- A qualified beneficiary is disabled (as determined by the Social Security Administration ("SSA") on any day during the first 60 days of COBRA coverage;
- The qualifying event was the covered employee's termination of employment or reduction of hours;
- The qualified beneficiary notifies the plan administrator of his or her disability within 60 days after the latest of (1) the date of the SSA;s determination of disability; (2) the date of the qualifying event; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; and (4) the date on which the qualified beneficiary is informed of the obligation to provide notice of his or her disability to the plan administrator; and
- The qualified beneficiary notifies the plan administrator before the end of the original 18-month maximum coverage period;

You or a family member must notify the Plan Administrator. This notice should be sent to: Employee Benefits, WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402

If you (or a dependent) are receiving Social Security Administration disability benefits, and the Social Security Administration subsequently determines that you are no longer disabled, you must notify the Plan Administrator within 30 days of the Social Security Administration's final determination.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage,

the spouse and dependent children in your family can get additional months of COBRA continuation coverage (as long as they are considered to be qualified beneficiaries), up to a maximum of 36 months. This extension is available to the spouse and dependent children if:

- ❖ You (as the former employee) dies
- ❖ Your divorce or legal separation (where recognized); or
- ❖ Your child ceases to be eligible as a dependent child under the Plan.

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These events can be a second qualifying event only if they would have caused a loss of coverage under the Plan if the first qualifying event had not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Employee Benefits, WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402.

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When the qualifying event is due to the reasons set forth below, you must provide documentation as shown beside each reason:

- ❖ Death of an employee – death certificate; or
- ❖ Legal separation (where recognized) or divorce – copy of legal separation papers or divorce decree.

How to Elect Cobra

When the Plan Administrator receives your timely written notice of a divorce or legal separation (where recognized), or a child's loss of eligibility status, the Plan Administrator will send you information on how to elect COBRA continuation coverage.

The Plan Administrator will automatically send you information on how to elect Cobra continuation coverage if you, your spouse, and/or your children will lose coverage because of:

- ❖ Termination of your employment – except when your employment ends due to gross misconduct
- ❖ Reduction in your hours of employment; or
- ❖ Your death.

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When you receive this information, read it carefully and respond within the time indicated in the notice.

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To elect COBRA, you must complete and return the election form included in the notice you receive, and you must pay the monthly premiums for COBRA continuation covered specified in the notice.

If You Fail to Elect COBRA

If you do not choose COBRA continuation coverage within the time allowed, your group medical coverage will terminate at the end of the month in which the qualifying event occurs.

Cost of Continuation Coverage

Each individual who elects to continue coverage under COBRA must pay the full cost of coverage, plus 2% for administrative expenses. You pay for COBRA continuation coverage in monthly premiums that are due on the first day of each month. Payments not received within 30 days after your premium is due will result in loss of coverage retroactive to the day before your premium was due. Your first payment must be made within 45 days after you elect COBRA continuation coverage and is retroactive to the date you lost coverage.

An administration fee equal to 50% of the full cost of coverage may be charged for COBRA continuation coverage for qualified disabled individuals beginning with the 19th month and continuing until COBRA coverage terminates. That means if you were disabled individual, for the first 18 months of COBRA coverage, you would pay 102% monthly, and for the remaining coverage period, you would pay 150% monthly. This includes a second (different) qualifying event that would allow you up to 36 months of continuation coverage.

However, if a second qualifying event occurs within the original 18-month period of coverage, you cannot be charged more than 102% at any time during the 36-month period.

Loss of Continuation Coverage

There are certain circumstances that will cut short the period during which you, your spouse, and/or children can have coverage continued under COBRA. These circumstances occur when:

- You fail to pay the monthly premium for the coverage within 30 days of its due date (or within 45 days, if it is the first monthly payment)

- ❖ You, your spouse, or child become covered under any other group health plan which does not have exclusions or limitations regarding that person's own pre-existing conditions (if any) after electing COBRA;
- ❖ You, your spouse, or child become entitled to (which means enrollment) Medicare (Part A, Part B, or both) after electing COBRA;
- ❖ WellSpan Health ceases to provide any group health plan to its employees; or
- ❖ You extend coverage for up to 29 months due to your disability, and there has been a determination that you are no longer disabled.

Proof of Insurability Not Required for COBRA

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all the costs for your continuation coverage. You will have a grace period of 30 days in which to pay the premium. The law also says that at the end of the 18-month or 36-month continuation coverage period, you must be allowed to enroll in any individual conversion health plan then provided under the WellSpan Medical Plan for employees, if available. The Plan described in this guide does not have an individual conversation option available.

How COBRA Applies if You Are on FMLA Leave

The Family and Medical Leave Act of 1993 (FMLA) allows you to continue your (and your covered dependents') participation in a WellSpan Health-sponsored benefit plan as long as:

- ❖ Your leave is approved by WellSpan Health
- ❖ You participate in the Plan before you begin your leave; and
- ❖ You make the required contributions for your coverage while on leave.

While you are on FMLA leave, your required contributions will be the same as your contributions as an active employee. Payments are due by the first of the month for that month's coverage. You must send your payment by the due date to the appropriate person/department to continue your benefits during your leave.

If you add a new dependent while you continue your coverage on an approved FMLA leave, your new dependent will be eligible for the coverage under the same terms as for active employees

If you do not return to work after your FMLA leave, you may be required to reimburse WellSpan Health for contributions paid on your behalf during your leave.

Your continued coverage while on FMLA leave will end on the earliest of the following events:

- The date you fail to make the required contribution for your coverage
- The date that WellSpan Health determines your approved FMLA leave is terminated; or
- The date coverage is no longer offered to the group to which you belong.

Your covered dependents' continued coverage will not be continued beyond the date if would otherwise end; see the heading "When Your Dependents' Coverage Ends" for a list of events.

If your coverage under the WellSpan Health-sponsored benefit Plan ends because your approved FMLA leave is terminated, you may be able to continue your coverage under COBRA.

Your continued coverage under COBRA will be available under the same terms as though you had stopped working for WellSpan Health on the date your approved FMLA leave ended.

Questions

If you have questions about your COBRA continuation coverage, you should contact Employee Benefits, WellSpan Health Human Resources Department, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to or receive from the Plan Administrator.

About the WellSpan Medical Plan Option

WellSpan Health is a comprehensive medical plan that offers you three tiers of benefit coverage. You may receive care from providers and facilities in the WellSpan Provider Network, The Capital Blue Cross Network (CBC), or outside the networks. This medical plan option combines important features such as low out-of-pocket costs, high benefit levels, and a wide choice of physicians and hospitals.

You have the flexibility to use providers and facilities in any network at any time. However, the benefit you or your family receives will depend upon which network your provider participates with. When you use a network provider, that provider has agreed to accept the Plan's Plan Allowance charge. In addition to each network, out-of-network benefits are also available at any time.

WellSpan is designed to provide the highest level of benefits when services are received by a WellSpan Provider Network provider or facility. Using WellSpan Provider Network providers, when possible, provides you and your family with an exceptional level of benefits. The Plan saves money when you use the WellSpan Provider Network, and those savings are passed on to you as higher benefit levels.

Network provider directories and updates can be found on the WellSpan Health website at https://hr.wellspan.org under "My WellSpan Benefits" or at www.wellspanpophealth.org. If you do not have access to the Internet or a printer, please contact the Human Resources Department or WellSpan Population Health Services to obtain a copy, free of charge.

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It is important to understand that the benefit level you or your family receives will depend on which network and tier your provider participates in. A network may not always include the provider you need, which means you will receive the benefit level for the network in which the provider participates – or receive the out-of-network benefit level if the provider does not participate with a network. WellSpan Provider Network providers and facilities may need to use Core Tier or Out-of-Network providers for some services. As above, these services will be paid under the tier of the provider rendering the service.

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The WellSpan Provider Network – Enhanced Tier (includes Other Select Providers)

Your Enhanced Tier Benefits uses the WellSpan Provider Network. This network includes WellSpan owned providers, facilities and select independent providers. Using your enhanced benefits, you will have less or no deductible, copayments, and coinsurance. Keep in mind that not all Specialists and services are available in the Enhanced Network. However, you will achieve maximum benefits by using the enhanced tier as much as possible.

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Claims for emergency hospital observation or admissions that occur at WellSpan Provider Network or non-WellSpan facilities will be covered at the Enhanced Tier WellSpan Provider Network benefit level (subject to Plan Allowance) and any per- admission co-payment will not apply. This includes all services you or your dependent receives while in observation or inpatient.

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Capital Blue Cross – Core Tier

Your Core Tier Benefits cover the widest range of services using the Capital Blue Cross PPO network. Using your core benefits tier, you may be subject to an annual deductible, copayments, coinsurance, and out-of-pocket maximums for services.

Out-of-Network

Providers that are in neither the Core nor Enhanced Tier Benefits will be considered out of network. This is the most expensive option for deductible, copayments, and coinsurance. In addition, the provider has the right to charge more than what is the Plan Allowance leaving you responsible for the difference.

Differences Between the Networks

Enhanced Tier WellSpan Provider Network (Includes Other Select Providers)	Core Tier CBC Network	Out-of-Network
Each time you need medical care, you may go to any WellSpan Provider Network provider.	Each time you need medical care, you may use any CBC network provider.	Each time you need medical care, you may use any provider you choose.

Enhanced Tier WellSpan Provider Network (Includes Other Select Providers)	Core Tier CBC Network	Out-of-Network
This level pays the highest benefit. WellSpan Provider Network services are based on predetermined rates that always fall within the Plan Allowance.	For most care you receive from a CBC network provider, this benefit level pays a percentage of the cost. CBC network services are based on predetermined rates that always fall within the Plan Allowance.	For most care you receive from a provider who is outside the networks, this benefit level pays the lowest benefit, subject to the Plan Allowance. You are responsible for any amounts in excess of the Plan Allowance
Your WellSpan provider files all your claims for you and handles pre- certification for you.	Your CBC provider files all claims for you. You need to handle your own pre-certifications. If you do not receive the appropriate pre- certification of your treatment, your benefits may be lower.	You will need to file your own claims for reimbursement. You must also handle your own pre- certification. If you do not receive the appropriate pre-certification of your treatment, your benefits may be lower.

How the Plan Works

Each time you seek medical care, you may choose to go to:

- A WellSpan Provider Network facility and receive the Enhanced Tier benefit level
- Any Capital Blue Cross network provider and receive the Core Tier benefit level; or
- Any provider outside the networks and receive the Out-of-Network level.

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The Plan excludes services provided by any Cancer Treatment Center of America. This includes, but is not limited to, the Eastern Regional (Philadelphia area), Midwestern Regional, Southeastern Regional, Southwestern Regional and Western Regional Facilities. If services are received at any of these facilities, there will be no reimbursement of benefits under the Plan, regardless of participation in any PPO network. To receive information about other facilities that provide care for cancer patients, please contact WellSpan Population Health Services at (800) 842-1768.

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Your Out-of-Pocket Costs

Your out-of-pocket costs depend on which type of provider you use. See the section "WellSpan Medical Plan Option Schedule of Benefits" at the beginning of this guide for specific information about your out-of-pocket costs:

- If you use WellSpan Provider Network providers, your only costs are usually a co-payment and/or a deductible, if any.
- If you use providers with the CBC network, your costs generally include your co-payments, co-insurance, and/or a deductible; or
- If you use providers who are outside of the networks, your out-of-pocket costs include any deductibles, co-payments, co-insurance, and any expenses that exceed the Plan Allowance.

Injectable Drug Deductible

This deductible is applied to services for outpatient injectable drugs covered through the medical benefits (including drugs given by infusion). The deductible applies to all benefit tiers. For example, if you receive an injection from your WellSpan provider, you will need to satisfy the deductible before the Plan makes a payment. Or, if you receive an injection from an out-of- network provider, you will need to independently satisfy both the injectable drug deductible and the calendar year deductible. Regardless of which providers you see (network or out-of-network), you will only be asked to meet one injectable drug deductible annually for Enhanced and Core Tiers. Out-of-Network has a separate injectable deductible.

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The annual injectable drug deductible does not apply to covered preventative immunizations (as show under the heading "Preventative Services").

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Please note that injectable drugs are covered, with a small co-payment, through your prescription drug benefits. Specialty Medications must be obtained from a WellSpan Pharmacy. For more information about Capital RX and specialty medications, see the section "Your Prescription Drug Benefits."

Per-Admission Inpatient Co-Payment (Applies to the Plus Plan option only)

If you are admitted as an inpatient to a facility that falls under the Core or Out-of-Network Tiers, you will need to pay a separate per-admission co-payment. There is no co- payment under Enhanced Tier. If you are admitted to a facility as an inpatient more than once for the same condition within a 90-day period, you only have to meet one per-admission co-payment.

Per-Procedure Ambulatory (Outpatient) Surgery Facility Co-Payment (Applies to the Plus Plan option only)

If you require outpatient surgery and use a Capital Blue Cross (CBC) or out-of- network surgical facility, you will need to pay a separate per-procedure co-payment – per operative session. When you use a WellSpan Provider Network facility, there is no co-payment.

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Many diagnostic procedures, other than radiological tests, are considered to be surgical procedures. If you have a question about your procedure, call WellSpan Population Health Services to find out if the co-payment will apply.

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Per-Procedure Diagnostic (Outpatient) MRI, MRA, PET and CT Scan Facility Co-Payment (Applies to the Plus Plan option only)

If you need an outpatient MRI (magnetic resonance imaging), MRA (magnetic resonance angiography), PET (Positron emission tomography) or CT (computed tomography imaging) scan, you will need to pay a separate per-procedure co-payment. When you use a WellSpan Provider Network facility, there is no co-payment.

Per-Visit Therapy Co-Payment

If you receive outpatient physical, speech, occupational or vision therapy services, you will need to pay a per-visit co-payment. Your co-payment is the lowest when you use a WellSpan Provider Network provider.

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If you receive multiple types of outpatient therapies, from the same provider on the same day, you will only need to pay one per-visit co-payment for all therapies received on that day from that provider.

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Medical Management Services

New Medical Technology, Prescription Drugs and Medical Procedures

The Plan regularly monitors medical literature concerning new medical technology, prescription drugs and medical procedures for which coverage may not be currently provided under the Plan. After considerable study and discussion of information from various sources, the Plan develops recommendations regarding coverage of new medical technology, prescription drugs, and medical procedures. The Plan will consider the following in determining recommendations for coverage:

- The technology, drug or procedure must have final approval from the appropriate governmental regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology, drug, or procedure on health outcomes;
- The technology, drug or procedure must improve the net health outcome;
- The technology, drug or procedure must be as beneficial as any established alternative; and
- The technology, drug or procedure must be beneficial in practice.

The Plan Administrator has the sole discretionary authority to decide whether a new medical technology, prescription drug, or medical procedure is to be covered by the Plan. Call the WellSpan Population Health Services phone number on the back of your medical identification card for information about this provision or about a particular service, before a charge is incurred.

Utilization Review and Pre-Certification

Utilization review is a program designed to help you and your covered dependents receive necessary, appropriate, and cost-efficient health care. For inpatient care and certain outpatient procedures, you or your provider will need to contact the Plan. How this is done depends upon your circumstances. WellSpan Population Health Services' Medical Management Department handles all Utilization Review and Pre-Certification. The contact number is listed on the back of your medical identification card.

If you receive services from a WellSpan Provider Network or WellSpan-owned provider, your provider is responsible for calling WellSpan Population Health Services with your pre- certification information. If you choose a CBC provider or out-of-network provider for your injectable drug, you are responsible for calling WellSpan Population Health Services with your pre-certification information.

If you, your CBC provider, or out-of-network provider fail to call when required, you will not receive the highest level of benefits under the Plan. It is important to discuss this with your provider when you need one of the services listed below.

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It is only necessary to pre-certify elective hospital stays and procedures. You are not required to pre-certify urgent or emergency services. Precertification will only be completed when this Plan is primary or as otherwise indicated in this document.

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Utilization Management (UM) decision making is based only on appropriates of care and service, and existence of coverage. WPHS does not specifically reward practitioners or other individuals for issuing denials of coverage. No financial incentives exist for UM decision makers that encourage decisions that result in underutilization.

Pre-Certification and Utilization Review is Required for all Non-Emergency:

Inpatient Admissions

- Medical/Surgical
- Inpatient Hospice
- Skilled Nursing Facility
- Inpatient Rehabilitation Program

Procedures

- Abdominoplasty
- Arthroscopic Surgery (excludes knee and shoulder)
- Bariatric Surgery
- Blepharoplasty
- Cardiac CT Angiography
- Colonoscopies (under age 45)
- Esophagogastroduodenoscopy (EGD)
- MRI of Brain
- MRI Spine (cervical, thoracic, lumbar)
- Nuclear Stress Test
- Orthognathic Surgery
- PET Scans/PET CT Scans
- Reduction Mammoplasty
- Referral to a Transplant Center
- Rhinoplasty/Septoplasty
- Temporomandibular Joint Dysfunction (TMJ) Surgery
- Total Joint Replacements (hips and knees)
- Uvulopalatoplasty

Injectable Drugs

- Certain injectable drugs. You or your provider must call WellSpan Population Health Services' Customer Service Department to pre-certify.

Home Health Care

- Aide Care
- Hospice
- Infusion Therapy
- Skilled Nursing
- Private Duty Nursing

Durable Medical Equipment & Orthotics

- Apnea Monitor
- Bone Growth Stimulator
- Continuous Glucose Monitors
- CPAP/BIPAP
- Hospital Bed
- Insulin Pump
- Lymphedema Pump
- Muscle Stimulator
- Oxygen Therapy
- Patient Lift/Stair Chair
- Wheelchair/Scoter
- Wound Vac

Pre-Notifications Recommended

- All maternity cases, as soon as a diagnosis of pregnancy has been established
- All genetic testing
- All outpatient clinical trials

Utilization review includes:

- Concurrent review based on the admitting diagnosis of the above services requested by the attending physician;
- Retrospective review of the above services and their medical necessity, provided on an emergency basis; and
- Discharge planning and management of the denials and/or appeals process.

Medical Review and Pre-Certification of Injectable Drugs

You are responsible for CBC or out-of-network pre-certification with WellSpan Population Health Services' Customer Service Department (the contact information is on the back of your medical identification card) when your physician.

- Prescribes certain injectable prescription drugs. This includes injectable drug prescriptions filled at a pharmacy or billed to you by your physician or by another pharmaceutical provider, or
- Administers certain injectable prescription drugs to you on an outpatient basis.

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The list of injectable drugs that require pre-certification can change periodically. To find out which injectable drugs require pre-certification and how the pre-certification process works, contact the Customer Service Department at (800) 842-1768 or (717) 851-6800 or visit the WellSpan Health website, https://hr.wellspan.org and sign in at "My WellSpan Benefits." If these drugs are not pre-certified, your benefits may be reduced.

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You and your provider will receive a letter from WellSpan Population Health Services acknowledging your pre-certification. The length of any pre-certification approval will be included in this letter and will vary depending on the drug being used and/or why this drug was prescribed for you. This means that if your physician wants you to continue using this injectable drug beyond the date specified in the letter, your network or you (from an out-of-network provider) will be responsible for pre-certifying again.

When your provider calls WellSpan Population Health Services to pre-certify, you will be asked for the following information:

- The name of the drug;
- The name of the physician ordering the drug; and
- The diagnosis for which the drug is prescribed.

It is especially important that your provider or you call to pre-certify whenever you are given injectable drugs as part of a "clinical trial", as these drugs may not be covered by the Plan.

Utilization Review and Pre-Certification Procedure

Remember, if you receive your care from a WellSpan Provider Network, CBC Network provider or an out-of-network provider, you will need to call the appropriate Medical Management Organization.

When you or your provider calls WellSpan Population Health Services to request a pre- certification and utilization review, you will need to provide the following information:

- The name of the patient and the patient's relationship to the covered employee;
- The name, identification number, and address of the covered employee;
- The name and telephone number of the attending physician;
- The name of the professional provider and requested medical service;
- The name of the facility provider, the proposed date of admission, and the proposed length of stay (if applicable); and
- The diagnosis for requesting medical services.

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Penalties for Not Calling!

In order to receive the best level of benefits, you or your provider must call the WellSpan Population Health toll-free number at (800) 842-1768. This ensures that you are receiving benefits from a network provider. You must pre-certify all non-emergency inpatient services. If you do not pre-certify these services when provided by an out-of-network provider, your benefit under the Plan will be reduced by $250. This is called a pre-certification penalty. If you are admitted as an inpatient on an emergency basis, you must notify WellSpan Population Health within 2 business days of the admission. There is no penalty for not pre-certifying urgent or emergency services.

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Genetic Testing

Before having any genetic testing performed, you or your provider should verify that there are benefits available under the Plan. To do this, you or your provider needs to request a "pre- notification review." Call WellSpan Population Health Services' Customer Service Department to begin this review. Pre-notification should be requested for all genetic tests.

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Have your provider call if genetic testing is being recommended! Even though the Plan does not require pre-certification for genetic tests, you may be responsible for the cost of the test if it is determined that it was not medically necessary. Many of these tests are very expensive and may be considered experimental or investigational and, therefore, not covered by the Plan. Call the WellSpan Population Health Services' Customer Service Department at (800) 842-1768 for more information. Please read "Genetic Testing" under the section "What is Covered" to find out what genetic tests are covered by the Plan.

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Genetic testing is only covered by the Plan when it is medically necessary and related to treatment decisions because of an existing condition. There are many genetic tests available and many more being developed, many of which are still being investigated and are not yet proven to be of value.

The way to understand genetic testing and how it may relate to you, is through genetic counseling. Genetic counseling can be provided by either a licensed genetic counselor or a knowledgeable provider who specializes in this area of medicine.

If you are unclear how a genetic test will affect your medical care or treatment, please call your ordering provider for more information. If you have questions about genetic testing coverage under the Plan, call WellSpan Population Health Services' Customer Service Department at (800) 842-1768 or(717) 851-6800.

Second Surgical Opinion Program

In order to prevent unnecessary or potentially harmful surgical treatments, your coverage includes the second surgical opinion program.

If your physician suggests elective surgery, you may obtain a second surgical opinion from a board-certified specialist physician whose board certification is relevant to your medical condition and who is not professionally or financially associated with your physician. A third opinion is also covered if the second opinion disagrees with the first.

An elective surgical procedure is one that can be scheduled in advance, and it is not a medical emergency or of a life-threatening nature.

Pre-Admission Testing Service

Covered charges include services that are:

- Performed on an outpatient basis prior to the hospital confinement;
- Related to the condition which will cause the confinement; and
- Performed in place of tests while hospital confined.

Clinical Trials for Treatment of Cancer or Other Life-Threatening Conditions

Benefits are provided for "routine patient care" for covered persons who have been accepted into an "approved clinical trial" for treatment of cancer or other "life-threatening conditions" under the following circumstances.

- The clinical trial has a therapeutic intent, and your provider determines that participating would be appropriate based on either the clinical protocol or medical and scientific information provided by you or your provider, and
- The facility or physician conducting the clinical trial participates in the WellSpan Provider Network unless protocol for the trial is not available through either network.

Services for routine patient care will be covered to the same extent and benefit levels as other covered services. Routine patient care consists of those services that would otherwise be covered by the Plan if those services were not provided as part of an approved clinical trial.

"Routine patient services" do not include:

- The investigational item, device, or service itself;
- Drugs or devices that have not been approved by the Federal Drug Administration (FDA);
- Services other than healthcare services such as travel, housing companion expenses and other non-clinical costs;
- Any item or service provided solely for data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services, except for the fact that are being provided in the clinical trial, are excluded by the Plan;
- Services customarily provided free of charge to any clinical trial enrollee; and
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular condition or disease.

An "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening condition, and is:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigation new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

A "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The WellSpan Health Plan option does not discriminate against any covered person participating in a clinical trial, whether or not the trial is an "approved clinical trial." The Plan provides benefits for services unrelated to the clinical trial to the extent that the services are otherwise covered under the Plan.

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Have your provider call WellSpan Population Health Services if he/she is recommending a clinical trial for you or your dependent. Even though the Plan does not require pre-certification for outpatient clinical trials, it is important the Plan verifies that the trial qualifies as an "approved clinical trial." All inpatient admissions require pre-certification.

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Case Management

In cases where a patient's condition is expected to be, or is of, a serious nature, the Plan Administrator may arrange for case management services. Additionally, you or your dependent may request case management services.

Case management is a program through which a case manager, who is qualified to perform such services, monitors a patient's condition, and explores, discusses, and recommends coordinated and/or alternate types of medically appropriate care that the Plan not my generally cover. Here's how it works:

- The case manager consults with the patient, his or her family, and the attending physician to develop a plan of care for their approval;
- The Plan Administrator, who is WellSpan Health, must approve all alternate treatment plans; and
- Once an agreement has been reached, the Plan will reimburse all medically necessary expenses that are outlined in the treatment plan, even if they are expenses that the Plan does not normally cover.

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Alternate care will be determined on the merits of each individual case. Any alternate care or treatment provided will not be considered to be setting any precedent or creating any future liability with respect to the *covered person* or any other *covered person* under the *Plan*.

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What Is Covered

The following services are covered under the WellSpan Medical Plan at the level specified. For expenses to be covered, they must be:

- ❖ Incurred while covered under the Plan;
- ❖ Medically necessary; and
- ❖ Provided by a covered health care provider or facility, where appropriate.

If you have any questions regarding a specific covered service, please call WellSpan Population Health Services at (800) 842-1768 or (717) 851-6800.

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Charges that are greater than the charges for an alternative service or supply that could have safely and adequately diagnosed or treated you or your dependent's physician or mental condition will not be considered medically necessary under this Plan. Call the telephone number on the back of your medical identification card for more information about this provision or about a particular service before the charge is incurred.

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Covered Charges

Covered charges are explained below. For specific benefit levels and maximums associated with these services, see the section "WellSpan Medical Plan Option Schedule of Benefits" at the beginning of this guide.

Acupuncture

Benefits are available for acupuncture used to induce surgical anesthesia or for therapeutic treatment for a medical condition.

Ambulance Services

Coverage includes benefits for the following land/air ambulance services:

- ❖ Land ambulance services (for emergencies) from the place of the emergency to the nearest hospital or facility where emergency care can be given;
- ❖ Land ambulance services or wheelchair vans (for non-emergencies) are covered when:
  - Transporting a person from one hospital or skilled nursing facility to another when the first location cannot provide the appropriate treatment and the second location can;
  - Transporting a person from a hospital or skilled nursing facility to home, a skilled nursing facility, or a nursing home when the person cannot be safely transported in another way without endangering their health; or

- Transporting a person between a hospital or skilled nursing facility to received necessary specialized diagnostic and/or therapeutic services and the following requirements are met:
    - The person's condition is such that the use of any other method of transportation would be contrary to their health;
    - The services are not available in the hospital or skilled nursing facility where the person is an inpatient; and
    - The hospital or skilled nursing facility providing the services is the nearest reasonable place to provide such services; and

❖ Air Ambulance services are covered when:

- The point of pick-up is inaccessible by land vehicles; or
- Great distances or other obstacles are involved in getting the person to the nearest hospital with appropriate facilities and speedy admission is essential.

Benefits are also available for ambulance or emergency medical services when medically necessary and when appropriate services are rendered, regardless, if transportation to a facility occurs.

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For all ambulance transport, charges are not covered if the ambulance service was used because it was more convenient than other transportation, was for the patient's convenience, or was not medically necessary as defined by the Plan.

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Ambulatory (Outpatient) Surgical Facility

Ambulatory, or outpatient, surgical facility services are covered when you need a surgical procedure that cannot be done in your physician's office.

Keep in mind that some surgical procedures must be pre-certified!

Anesthesia

Benefits include anesthesia that is administered in connection with a covered surgical procedure and given by a physician (other than the operating surgeon) or by a Certified Registered Nurse Anesthetist.

Anesthesia means the administration of spinal anesthetic, rectal anesthetic, or other anesthetic agents by injection or inhalation for muscle relaxation, loss of sensation, or unconsciousness, except that local infiltration anesthesia (that is, topical anesthesia) is not covered as a separate service.

Biofeedback

Benefits include medically necessary biofeedback, defined as a method of learning to voluntarily control body functions that normally operate outside of consciousness with the help of a special machine. However, biofeedback which is ordered due to a mental health or substance use disorder is not covered under the medical benefits. See the section "Mental Health and Substance Use Disorder Benefits" for detailed information on contacting Quest Behavioral Health.

Birthing Center

Benefits are available for the use of a birthing center. A birthing center is a licensed free-standing health facility, which is not a hospital, where births occur in a home-like atmosphere.

Keep in mind that all non-emergency inpatient care must be pre-certified!

Cardiac Rehabilitation

Benefits are available for cardiac rehabilitation for patients with certain types of heart disease or who have had heart surgery. Cardiac rehabilitation must be medically necessary and prescribed by your physician.

Chemotherapy

Coverage includes benefits for the treatment of malignant disease by chemical or biological agents. The cost of the injectable antineoplastic agent is covered under the medical benefits when administered where dispensed. The materials and services of technicians are also included.

Keep in mind that some procedures and services must be pre-certified!

Chiropractic Care

Benefits are available for chiropractic services, performed by a Licensed Chiropractor (D.C.), for the treatment of a musculoskeletal disorder (bone, muscle, tendon and joint) or misalignment/partial dislocation of/or in the vertebral column. Covered services include:

- Initial consultation
- Work-up; and
- X-rays and treatment

Cleft Palate and Cleft Lip

Your coverage provides benefits for cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the lip fails to close. Coverage includes the following expenses when provided by physicians, providers, or facilities, and are medically necessary:

- Oral and facial surgery, surgical management, and follow-up care;
- Speech Therapy;
- Otolaryngology treatment;
- Audiological assessments and treatment
- Medically necessary orthodontic treatment directly related to a diagnosis of cleft palate or cleft lip;
- Medically necessary prosthodontic treatment directly related to a diagnosis of cleft palate or cleft lip; and
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances.

Keep in mind that some procedures and services must be pre-certified!

Contact Lenses and Glasses

Covered charges include one (1) pair of conventional eyeglasses with standard frames (or one set of contact lenses) after each cataract surgery that implants and intraocular lens. Eyeglasses and lenses are limited to those that provide for the covered person's vision needs. Charges for cosmetic or convenience items/upgrades are not covered.

Contraceptive Management/Family Planning Services for Men

Benefits include physician services and surgery.

See the "Infertility" heading for benefits related to the treatment of infertility and reproductive disorders.

Keep in mind that some procedures and services must be pre-certified!

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See the heading "Preventative Services" for benefits related to contraceptive management and family planning for women.

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CT Scan (Outpatient) Services (Technical Component)

When medically necessary, benefits include facility or physician charges to perform diagnostic computed tomography(CT) scan facility services.

Keep in mind that some procedures and services must be pre-certified!

Dental Services

Coverage includes dental services provided by a physician or dentist only when services begin within 18 months of an accidental injury to the jaw, sound natural teeth, gums, alveolar processes, or face. However, if your injury was the result of chewing or biting, it will not be considered an accidental injury.

Benefits are also available for inpatient and outpatient facility charges and anesthesia charges for oral surgery or dental treatment that would normally be provided in a dentist's office when necessary for a child, an individual with a serious mental condition, or for an individual who has a serious underlying medical condition. Coverage is available for these services only when the condition cannot be treatment safely in an outpatient or office setting.

Keep in mind that some procedures and services must be pre-certified!

Diabetes Education

Benefits are available for diabetes self-management education programs and consultations. These services must be provided by a program that is certified by the Pennsylvania Department of Health or the American Diabetes Association.

Diagnostic Services

Benefits for diagnostic services from professional providers and facilities include:

- X-rays, consisting of radiology, ultrasound, and nuclear medicine;
- Physician services to interpret CT, MRI, MRA and PET scans;
- Laboratory and pathology tests;
- Medical Procedures consisting of EKG, EEG, and other electronic diagnostic procedures;
- Pre-admission pre-surgical tests which are performed before, and are related to, inpatient or outpatient surgery;
- Allergy tests consisting of percutaneous, intracutaneous, and patch tests; and
- Other medically necessary diagnostic tests.

Keep in mind that some procedures and services must be pre-certified!

Dietary Counseling

Coverage includes services for dietary counseling by a Registered Dietician. This benefit is limited to medically necessary dietary counseling for conditions such as:

- High blood pressure
- Cholesterol abnormalities
- Lactose intolerance
- Chronic kidney disease; or
- Obesity

See the heading "Preventative Services" for services covered under those benefits.

Doula

BirthWell Doula Benefit – continuous support for women during childbirth.

- 1:1 visits during pregnancy and after birth
- In person labor support at birthing location
- Text, email, and phone support between visits
- 24/7 on call support from 37 weeks until birth
- Visits can be at your home, doctor's office, or public place;
- Maximum benefit for Doula services is $1,950 per pregnancy.

The Doula Network www.thedoulanetwork.com (877) 436-8527 or email hello@thedoulanetwork.com.

Durable Medical Equipment

Benefits include the rental, and, in some cases, the purchase of durable medical equipment (DME) and surgical equipment when it is prescribed by a provider and required for therapeutic use. Benefits are not provided for durable medical equipment that is more elaborate than necessary for your needs.

The initial purchase of such equipment and accessories needed to operate it are covered only if:

- Long term use is planned; and
- It is likely to cost less to buy than to rent; or
- The equipment cannot be rented; or
- Manufacturer required batteries for approved devices only; or
- The Plan decides, at its sole discretion, to purchase rather than rent.

Replacement will be covered only if it's shown that:

- It is needed due to a change in the physical condition of the patient; or
- It is likely to cost less to buy a replacement than to repair existing equipment or to rent like equipment.

If purchased, charges for repair or replacement will be covered, except when the repairs or replacement are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for durable medical equipment that is rented or is under warranty from the manufacturer.

Keep in mind that some procedures and services must be pre-certified!

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Ostomy and respiratory therapy DME are either covered under the prescription drug benefits or the medical plan benefits. Diabetes supplies are covered under the prescription drug benefits of the plan only. See the section "Prescription Drug Benefits" for information about the prescription drug coverage.

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Emergency Department Services

Benefits are available for these services in the Emergency Department:

- Emergency services, including facility and professional provider services and supplies, for the initial treatment of traumatic bodily injuries resulting from an accident; and
- Emergency services, including facility and professional provider services and supplies, or the treatment of a sudden medical condition that manifests itself by acute symptoms (including severe pain) of enough severity that the absence of immediate medical attention could reasonably result in:
  - Permanently placing the patient's health in jeopardy;
  - Causing other serious medical consequences;
  - Causing serious impairment to bodily functions; and
  - Causing serious and permanent dysfunction of any bodily organ or part.

Should a prudent layperson, who possesses an average knowledge of health and medicine, believe a serious medical condition exists, the Emergency Department visit is justified.

If you or your dependent is admitted to observation or as an inpatient from the Emergency Department, the Emergency Department co-payment is waived. If Emergency Department services are used for a non-emergency situation the Emergency Room facility charge is not covered by the Plan.

When you or a dependent need urgent, but not emergency, care, the Plan covers charges in an urgent care center, walk-in clinic, or a facility that sees patients for non-medical emergency, yet necessary, care. See the heading "Urgent Care Services, Walk-In Clinics, Retail Clinics" for a description of the benefit.

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What is a Medical Emergency?

The WellSpan Medical Plan Option defines the term "medical emergency" as a sudden onset of a condition with acute symptoms (including severe pain), which would require immediate medical care. It could include such conditions as chest pain, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions. Emergency care is justified if the average non-medical person believes a serious medical condition exists.

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Emergency Department Physician Services

Your coverage includes benefits for physician services while you are in the Emergency Department.

Gender Re-Assignment

Your coverage includes benefits for surgery and other related services. Some restrictions do apply. Please contact WellSpan Population Health Services for more information.

Genetic Counseling and Genetic Tests

Charges for the following medically necessary genetic tests are covered by the Plan.

- State-mandated newborn screening tests for genetic disorders (See Preventative Services);
- Analysis of fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) in covered pregnant women;
- Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease;
- Some tests to determine sensitivity to FDA-approved drugs;
- Tests to detect or evaluation chromosomal abnormalities; and
- Genetic counseling and genetic tests required as a Preventative Service under the Affordable Care Act (ACA) (See "Preventative Services").

Other covered genetic tests are covered by the Plan if:

- You have symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that you are at risk for carrier status as supported by existing scientific and medical literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing scientific and medical literature to directly impact treatment options.

Only those genetic tests that meet the criteria above are covered by the Plan. This could mean that certain genetic tests to determine carrier status for preconception purposes may not be covered by the Plan.

Genetic testing of WellSpan members is excluded from coverage under the WellSpan Plan if the testing is performed primarily for the medical management of other family members who are not covered by the WellSpan Plan. In these circumstances, the group health plan for the family members who are not covered by this Plan should be contacted regarding coverage of genetic testing. Occasionally, genetic testing of tissue samples from other family members who are not covered by WellSpan, may be required to provide the medical information necessary for the proper medical care of a WellSpan member. This Plan covers genetic testing for inheritable diseases in non-WellSpan members when all of the following conditions are met:

- The information is needed to adequately access risk in the WellSpan member; and
- The information will be used in the immediate care plan of the WellSpan member; and
- The non-WellSpan member's benefit plan, if any, will not cover the test.

Genetic counseling is covered if you are undergoing covered genetic testing or if you have an inherited disease and are a potential candidate for genetic testing.

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Have your provider call if genetic testing is being recommended! Even though the Plan does not require pre-certification for genetic tests, you may be responsible for the cost of the test if it is determined that it was not medically necessary. Many of these tests are very expensive and may be considered experimental or investigational and, therefore, not covered by the Plan. Call the WellSpan Population Health Services' Customer Service Department at (800) 842-1768 for more information.

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Hearing Aids and Associated Services

Benefits are provided for hearing aids, cochlear implants, associated services, and exams for their fittings.

Certain hearing aid supplies, including but not limited to, batteries are not covered by the Plan. Hearing aid accessories are only covered if medically necessary.

Home Health Care

Home health care services and supplies are covered when prescribed by a physician. Covered services include:

Part-time or intermittent skilled nursing care by a nurse

- Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;
- Physical, respiratory, occupational and speech therapy;
- Infusion therapy;
- Oxygen and its administration; and
- Medical social service consultations.

Keep in mind that home health care services must be pre-certified!

Hospice Care (Inpatient and Home)

Hospice care services and supplies are covered for terminally ill patients with a life expectancy of six months or less when care is medically necessary. Covered services include:

- Inpatient or outpatient care;
- Nutritional counseling and special means;
- Part-time nursing;
- Short-term respite care;
- Homemaker services;
- Physical and chemical therapy; and
- Bereavement counseling for the spouse and/or children for a period of six months after the death – up to a combined maximum of six visits.

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Charges incurred during periods of remission will not be covered as hospice care expenses and are subject to the Plan's provisions for other types of services.

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Keep in mind that hospice care services must be pre-certified!

Hospital Services (Inpatient)

Benefits include semi-private room and board expenses, including medical and education services and supplies furnished by the hospital. A private room, intensive care, coronary care, and other specialized care units are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition. When room and board for other than semi-private care is for your convenience, payment will be made only for semi-private accommodations.

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Claims for emergency hospital observation and admissions that occur at WellSpan Provider Network or non-WellSpan facilities will be covered at the Enhanced Tier WellSpan Provider Network benefit level (subject to Plan Allowance) and the per-admission co-payment will not apply. This includes all services you or your dependent receives while an inpatient.

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Keep in mind that all non-emergency inpatient care must be pre-certified!

Immunization for Adults and Children

Coverage includes immunizations recommended by the Centers for Disease Control (CDC) and that are not included in the preventative benefits as required by the Affordable Care Act (ACA).

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Injectable drugs reimbursed under the medical benefits are subject to the calendar year injectable prescription drug deductible and the limitations and exclusions under the prescription drug benefits. This includes drugs given by infusion. See the heading "injectable Drug Deductible" for detailed information.

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Infertility – Treatment and Assisted Reproduction Services

Coverage includes benefits for infertility treatment and assisted reproduction services. Benefits are available for drugs and services to assist in fertility which are not essential for general health. All prescription drugs related to a diagnosis of infertility or for assisted reproduction will be covered under the medical benefits, not the prescription drug benefits. NOTE: Injectable prescription drugs are subject to the annual $150 injectable drug deductible. Plan exclusions such as experimental and investigational may apply.

Keep in mind that some services may require pre-certification!

Infertility – Diagnostic Services

Coverage includes benefits for the diagnosis of infertility.

Keep in mind that some services may require pre-certification!

Mastectomy Services

Your benefits cover reconstructive surgery, prosthesis, and treatment of the physical complications during all states of a mastectomy, including lymphedemas and reconstruction of the healthy breast to achieve a symmetrical appearance.

Keep in mind that some services may require pre-certification!

Maternity Services

Coverage includes benefits for facility and provider charges for pregnancy of female employees, spouses of employees and dependent daughters. Birthing facility services are covered if the facility meets all legal requirements and the physician in charge is acting within the scope of his or her license. Midwife delivery and Doula services are also covered if your state legally recognizes midwife births, and the midwife is licensed at the time of delivery.

Remember to call your Medical Management organization as soon as pregnancy is confirmed!

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According to the Newborns' and Mothers' Health Protection Act (NMHPA), coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both the mother and the newborn child.

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See the heading "Preventative Services" for services covered under those benefits. Keep in mind that some services may require pre-certification!

Mental Health Services

Mental health benefits for the WellSpan Medical Plan Option are provided by Quest Behavioral Health. See the section "Mental Health and Substance Use Disorder Benefits" for detailed information on covered services.

MRA/MRI Scan (Outpatient) Services (Technical Component)

When medically necessary, benefits include facility or physician charges to perform diagnostic magnetic resonance angiography/imaging(MRA/MRI)scan facility services.

Newborn Care

Nursery charges, other hospital services and supplies and physician charges for hospital visits of newborn children and circumcision of a newborn male child are covered.

No Surprises Act

When you get emergency care or are treated by an out-of-network provider at an Enhanced or Core hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's co-payments, co-insurance, and/or deductible.

Nutrition Therapy

Coverage includes benefits for nutrition therapy. These services include:

- Enteral therapy and parental therapy (TPN and PPN) formulas, limited to medically necessary formula, when ordered by a physician. The formula must be the sole source (or an essential source) of nutrients, and it has been proven effective as the disease=specific regimen for those persons who are or will become malnourished or who suffer from disorders which, left untreated, cause chronic disability, mental retardation, or death; and
- Metabolic formulas limited to medically necessary formulas for inherited metabolic disorders when ordered, in writing, by a physician. An inherited metabolic disorder means a genetically acquired disorder of metabolism, present at birth, involving the inability to properly metabolize amino acids, carbohydrates or fats as diagnosed by a physician using standard laboratory tests and can include phenylketonuria (PKU) maple syrup urine disease, homocystinuria and galactosemia. Lactose intolerance without a diagnosis of galactosemia is not considered to be an inherited metabolic disorder under the Plan. Metabolic formulas must be:
  - Formulated to be consumed under the direction of a physician;
  - Processed or formulated to be deficient in one or more of the nutrients present in typical food stuffs;
  - Administered for the medical and nutritional management of a patient with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
  - Essential to the patient's optimal growth, health, and metabolic homeostasis.

Coverage is not available for any of the following:

- Metabolic formulas for any medical condition other than for inherited disorders as defined above;
- Natural foods that are naturally low in protein and/or galactose;
- Spices/flavorings; and
- Foods and/or formulas available to any person, even a person with an inherited metabolic disorder as defined above, which may be purchased without a prescription and/or do not require supervision by a physician.

Obesity

Services related to a diagnosis of obesity is covered. This could include:

- Physician services;
- Diagnostic tests;
- Dietary counseling;
- Prescription generic medications; and
- Surgery.

Commercial weight loss programs, non-prescription items and fitness center memberships are not covered. Also, the patient must meet the definition of obesity to be eligible for this benefit. See the "Terms You Should Know" section later in this guide for a complete definition.

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Benefits for bariatric surgery are available when performed in a facility accredited by a national medical society who offers accreditation for such surgery. Surgery must be performed by surgeons who are members or affiliate members of a nationally recognized medial society for bariatric surgery. WellSpan Ephrata Community Hospital and WellSpan Chambersburg Hospital may also be utilized for this service.

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Keep in mind that some services may require pre-certification!
See the heading "Preventative Services" for services covered under those benefits.

Oral Surgery

Charges for injury to, or care of, the mouth, teeth, gums, and alveolar processes will be covered only if that care is for the following oral procedures:

- Excision of tumors and cysts of the jaws, cheeks, limps, tongue or roof and floor of the mouth;
- Dental services received from a physician or dentist which are necessary because of an accidental injury to the jaws, sound natural teeth, mouth, or face. However, if your injury was the result of chewing or biting, it will not be considered an accidental injury;
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, or roof of the mouth;
- Excision of benign bony growths of the jaw and hard palate;
- External incision and drainage of abscesses and the treatment of cellulitis;
- Incision of sensory sinuses, salivary glands, or ducts; and
- Removal of full and partially bony impacted teeth.

The medical benefits do not cover dental or oral surgical procedures involving orthodontic care of teeth, periodontal disease and/or preparing the mouth for the fitting and continued use of dentures.

Keep in mind that some services may require pre-certification!

Orthotic Devices (Orthoses)

Charges for medically necessary orthotic devices, including custom-molded (but not over-the- counter) foot orthoses are covered. An orthotic device is a support, brace or splint used to support, align, prevent, or correct the function of movable parts of the body. Replacements will be covered only if it is show that:

- It is needed due to a change in the physical condition of the patient to make the original device no longer functional;
- It is needed due to normal wear and tear as determined by the manufacturer and the Plan; or
- It is likely to cost less to buy a replacement than to repair the existing device.

Charges for repair or medically necessary replacement of an orthotic device will be considered a covered charge, except when such repairs or replacements are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for devices when under warranty from the manufacturer.

Orthopedic shoes are not covered unless they are part of a leg brace.

Patient Education

The Plan includes benefits for medically necessary patient education services.

See the heading "Preventative Services" for services covered under those benefits.

PET Scans (Outpatient) Services (Technical Component)

When medically necessary, benefits include facility or physician charges to perform diagnostic positron emission tomography (PET) scan facility services.

Keep in mind that PET scans must be pre-certified!

Physician Visits

Your benefits cover services from a physician or inpatient, outpatient, and office services. This includes those individuals, such as a Physician Assistant or Nurse Practitioner, who work under a physician's supervision.

Telephonic, video or email visits (collectively known as "virtual" visits) may also be covered by the Plan when such visits meet the definition of medical necessity.

Benefits are also available for outpatient and office visits when you see a physician for a mental health or substance use disorder. These visits must be provided by a physician who is not a behavioral health specialist. Quest Behavioral Health provides benefits for services from behavioral health specialists. See the section "Mental Health and Substance Use Disorder Benefits" for more information about this coverage.

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It is important that when you need to see a physician, especially for a new issue, to visit your primary care physician first. He or she will be able to assist you in receiving the best care for your situation. Remember that co-payments to see a specialist physician are higher than when you see your primary care physician.

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The Plan considers a primary care physician (PCP) to be one of the following:

- Internal Medicine;
- Family Practice;
- General Practice; and
- General Pediatrics

All other types of physicians are considered to be specialists under the terms of the Plan.

Podiatry Services

Benefits are available for services related to conditions and the function of the foot. This includes examinations and diagnosis by medica land surgical methods. Surgical podiatry services include:

- Incision and drainage of infected foot tissues and toenails of the foot;
- Removal of lesions (not including corns and calluses);
- Treatment of fractures, deformities, and dislocations of bones of the foot; and
- Medically necessary foot care for covered persons with metabolic, neurological, or peripheral-vascular disease.

Podiatry, or foot care, services are not covered when those services and procedures are considered to be in the realm of self-care, such as:

- Cutting, shaving, paring or removal of corns and calluses;
- Clipping, trimming or non-surgical care of toenails;
- Other hygienic and preventative maintenance care in the realm of self-care, such as cleaning the feet and the use of skin creams; and
- Any service performed in the absence of localized sickness, injury or symptoms involving the foot.

However, foot care for those with metabolic, neurological, or peripheral vascular disease, such as diabetes, will be covered.

Keep in mind that some procedures and services must be pre-certified!

Prescription Drugs

A Prescription Benefit Manager (PBM) provides prescription drug benefits for the WellSpan Medical Plan Option. See the section "Prescription Drug Benefits" for detailed information on covered services. Injectable prescription drugs, either administered by your provider or self- administered, can be reimbursed through either the medical or prescription drug coverage for benefits, but not through both – except that insulin is only covered under the prescription drug benefits.

Self-injectable drugs, and those supplies necessary to administer these drugs, can only be reimbursed under the prescription drug coverage. Diabetes supplies can only be obtained through the prescription drug coverage.

All prescription drugs that are administered in the place where they are dispensed, such as in an Emergency Department, a physician's office, a place providing urgent care, for oncology treatment or as part of an inpatient hospital admission, will be covered under the medical benefits. Prescription drugs dispensed, but not administered, such as "take home" drugs, are not covered under the medical or prescription drug benefits.

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Injectable drugs reimbursed under the medical benefits are subject to the calendar year injectable prescription drug deductible and the limitations and exclusions under the prescription drug benefits. This includes drugs given by infusion. See the heading "Injectable Drug Deductible" for detailed information.

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Keep in mind that certain injectable drugs must be pre-certified!

Preventative Services

Your coverage provides benefits for certain routine or preventative services – that is, services that are not for the treatment of a sickness or injury. These benefits are provided to you and your dependents with no cost-sharing when received by a network provider (Enhanced Tier or Core Tier). If you receive services from an out-of-network provider, you are responsible for a large share of the cost. Out-of-network providers will only receive the network level of benefits when a network provider cannot reasonably provide the service.

Some preventative services are also covered under the Prescription Drug benefits.

Covered services include those that have been demonstrated by clinical evidence to be safe and effective in either early detection of disease or in the prevention of disease and have been proven to have a beneficial effect on health outcomes and include the following as required by the Affordable Care Act (ACA):

- Evidence-based items or services that have in effect a rate of “A” or “B” in the current recommendations of the United States Preventative Services Task Force(USPSTF);
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices(ACIP) of the Centers for Disease Control and Preventative(CDC);
- With respect to infants, children and adolescents, evidence-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) and American Academy of Pediatrics;
- With respect to women, such additional preventative care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administrator (HRSA).

The Plan may apply reasonable medical management techniques to determine frequency, treatment or setting for recommended preventative service to the extent not specified in the recommendation or guideline.

Providers are legally required to code and bill accurately for services they provide to patients. Covered services are paid based on the billing codes used by the covered person’s provider on the claim submitted to the Plan. Therefore, the covered person may be responsible for a portion of the preventative care visit when the service is not billed as preventative care (including those that may have been received at the same time as your preventative care visit).

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To see what is specifically included under your preventative benefits, see the section "WellSpan Medical Plan Option Schedule of Benefits" at the end of this guide.

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For more information about preventative services covered under the Plan, call WellSpan Population Health Services, or visit the following websites:

- United States Preventative Services Task Force
  http://www.uspreventativeservicestaskforce.org
- Advisor Committee on Immunization Practices (ACIP)
  http://www.cdc.gov/vaccines/acip/index.html
- Health Resources and Services Administration
  http://www.hrsa.gov/index.html
- American Academy of Pediatrics (Bright Futures)
  http://brightfutures.aap.org/

Private Duty Nursing Care

Benefits include private duty nursing care, defined as skilled nursing care, in the home by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) whose purpose is to access, monitor and provide skilled nursing care in the home on an hourly basis.

Your physician must certify that your condition requires care that can only be provided by a Registered Nurse or a Licensed Practical Nurse and that such care is medically necessary. Nursing services must be provided by a nurse who does not live in your home and who is not a member of your immediate family.

Keep in mind that private duty nursing care must be pre-certified!

Prosthetic Devices

Coverage includes prosthetic devices (other than dental) to replace all or part of an absent body part, including contiguous tissue, or to replace all or part of the function of a permanently inoperative or malfunctioning body part. A replacement device will be covered only if it is show that:

- It is needed due to a change in the physical condition of the patient to make the original device no longer functional;
- It is needed due to normal wear and tear as determined by the manufacturer and the Plan; or
- It is likely to cost less to buy a replacement than to repair the existing device.

Charges for repair or medically necessary replacement of a prosthetic device will be considered a covered charge, except when such repairs or replacement are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for devices when under warranty from the manufacturer.

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Benefits are available for up to $250 for the initial purchase of a wig following chemotherapy, limited to one per lifetime.

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Radiation Therapy

Benefits are provided for radiation therapy benefits for the treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neurons, radium, or radioactive isotopes.

Renal Dialysis

Benefits are provided for the treatment of acute renal failure or chronic irreversible renal insufficiency through the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Benefits include medically necessary dialysis education. There is coverage available when traveling in an area that does not have an Enhanced or Core Tier provider available for this service.

Respiratory Therapy

Coverage includes benefits for respiratory treatment needed to help improve or restore lung function.

Second Surgical Opinion

If your physician recommends elective surgery, you may get a second surgical opinion by a board- certified specialist's physician whose board certification is relevant to your medical condition and who is not professionally or financially associated with your physician. A third opinion is also covered if the second opinion disagrees with the first.

Skilled Nursing Facility (Extended Care Facility)

Coverage includes inpatient skilled nursing facility services when you need skilled nursing care, but do not need the level of care provided by a hospital.

Keep in mind that skilled nursing facility admissions must be pre-certified!

Substance Use Disorder (Drug and Alcohol)

Substance use disorder benefits for the WellSpan Medical Plan option are provided by Quest Behavioral Health. See the section "Mental Health and Substance Use Disorder Benefits" for detailed information on covered services.

Supplies and Catheters

Benefits are available for medically necessary medical supplies and catheters but not common first aid supplies. Medical supplies that are inclusive in other covered services will not be considered as a separate benefit or as a covered charge under this benefit.

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Colostomy, ileostomy, and respiratory therapy supplies are covered either under the prescription drug benefits or medical benefits – but not both. Diabetic supplies are only covered under the prescription drug benefits.

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Keep in mind that some services must be pre-certified!

Surgical Dressings

Medically necessary surgical dressings such as splints, casts and other devices used in reduction of fractures and dislocations are covered. Surgical dressing that are inclusive in other covered services will not be considered as a separate benefit or as a covered charge under this benefit.

Surgical Procedures (Inpatient, Outpatient, and office)

Emergency and elective inpatient, outpatient, and office surgery for the treatment of a sickness or injury is covered. Covered services also include:

- Cutting procedures for the treatment of sickness, injuries, fractures, and dislocations of the jaw – and extraction of soft tissue and bone impacted teeth when the services is provided by a physician or dentist;
- Sterilization procedures (see the "Preventative Services" heading for women's services);
- Diagnostic surgical procedures;
- Pregnancy termination for therapeutic, medical, or elective indications; and
- Services of a physician who actively assists the operating surgeon when your condition requires such service.

Keep in mind that some surgical procedures must be pre-certified!

Temporomandibular Joint Dysfunction (TMJ)

Benefits are provided for services related to a diagnosis of temporomandibular joint dysfunction and myofascial pain dysfunction. Benefits are limited to the following covered services which must be ordered by a physician:

- Physical therapy;
- Physician services;
- Diagnostic tests;
- Oral surgery; and
- Intra-oral orthotic devices (except for orthodontia and prosthetic devices).

Keep in mind that temporomandibular joint dysfunction surgery must be pre-certified!

Therapeutic Shoes and Inserts

Coverage includes benefits for molded or depth-inlay shoes and custom molded shoe inserts for the prevention and treatment of foot complications associated with diabetes or neuropathies related to other conditions. The footwear and associated inserts must be medically necessary, prescribed by a physician or other provider, and be fitted and furnished by a podiatrist, pedothrist, orthotist or prosthetist.

Therapy Services (Physical, Occupational and Speech)

Your benefits cover therapy services that are being used as part of a physician's written treatment plan for the treatment of sickness or injury. Covered therapies include:

- Physical Therapy – the treatment by physical means, including:
  - Hydrotherapy, heat, or similar modalities;
  - Physical agents;
  - Bio-mechanical and neuro-physical principles; and
  - Devices to relieve pain, restore maximum function lost or impaired by sickness or accidental injury and prevent disability following sickness, injury, or loss of a body part.
- Occupational therapy – the treatment for a physically disabled person by means of constructive activities designed to restore the person's ability to satisfactorily perform the ordinary tasks of daily living; and
- Speech therapy – the treatment for the correction of a speech impairment resulting from sickness, surgery, injury, congenital or developmental anomalies or previous therapeutic processes.

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If you receive multiple types of outpatient therapies from the same provider on the same day, you will only need to pay one per-visit co-payment for all therapies received on that day from that provider.

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Tobacco Cessation

Services for tobacco cessation are covered under the Plan as a preventative service. Services could include tobacco cessation programs, physician services or tobacco cessation drugs and aids. See the heading "Preventative Services and the Prescription Drug section for more information.

Transplant Services

Benefits cover human-to-human organ or tissue transplants. Only those transplants that are medically necessary and not experimental or investigational will be covered under this Plan.

If you or your covered dependent is the donor, expenses are covered the same as for any other sickness. Benefits will be available for the donor, if not a covered person under this Plan, if you or your dependent's benefits have not been exhausted and if the donor's expenses are not covered under any group health plan.

Covered expenses will be paid for each transplant procedure that is completed, including:

- Organ or tissue procurement from a cadaver, including the removal, preservation, and transportation of the donated part;
- Services and supplies furnished by the facility;
- Treatment and surgery by a professional provider;
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue (outpatient drugs are only available through the prescription drug benefits); and
- Surgical, storage and transportation costs directly related to the procurement of an organ or tissue.

Keep in mind that some surgical procedures and services must be pre-certified!

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If a covered transplant procedure is not performed because of the intended recipient's medical condition or death, benefits will be paid for charges incurred for the organ or tissue procurement. The Plan will not cover the purchase price of an organ that is sold.

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Urgent Care Services, Walk-in Clinics, Retail Clinics

Coverage is available for charges received in an urgent care center, walk-in clinic, retail clinic or a facility that sees patients for non-emergency, yet necessary, care. These facilities usually see patients for unscheduled walk-in care that is not through a hospital's Emergency Department. Prescription drugs that are dispensed, but not administered, are not covered under the medical or prescription drug benefits.

Vision Therapy

Benefits are available for treatment involving non-surgical methods aimed at improving visual skills resulting from binocular impairments.

What is Not Covered

The following expenses are not covered under the WellSpan Medical Plan Option. If you have any questions about specific service, please contact WellSpan Population Health Services at (717) 851-6800 in York or toll-free at (800) 842-1768.

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Should this Plan pay benefits and it is later determined that these benefits should not have been paid based on the exclusions mentioned below, the Plan explicitly reserves the right to recover any and all benefits paid in error.

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Charges for the following are not covered:

Administrative Charges

Charges for missed appointments, or the completion of forms or other administrative charges.

Alternative or Complimentary Treatment

Including hypnosis, relaxation massage therapy, acupressure, aromatherapy, homeopathy, naturopathy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine of the National Institute of Health (or other U.S. government agency charged with a similar mission), unless the services is specifically listed as covered under the heading "What is Covered."

Cancer Treatment Centers of America

The Plan excludes services provided by any Cancer Treatment Center of America. This includes, but is not limited to, the Eastern Regional (Philadelphia area), Midwestern Regional, Southeastern Regional, Southwestern Regional and Western Regional facilities. If services are received at any of these facilities, there will be no reimbursement or benefits under the Plan, regardless of participating in any PPO network. To receive information about other facilities that provide care for cancer patients, please contact WellSpan Population Health Services at (800) 842-1768.

Chelation Therapy

Charges in connection with or for chelation therapy, except when medically necessary for the treatment of a metal poisoning.

Cosmetic Services and Surgery

Care, services, and treatment provided for cosmetic reasons. Complications directly related to cosmetic surgery would not be covered. Reconstructive surgery that is medically necessary to restore bodily function or to correct deformity resulting from sickness, trauma, congenital or developmental anomalies, previous therapeutic processes, or is for repair of damage from an accidental injury is covered under the Plan.

Counseling/Analysis/Support Groups

Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling, sex therapy or support groups.

Court Ordered Services

Treatment ordered by a court of law unless the Plan deems the service to be medically necessary.

Custodial Care

Services and supplies provided mainly as a rest cure, domiciliary care, or custodial care.

Dental Services

Except those services, treatment or supplies specified or listed as covered under the heading "What is Covered."

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For more information about dental benefits, please refer to your annual enrollment materials or call the WellSpan Health Human Resources Department.

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Educational or Vocational Testing

Services for educational or vocational testing or training, or training programs regardless of diagnosis or symptoms that may be present, except as specifically listed as covered under the heading "What is Covered."

Exceeds Limitations

Services and expenses that exceed any limits or maximums as found under the section "Schedule of Medical Benefits."

Excess Charges

The part of an expense for care and treatment of an accident injury or sickness that is in excess of the Plan Allowance.

Exercise Programs

Exercise programs for treatment of any condition, except for physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan. Charges for exercise programs or use of exercise equipment, special diets, or diet supplements, Nutrisystem programs, Weight Watchers or similar programs and hospital confinements for weight reduction programs will not be covered.

Experimental/Investigational and/or Not Medically Necessary

Care, treatment, drugs, devices or other medical services or procedures that are either experimental/investigation or not medically necessary.

See the heading "Clinical Trials for Cancer and Other Life-Threatening Conditions" for information relating to benefits for some clinical trials.

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The Plan Administrator has the sole discretion to determined what services and treatment are considered to be experimental, investigational, or medically necessary.

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Eye Care

Radial keratotomy or other eye surgery to correct near-sightedness or any surgical technique performed for the correction of myopia or hyperopia, including but not limited to keratomileusis, keratophakic, or radial keratotomy (plastic surgeries on the cornea in lieu of eyeglasses), and all related services. Additionally, routine eye examinations, including refractions, lenses for the eyes and exams for the fitting are excluded. This exclusion does not apply to aphakic patients and soft lenses, or sclera shells intended for use as corneal bandages.

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For more information about vision benefits, please refer to your annual enrollment materials or call the Human Resources Department.

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Foot Care

Foot care services that are not covered are those services and procedures considered to be in the realm of self-care, such as: cutting, shaving, paring or removal of corns and calluses; clipping, trimming or non-surgical care of toenails; other hygienic and preventative maintenance care in the realm of self-care, such as cleaning the feet and the use of skin creams; and any services performed in the absence of localized sickness, injury or symptoms involving the foot. Foot care for those with metabolic, neurological, or peripheral vascular disease, such as diabetes, will be covered.

Orthopedic shoes are not covered unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, except under those circumstances for which therapeutic shoes and inserts are listed as covered.

Gene Therapy

Any technique that modifies a person's genes via a surgical or other medical method.

Government Coverage

Care, treatment, or supplies furnished by a program or agency funded by any government, except where such exclusion is prohibited by law.

Hair Loss

Cosmetic care and treatment for hair loss including wigs (other than the initial wig following chemotherapy), artificial hair pieces, human or artificial hair transplants or any drug that promises hair growth, whether or not prescribed by a physician.

However, medically necessary care and treatment to diagnose, minimize or eliminate a medical condition related to hair loss is covered.

Hospital Employees

Professional services billed by a physician or nurse who is an employee of a hospital or skilled nursing facility and paid by the hospital or facility for the service.

Illegal Acts

Charges for services received because of accidental injury or sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault, or other felonious behavior; or by participating in a riot or public disturbance.

This exclusion does not apply if the accidental injury or sickness resulted from an act of domestic violence or a medical (including both physician and mental health) condition.

Incomplete Statements

Charges contained in statements that are incomplete. The documentation submitted by you or your dependent (or the provider on your behalf) must include itemized statements identifying the patient, date of treatment, diagnosis, type of service provided, the tax identification or other identifier of the provider and the charge for each service. Photocopies, cash register receipts, canceled checks and similar documents are examples of unacceptable statements.

Massage Therapy

This exclusion applies to all WellSpan Plans.

Military Service

Care, services, and treatment in connection with injuries sustained or a sickness contracted while on active duty in military service.

Motor Vehicle

Expenses in connection with an accident injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal or like type of vehicle).

This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any accidental injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance.

However, this exclusion does not apply to a covered person who is a non-driver when involved in an uninsured motor vehicle accident. For the purpose of this exclusion, a non-driver is defined as a covered person who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle.

No Charge

Care and treatment for which there would not have been a charge if no coverage had been in force.

Non-Compliance

Non-compliance with a patient's primary coverage will result in no payment under this Plan as a secondary payer. This would include services to an HMO participant by a facility or professional provider, who is not a member of the HMO.

Non-Emergency Hospital Admission

Care and treatment billed by a hospital for non-medical emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within twenty-four (24) hours of admission.

No Obligation to Pay

Charges incurred for which the Plan has no legal obligation to pay.

No Physician Recommendation

Care, treatment, services or supplies not recommended and approved by a physician or treatment, services, or supplies when the covered person is not under the regular care of a physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the accidental injury or sickness.

Not Listed As Covered

Any care, treatment, service, or supply that is not described under the heading "What is Covered."

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For more information about covered services, please call WellSpan Population Health Services.

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Nutritional Supplements

Except as nutrition therapy is specifically defined as covered.

Obesity

Care and treatment of obesity, weight loss or dietary control whether or not it is a part of the treatment plan for another sickness, except as those services related to obesity are defined as covered under the heading "What is Covered."

Occupational

Care and treatment of an injury or sickness that is occupational in nature as it arises from work for wage or profit and for which the covered person is required to be covered under Worker's Compensation or similar law. The Plan will not pay for expenses related to an accidental injury or sickness when the covered person is legally required to be covered under Worker's Compensation coverage, even if such coverage is not in force at the time.

Personal Comfort Items

Personal comfort items or other equipment, such as, but not limited to, air conditioners, air- purification units, humidifiers, allergy-free pillows, blanket, or mattress covers, exercising equipment, vibratory equipment, elevators, stethoscopes, clinical thermometers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds.

Prescription Drugs

Prescription drugs generally are covered under the prescription drug benefits. Injectable prescription drugs covered under the medical benefits are subject to the same limitations and exclusions listed under the prescription drug benefits.

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Prescription drug coverage for the WellSpan Medical Plan Option is provided by a Prescription Benefit Manager (PBM). See the section "Prescription Drug Benefits" for more information about prescription drug benefits.

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Routine Care

Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care or treatment of services not directly related to the diagnosis or treatment of a specific accidental injury, sickness, or pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically listed as covered under the heading "What is Covered."

Sales Tax

Any sales tax related to care, treatment, services, or supplies

Service Before or After Coverage

Care, treatment or supplies for which a charge was incurred before you or your dependent was covered under this Plan or after coverage ceased under this Plan.

Shipping and Handling

Any charges for shipping, handling, postage, interest, or financing charges.

Surgical Sterilization Reversal

Care and treatment for the reversal of surgical sterilization.

Tobacco Cessation

Care and treatment of tobacco cessation unless specifically listed as covered.

Travel or Accommodations

Charges for travel or accommodations, whether or not recommended by a physician, except for ambulance or other travel charges defined as a covered charge.

Treatment of self or immediate family

Professional services performed by a person who ordinarily resides in the covered person's home or is related to the covered person as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

Treatment of self or immediate family is not covered under the Plan. Exceptions will be granted for urgent or emergent prescription medication.

This exclusion includes but is not limited to writing prescriptions, ordering tests, performing procedures, or rendering any type of formal treatment.

Virtual PCP

Election of a WellSpan Online Primary Care Practice (available only through the Plus and Standard plan options) is paid for through a capitated arrangement with the provider. There is no patient responsibility.

Vitamins

Charges for vitamins, except those that require a prescription, are specifically listed as covered or are prescribed to treat a specific sickness or injury and are administered at the place where they are dispensed, such as a hospital or physician's office.

War

Any loss that is due to a declared or undeclared act of war.

Filing Claims

You do not need to file a claim when you use providers who are in the WellSpan Provider Network or Capital Blue Cross Network. Your network provider files them for you.

If you use out-of-network, you must file your own claim, or make sure the provider's office files one for you. Claim forms are available on the WellSpan Population Health Services website **(www.wellspanpophealth.com)** under Forms. You must attach an itemized bill for the services you received. The bill must include the:

- Plan name;
- Plan's group number (see your medical identification card);
- Employee's name;
- Patient's name;
- Identification number (see your medical identification card);
- Name, address and telephone number of the person or facility who provided the care;
- Tax Identification Number of the provider;
- Type of service provide, including diagnosis and procedure codes;
- Date the service was provide; and
- An itemized list of the charges.

Mail your completed claim form and itemized bill to:

Medical Claims Processing
P.O. Box 211457
Eagan, MN 55121-3057

All claims should be submitted as soon as possible. No claim will be paid when filed 12 months or more after the date of service unless it was not reasonably possible to submit the claim within that timeframe. Benefits are based on the Plan's provisions at the time the charges were incurred.

In addition, if information requested from a Plan member is not received within the timely filing period, the claim will not be paid. This includes requests for forms or documents.

The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the covered person. The Plan reserves the right to have a covered person seek a second opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish you with a written notice of this denial. The written notice will contain the following information:

- The specific reason or reasons for the denial;
- Specific reference to those Plan provisions on which the denial is based;
- A description of any additional information or materials necessary to correct the claim and an explanation as to why such material or information is necessary; and
- Appropriate information as to the steps to be taken if you wish to submit a claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator will send written notice of such extension to you. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim.

Release of Medical Records and Medical Reviews

Generally, medical or pharmacy information may be used without obtaining authorization or consent for purposes of claims payment and other health care or prescription drug operations required by the Plan. However, in some circumstances, an authorization for the release of medical records may be required. If this is required, you or your dependent may be asked to sign an authorization permitting the disclosure of medical records for this purpose.

Expenses Incurred Outside the United States

If you or a dependent incurs covered medical expenses outside the United States, you must pay the bill and then file a claim.

The claim must be translated into English and the charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount in U.S. dollars. When submitting the claim, you must also include a receipt showing that the bill was paid in full.

Claims Procedures and Appeals

This section describes the claim and appeal procedures for the Medical and Prescription Drug benefits along with Mental Health and Substance Use disorder benefits under the WellSpan Medical Plan Option.

A claim is defined as any request for a Plan benefit, made by you or your dependent or by an authorized representative that complies with the Plan's reasonable procedure for making benefit claims.

If a denied claim is submitted for external review, the Plan has authorized the Claims Administrator to submit to the Independent Review Organization (IRO) conducting the review.

The date on which WellSpan Population Health Services, Capital Rx, or Quest Behavioral Health received a claim will determine the claim's "receive date" by the Plan.

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It is important to understand that if you believe you need emergency medical care, you should not forgo that care because you believe that it will not be covered under the WellSpan Medical Plan Option.

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Wherever the terms "you" or "your" are used, they are meant to include you the employee and any dependents that are covered under the Plan.

Following is a description of how the Plan processes claims for benefits. The times listed are maximum times only. A period of time begins when it is received by WellSpan Population Health Services, Capital Rx, or Quest Behavioral Health.

Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of claims and each one has a specific timetable for approval, payment, request for further information, or denial of the claim. Contact WellSpan Population Health Services, Capital Rx, or Quest Behavioral Health with any questions about these procedures.

Eligibility and Enrollment Claims

All claims or disputes regarding eligibility and enrollment, including disputes relating to dependents removed from the Plan due to failure to provide proof of eligibility, must be submitted in writing to the Claims Administrator:

Medical and Prescription claims:	WellSpan Population Health Services PO Box 2347 York, PA 17405
Mental Health and Substance Use Disorder:	Quest Behavioral Health PO Box 1032 York, PA 17405

You will receive, within sixty (60) days of the appeal receipt, a written notification of the decision. If the claim is denied, in whole or in part, additional review rights will be included in the adverse benefit determination.

An internal appeal request must be sent, in writing to address above. This appeal should include any documentation supporting the claim for benefits.

Internal Claims Procedures

Under ERISA's claim procedures, there are three (3) types of claims:

- Post-Service Claims. Any claim for payment submitted after the service or supply was received and any other claim that is neither a pre-service claim nor a claim involving urgent care;
- Pre-Service Claims. Any claim for a benefit that, under the terms of the Plan, requires pre- certification, prior authorization, or pre-approval prior to receiving the service or supply; and
- Claims Involving Urgent Care. A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations: 1) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgement, or 2) could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or 3) in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

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Your Plan does not require the pre-certification or pre-approval of emergency or urgent care.

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The time period for deciding each type of claim and notifying the covered person of the decision differs based upon the type of the claim. The chart below provides the time frames for notification of the initial claim decisions, any possible extensions, and the time periods for the covered person to provide additional information if needed.

Within the time frames indicated on the chart, the covered person will receive either a:

- Written notice of the decision; or
- For post-service claims, a notice describing the need for additional time to reach a decision due to reasons beyond the control of the Plan;
- For pre-service claims, a notice describing that the claim was incorrectly filed and information about how to correctly file a claim, or notice describing the need for additional time to reach a decision due to reasons beyond the control of the Plan; or
- For a claim involving urgent care, notice that the claim was incomplete.

If additional time is needed, the notice will describe the reason(s) for the extension and the date by which the covered person can expect a decision.

If the claim is incomplete or additional information is needed, the notice will specifically describe the additional information needed to complete the claim. The covered person then will have the time period indicated in the fourth column of the chart to provide the specified additional information. The time between the date the notice is sent and the date the requested information is received from the covered

person will not count against the time period for deciding the claim.If the covered person fails to follow the procedures for submitting a pre-service claim, the covered person will be notified of the correct process for submitting a pre-service claim within 5 days after the incorrect claim is received. This notice may be provided orally unless the covered person requests written notification.

The time frames below are maximum times only. A period of time begins at the time it is received by WellSpan Population Health Services, Capital Rx, or Quest Behavioral Health. "Days" means calendar days.

Type of Claim	Deadline for Notifying Claimant of Initial Claim Determination	Extension to Deadline for Notifying Claimant of Initial Claim Determination	Type Period, if Any, for Claimant to Provide Additional Information
Post-Service Claim	30 days after receipt of the initial claim	15-day extension available	45 days after claimant receives notice of need for additional information
Pre-Service Claim	15 days after receipt of the initial claim. INCORRECTLY FILED CLAIMS – 5 days from the date the incorrect claim was received by a person regularly responsible for handling claims	15-day extension available	45 days after claimant receives notice of need for additional information
Claim Involving Urgent Care	No later than 24 hours (if the request to extend urgent concurrent care was less than 24 hours prior to the expiration of the previously approved treatments) after receipt of initial claim, taking into account the medical urgency	COMPLETE CLAIMS NOT APPLICABLE. INCOMPLETE CLAIMS – 48 hours after whichever is earlier; the date the claimant provides requested information OR 48-hour period for claimant to provide requested information	48 hours from the time Claimant receives notice of incomplete claim

If a claim is denied, in whole or in part, the covered person will receive a notification of adverse benefit determination, which includes:

- Specific information about the claim and reason(s) for the denial, in an easily understandable language;
- The Plan provision(s) on which the denial is based;
- An explanation of the right to request a peer-to-peer review;
- A statement indication whether an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the claim and information explaining the covered person's right to such information, free of charge;

- If the adverse benefit determination is based on medical necessity or investigational/experimental treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgement for the determination applied to the covered person's medical circumstances;
- For claims involving urgent care, a description of the expedited review process applicable to such claims;
- Description of the Plan's standard, if any, used in denying the claim (for example, if a medical necessity standard is used to deny the claim, the notice must describe the medical necessity standard)
- Description of available internal appeals and external review processes
- A statement of the covered person's right to file a civil action under section 502(a) of ERISA if his/her claim is denied upon a request for review (appeal); and
- Disclosure of availability of and contact information for any applicable office or health coverage consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist on internal claims, appeals and external review process.

The covered person will receive notice of approved claims as well as denied claims.

If a Claim is Denied

If your claim for benefits is denied, in whole or in part, you may call the WellSpan Population Health Services', Capital Rx, or Quest Behavioral Health Customer Service Department before requesting a formal appeal. Calling WellSpan Population Health Services, Capital Rx, or Quest Behavioral Health alone will not start the formal appeal process.

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The appeal must be submitted in writing and be sent to the Claims Administrator.

Medical claims:	**WellSpan Population Health Services** **Attention Appeals Department** **PO Box 2347** **York, PA 17405**
Prescription claims (denied by Capital Rx): **(Level 1 – internal)**	**Capital Rx** **Attention Appeals Department** **9450 SW Gemini Dr., #87234** **Beaverton, OR 97008**
Mental Health and Substance Use Disorder:	**Quest Behavioral Health** **PO Box 1032** **York, PA 17405**

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Request for Review (Appeal) of Adverse Benefit Determination

If an initial claim is denied, in whole or in part, and the covered person disagrees with the decision, he/she may request that the adverse benefit determination be reviewed. An adverse benefit determination is defined as:

- A denial, reduction, or termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit.

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A rescission of coverage is also an adverse benefit determination. See the heading "Special Rules for Claims Related to Rescissions" in this section for information on how to appeal a rescission.

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A covered person has 180 days from the date the adverse benefit determination is received to submit a request for review to the Claims Administrator. With the exception of a claim involving urgent care, all requests must be submitted in writing. Requests for review of adverse benefit determinations relating to claims involving urgent care may be made either orally or in writing.

An appeal for review may (but is not required to) include issues, comments, documents, records, and other information relating to the claim that is to be considered in reviewing the claim. The covered person may request reasonable access to, and copies of, all documents, records, and other information relevant to the adverse benefit determination. In reviewing the claim, the Plan will ensure that it is reviewed by individual(s) who were not involved in the initial adverse benefit determination. The Plan will not defer to the initial claim reviewer's decision and will look at the claim anew. If the adverse benefit determination was based upon medical judgement, a health care professional with the appropriate training and experience in the field of medicine involved will be consulted during the review of the claim. The individual will not have been involved in the initial adverse benefit determination (nor a subordinate of any person previously consulted). The covered person may request information regarding the titles and qualifications of any health care professional whose advice was obtained during the review of the claim.

The covered person may also review the claim file and present evidence and written testimony.

Please note that WellSpan Population Health Services or Quest Behavioral Health coordinate a single level of Internal review for medical reviews. WellSpan Population Health Services coordinates a two-level Internal review for prescription denials issued by Capital Rx.

Determination Upon Request for Review

The time period for deciding a request for review of an adverse benefit determination and notifying the covered person of such a decision depends upon the type of claim at issue. The chart below provides the time periods in which the Plan will notify the covered person of its decision for each type of claim. These time periods will not be extended by the Plan for any reason, except that the covered person voluntarily agrees to an extension request made by the Plan.

Medical, Mental Health, and Substance Abuse Claims	Deadline for Notifying Claimant of Request for Review Determination
Post-Service Claim	60 days after receipt of the request for review
Pre-Service Claim	30 days after receipt of the request for review
Claim Involving Urgent Care	No later than 72 hours after receipt of request for review, taking into account the medical urgency

Prescription Claims (issued by Capital Rx) – Level 1 (one)	Deadline for Notifying Claimant of Request for Review Determination
Post-Service Claim	30 days after receipt of the request for review
Pre-Service Claim	15 days after receipt of the request for review
Claim Involving Urgent Care	No later than 36 hours after receipt of request for review, taking into account the medical urgency

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If a Level 1 (one) Appeal is denied by Capital Rx, a covered person can request a Level 2 (two) Internal appeal by submitting the appeal request to WellSpan Population Health Services at the above address.

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Prescription Claims (issued by Capital Rx) – Level 2 (two)	Deadline for Notifying Claimant of Request for Review Determination
Post-Service Claim	30 days after receipt of the request for review (not to exceed 60 calendar days combined with internal review)
Pre-Service Claim	15 days after receipt of the request for review (not to exceed 30 calendar days combined with internal review)
Claim Involving Urgent Care	No later than 36 hours after receipt of request for review, taking into account the medical urgency (not to exceed 72 hours combined with internal review)

If upon review of the denial of the claim is upheld, in whole or in part, the covered person will receive a notice from the Plan which includes:

- Specific information about the claim and reason(s) the denial was upheld, in easily understandable language;
- The Plan provision(s) on which the denial is based;
- An explanation of the covered person's right to request reasonable access to and copies of the relevant documents, records, and information used in the claim process without charge;
- Will include a list of titles and qualifications, including specialties, of individuals participating in the appeal review;
- A description of any voluntary appeal procedures offered by the Plan (although currently the Plan does not have such voluntary procedures);
- A statement indicating whether an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the claim and information explaining the covered person's right to such information, free of charge;
- If the adverse benefit determination is based on medical necessity or investigational/experimental treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgement for the determination applied to the covered person's medical circumstances;

- Description of the Plan's standard, if any used in denying the claim (for example, if a medical necessity standard is used to deny the claim, the notice must describe the medical necessity standard);
- Discussion of the decision;
- Description of the external review process and procedures;
- A statement of the covered person's right to file a civil action under section 502(a) of ERISA if the claim is denied upon request for review (appeal); and
- Disclosure of availability of and contact information for any applicable office or health coverage consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist in internal claims, appeals and external review process.

The covered person will receive notice of approved claims as well as denied claims.

Special Rules for Concurrent Care Decisions Claims

Concurrent care decisions claims are claims that relate to a previously approved period of time or number of treatments for an ongoing course of medical treatment.

If the covered person requests an extension of a previously approved period of time or number of treatments and the claim involves urgent care, the Plan will decide the claim and notify the covered person of its decision within 24 after receipt of the request, provided the claim is filed at least 24 hours prior to the end of the approved time period or number of treatments. The organization may treat the request as urgent pre-service and send a decision notification within 72 hours. If the claim is not filed at least 24 hours prior to the end of the approved treatment, the claim will be treated as and decided within the time frames for a claim involving urgent care as described under the heading "Initial Claim Determination" earlier in this section. If the claim does not involve urgent care, then the time periods for deciding pre-service and post-service claims, as applicable, will govern.

If there is a reduction in or termination of the ongoing course or treatment for which the covered person received prior approval (for reasons other than amendment or termination of the Plan), the Plan will notify the covered person. This reduction or termination of an ongoing course of treatment will be considered an adverse benefit determination. The covered person will receive notice in advance of the date the reduction of termination will occur so that he/she has sufficient opportunity to appeal the decision before the reduction or termination occurs. If the covered person appeals the reduction or termination of his/her ongoing course of treatment, the reduction or termination will not occur before a final decision is made on his/her appeal. If the covered person disagrees with the reduction or termination, he/she should follow the procedures described previously for requesting a review of an adverse benefit determination. The time periods that will apply to the request will depend on the nature of the concurrent care decision (for example, urgent, pre-service, and post-service).

for example, urgent, pre-service, and post-service).

Special Rules for Claims Related to Rescissions

A rescission is a retroactive termination of coverage. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan (See the heading "Misrepresentations" under the section "Administrative Information" for more information).

However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage at time. A prospective termination of coverage is not a rescission. If coverage is going to be rescinded, the covered person will receive a written notice thirty (30) days before the coverage will be cancelled. A rescission will be considered an adverse benefit determination. The covered person will then have the opportunity to appeal the rescission as described under the heading "Request for Review of Adverse Benefit Determination" earlier in this section. Appeals of rescissions should be submitted (in writing) to WellSpan Population Health Service or Quest Behavioral Health.

The Plan will decide all appeals for rescissions.

External Appeal Process

If, upon review, the covered person's claim is still denied, and the covered person disagrees with the Plan's decision, he/she may submit claim to the external appeal process described below. This step is not mandatory. Additionally, if a denial, reduction, termination, or refusal to provide payment for a benefit is based on a determination that an individual is not eligible under the Plan or the claim denial did not have a medical component, no external review is available.

In most circumstances, before an appeal for external review can be requested, the covered person must first follow the claim procedures outlined above by filing an initial claim and a request for review of an adverse benefit determination with the Claims Administrator. However, in certain circumstances (described below), the covered person may receive an expedited external review. In this case, the covered person may not have to exhaust the internal claim process before filling a request for external review.

Within 4 months of the date the covered person received the notice, that upon review, the claim continues to be denied, the covered person may submit request an external review of the claim by writing the Claims Administrator.

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The request for external review must be submitted in writing and be sent to the Claims Administrator.

Medical and Prescription claims:	**WellSpan Population Health Services** **Attention Appeals Department** **PO Box 2347** **York, PA 17405**
Mental Health and Substance Use Disorder:	**Quest Behavioral Health** **PO Box 1032** **York, PA 17405**

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The written external appeal may (but is not required to) include issues, comments, documents, records, and other information relating to the claim that the covered person wants considered in reviewing the claim.

Appeals regarding network usage are not available for external review because they are based on contracts terms and not medically based decisions.

Under the following circumstances, the covered person can request an expedited external review:

- If the covered person received an initial claim determination that denied the claim, the covered person may request expedited external review if he/she filed a request for a claim involving urgent care and time for completing the internal review process would seriously jeopardize life, health, or ability to regain maximum function; or

- If the covered person appealed the initial claim denial and received a final internal claim denial and the time for completing the external review process would seriously jeopardize life, health, or ability to regain maximum function or the denial of the internal appeal concerned the admission, availability of care, continued stay, or health care item or service for which the covered person received emergency services, but the covered person has not been discharged from a facility.

If the Plan considers, relies upon, or generates new or additional evidence in connection with its review of the claim, the covered person will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to the covered person (see the chart under the heading "Determination Upon Request for Review" below) so that the covered person will have an opportunity to respond.

If the Plan relies on a new or additional rationale in denying the claim on review, the covered person will be provided with the new or additional rationale as soon as possible and with enough time before a final determination is required to be provided (see the chart under the heading "Determination Upon Request for Review" below) so that the covered person will have an opportunity to respond.

Preliminary Review of Standard (Not Expedited) External Claims

Within 5 days of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine if the claim is eligible for external review. The covered person's claim is eligible for external review if:

- The covered person is or was covered under the Plan when the item or service was requested or provided;
- The claim or appeal denial does not relate to the covered person's failure to meet the Plan's eligibility requirements;
- The covered person has exhausted the internal appeal process (unless he/she is not required to exhaust the internal claim procedures); and,
- The covered person provided all information required to process an external review.

Within 1 business day after completion of the preliminary review, the Claims Administrator will notify the covered person in writing whether the claim is eligible for external review. If the request was not complete, the notice will describe information or materials needed to complete the request.

The covered person will have until the end of the 4-month period he/she had a file a request for an external review or 48 hours (whichever is later) to complete the request. If the request is complete but not eligible for external review, the notice will include the reason(s) the request was ineligible and contact information for the Employee Benefits Security Administration (EBSA).

External Review Process

If the Claims Administrator determines that the claim is eligible for external review, the claim will be assigned to an Independent Review Organization (IRO). The IRO will notify the covered person that the claim is eligible for external review and that the review process is beginning. The notice will also inform the covered person that he/she has 10 business days following receipt of the notice to provide additional information to the IRO for it to consider.

The IRO will not defer to the decisions made during the internal review process and will look at the claim anew. The IRO will consider all the information and documents that it receives in a timely manner when making its decision.

The IRO and/or the Plan Administrator will provide written notice of the final external review decision within 45 days after it receives the request for external review.

If the IRO reverses the Plan's denial of the claim, the decision will be final, and the Plan must immediately provide coverage or payment.

Expedited External Review Process

In general, the same rules that apply to standard external review apply to expedited review, except that the time frame for decisions and notifications are shorter.

The Claims Administrator will immediately conduct a preliminary review to determine if the claim is eligible for external review. After the preliminary review is completed, the Claims Administrator will immediately notify the covered person of its determination. If the request was not complete, the notice will describe information or materials needed to complete the request. The covered person will have until the end of the 4-month period he/she had to file a request for an external review or 48 hours (whichever is later) to complete the request.

If the claim is eligible for expedited external review, the claim will be assigned to an Independent Review Organization (IRO). Expedited review determination is made including member and practitioner notification within seventy-two (72) hours after receipt of the request. Oral notification is provided within seventy-two (72) hours of the receipt of the request to a live person, with written notification following the oral decision within three (3) calendar days.

General Rules

These general rules apply to the Plan's reasonable claim and appeal procedures:

- The initial claim, any request for review of adverse benefit determination and any request for external appeal must be made in writing, except for request for review of adverse benefit determinations relating to claims involving urgent care, which may also be made orally
- The covered person must follow the claim and review procedures contained in this Plan Document carefully and completely and he/she must file a claim before any applicable deadlines. If this is not done, the covered person may give up important legal rights
- A covered person's casual inquires, and questions will not be treated as claims or requests for a review or submissions to the external appeal process
- The covered person may have a lawyer or other authorized representative help with the claim at his/her own expense (the Plan will require written authorization to verify that an individual has been authorized to act on the covered person's behalf except that for a claim involving urgent care, a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative)
- The covered person is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any adverse benefit determination. The covered person will also be allowed to review the claims file and present evidence and written testimony as part of the internal claim and appeal process; and
- The covered person must comply with any additional requirements for filing a claim (for example, completing forms and following claim filing deadlines) imposed by the Plan.

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Who Is the Plan Administrator?

The Plan Administrator is the formally identified Plan Fiduciary and has the responsibility for final Plan determinations. The Plan Administrator manages the Plan on a day-to-day basis and answers questions about Plan details. The Plan Administrator for the WellSpan Medical Plan is WellSpan Health. The Claims Administrator is responsible for claims processing and other administrative duties related to the Plan. For more information about the Plan Administrator, see the sections "Administrative Information" and "Terms You Should Know."

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Plan's Failure to Follow Procedures

If the WellSpan Medical Plan fails to follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claims.

Exhaustion of Administrative Remedies

The exhaustion of the claim and review procedure (with the exception of the external claim review process) is mandatory for resolving every claim and dispute arising under this Plan prior to initiating legal action. In any legal action brought after the covered person has exhausted the administrative remedies, all determinations made by the Plan shall be afforded the maximum deference permitted by law.

For More Information

For more information about covered benefits and services for Medical and Prescription under this Plan, please contact WellSpan Population Health Services at (800) 842-1768 or (717) 851- 6800. You may also visit the WellSpan Population Health Service website at www.wellspanpophealth.com or the WellSpan Health web site at https://hr.wellspan.org under "My WellSpan Benefits."

For more information about covered benefits and services for Mental Health and Substance Use Disorder under this Plan, please contact Quest Behavioral Health Services at (800) 364- 6352. You may also visit the Quest Behavioral Health web site at www.questbh.com.

About Your Prescription Drug Coverage

When you are an ***active employee*** and you enroll in one of the WellSpan medical plan options, you automatically receive ***prescription drug*** coverage.

Prescription Drugs Through the Prescription Benefit manager (PBM)

The WellSpan Medical Plan has contracted with a Prescription Benefit Manager (PBM) to administer the ***prescription drug*** benefits. The Prescription Benefit manager takes advantage of a ***network*** of participating ***pharmacies***, allowing you to purchase ***prescription drugs*** for a per-prescription co-payment or co-insurance.

Mail order prescription benefits are also included in the ***prescription drug*** benefit program. It is also important to remember that certain ***prescription drugs*** must be ***pre-authorized*** and that certain specialty drug prescriptions can only be filled at a WellSpan Pharmacy!

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The PBM and *Claims Administrator* for the WellSpan Health *prescription drug* benefits is Capital Rx. The *Plan* uses the Capital Rx Liberty (closed) Formulary. This *formulary* is subject to change throughout the year. Copies of the *formulary* may be requested by calling (844) 265-1734 for the most recent copy.

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Prescription Drugs Formulary

The ***prescription drug*** coverage uses a closed ***prescription drug formulary***, which means the level of benefits is based on whether the ***prescription drug*** is ***generic***, ***brand-name formulary***, or ***brand-name*** non-***formulary***.

Generic drugs are those ***prescription drugs*** that have the same bioequivalence as the ***brand- name drug***, but they are not manufactured under a registered ***brand-name*** or trademark.

Brand-name formulary drugs are those ***prescription drugs*** that have been reviewed for, clinical efficacy, quality and cost effectiveness and are preferred by the PBM and ***Plan***, when appropriate. ***Brand-name formulary*** drugs are subject to periodic review and modification by the PBM.

Brand-name non-***formulary*** drugs are those ***prescription drugs*** which have not been chosen by the PBM to be a preferred ***brand-name drug***.

You are not required to have a prescription filled with a drug on the ***formulary*** list. However, you will pay more for ***brand-name drugs*** that are not on the ***formulary*** list. The ***formulary*** incudes a broad- based group of common class drugs, and you should find most of your medications on the list.

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Some drugs are not included in the *formulary* at all. This means that there is no coverage under the *Plan* for these *prescription drugs*. However, the *formulary* does include medically similar alternatives. It is important that you discuss these alternatives with your *provider*. For more information about what drugs are covered under the *formulary*, call Capital Rx at (844-306-5008) or visit the Capital Rx web site at www.cap-rx.com.

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If you have any questions about a particular drug, please call Capital Rx's number found on your medical identification card. You may also view the current formulary on the Capital Rx web site or on the WellSpan Health web site at https://hr.wellspan.org under "My WellSpan Benefits."

Specialty Prescription Drug Benefit

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Specialty drugs must be obtained through a WellSpan Pharmacy. This does not include drugs supplied or administered by your physician in his/her office. WellSpan Pharmacy will fill your prescription through their Fairfield, PA location. A one-time emergency fill of these medications is allowed at a non-WellSpan pharmacy for emergency situations when dispensing by a WellSpan Pharmacy is not possible.

Call WellSpan Population Health Services' Customer Service Department at (800) 842-1768 or (717) 851-6800 for the list of specialty prescription drugs. To have your prescription drug filled at WellSpan Pharmacy/Fairfield, call them at (855) 339-2305 and your specialty support team will assist you.

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Specialty prescription drugs treat chronic and complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. These drugs require frequent dosing adjustments, intensive clinical monitoring, patient training, and specialized handling. They may also require specialized administration, such as an injection.

Using the Prescription Benefit Manage Network Pharmacies

When you enroll for medical coverage, you will receive a medical identification card with the Capital Rx logo printed on it. Keep this card with you so that you can show it to your participating pharmacy when you purchase prescription drugs.

When you need a prescription filled, you can go to either a WellSpan Health pharmacy or another pharmacy that participates with Capital Rx (all WellSpan Health pharmacies participate with Capital Rx). You may receive up to a 34-day supply at a pharmacy. When you use a WellSpan Health pharmacy, you can reduce your out-of-pocket expenses and receive up to a 100-day supply for maintenance drugs. **All Maintenance medications MUST be filled at a WellSpan Pharmacy. The Plan is allowing a transition period of two (2) 30-day fills at a non-WellSpan pharmacy**. Most other pharmacies nationwide – including Wal- Mart and Giant – are members of the Capital Rx network. You may contact WellSpan Population Health Service or visit the Capital Rx website for information on how to find a list of participating pharmacies.

If you need to use a pharmacy that is not part of the network – or you forget your medical identification card at a network pharmacy – you will need to pay the full retail cost of the drug and file a claim for reimbursement. In this case, you will be reimbursed according to the negotiated discount price of the drug rather than the retail price. Contact WellSpan Health Human Resources or WellSpan Population Health Services for information on how to obtain a claim form.

You must use the WellSpan Pharmacy for maintenance medications. You may receive up to a 100-day supply. Filled prescriptions are mailed by first class postage or another package delivery service. Allow up to 14 days for delivery from the date the order is mailed from the WellSpan Pharmacy.

For more information about the mail order option, call WellSpan Pharmacy at (855) 339-2305.

Your Out-of-Pocket Costs

Your out-of-pocket costs depend on which pharmacy you use:

- If you use a WellSpan Health pharmacy, your cost is your copayment; or
- If you use a network PBM provider or an out-of-network provider, your out-of-pocket costs will include your co-insurance.

Your out-of-pocket costs also depends on the type of prescription drug you receive:

- If you use generic drugs, your only cost is your co-payment or co-insurance;
- If you use brand-name formulary drugs, you are responsible for a higher co-payment or higher co-insurance. If a generic drug was available, you will also be responsible for any amount over the cost of the generic drug – even if your physician's prescription states "dispense as written" or "brand medically necessary"; or
- If you use brand-name non-formulary drugs, you are responsible for the highest co-payments and co-insurance. If a generic drug was available, you will also be responsible for any amount over the cost of the generic drug – even if your physician's prescription states, "dispense as written" or "brand medically necessary".

Co-payments

When you have a prescription filled at a WellSpan Health pharmacy or use the WellSpan Pharmacy mail order program, you may be responsible for the co-payment. The amount of the co-payment depends on the type of drug you receive.

Co-Insurance

Co-insurance refers to the percentage you pay for covered prescription drug expenses when you have a prescription filled at a non-WellSpan Health pharmacy. The amount of the co- insurance depends on the type of drug you receive.

Out-of-Pocket Maximum

To protect you and your family from the cost of a catastrophic sickness or injury, the WellSpan Medical Plan prescription drug benefits have a calendar year out-of-pocket maximum. This means the amount you pay each calendar year for prescription drug covered expenses is limited.

Amounts applied to your out-of-pocket maximums accumulate across the Enhanced and Core Tiers. For example, amounts applied to the Core Tier out-of-pocket are also credited under the Enhanced Tier out-of-pocket maximum.

There is no out-of-pocket maximum for Out-of-Network.

Once an annual out-of-pocket maximum has been reached with the calendar year, the Plan will pay 100% of covered charges for the remainder of the calendar year, under that tier, subject to any benefit limitations.

Certain expenses do not count toward an out-of-pocket maximum, including:

- Your Plan contributions
- Expenses over the Plan Allowance
- Any amount in excess of the generic drug cost when you receive a brand-name formulary or brand- name non-formulary;
- Amounts covered by medication co-payment cards or Patient Assistance Programs; and
- Services that the Plan does not cover.

Out-of-pocket maximums accrued under the prescription drug benefits are not combined with the medical benefits and mental health and substance use disorder benefits but are separate.

Prescription Drug Management

Pre-Authorization of Drugs

Capital Rx and WellSpan Population Health Service monitor the utilization of specific drugs for patient safety as well as for appropriate care.

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This list of drugs that require pre-authorization and how the pre-authorization process works, contact Capital Rx at (844) 265-1734. If these drugs are not pre-authorized, you may not be able to have your prescription filled.

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Medical Review and Pre-Certification of Injectable Drugs

You or your network physician is responsible for per-certification with WellSpan Population Health Services' Customer Service Department (the contact information is on the back of your medical identification card) when your physician:

- Prescribes certain injectable prescription drugs. This includes injectable drug prescriptions filled at a pharmacy or billed to you by your physicians or by another pharmaceutical provider, or
- Administers certain injectable prescription drugs to you on an outpatient basis.

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The list of injectable and select oral drugs that requires pre-certification can change periodically. To find out which injectable drugs require pre-certification and how the pre-certification process works, contact WellSpan Population Health Services' Customer Service Department at (800) 842-1768 or (717) 851-6800 or visit the WellSpan Health website https://hr.wellspan.org. **If the prescribing physician is not a network provider, you are responsible for pre-certifying. If you do not pre-certify these drugs, your benefits may be reduced.**

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You and your physician will receive a letter from WellSpan Population Health Services acknowledging pre-certification. The length of any pre-certification approval will be included in this letter and will vary depending on the drug being used and/or why this drug was prescribed for you. This means that if you physician wants you to continue using this injectable drug beyond the date specified in the letter, a new pre-certification will be required.

When you or your physician calls WellSpan Population Health Service to pre-certify, the following information will be necessary:

- The name of the drug
- The name of the physician who ordered the drug; and
- The diagnosis.

It is especially important that you call to pre-certify whenever you are given injectable drugs as part of a "clinical trial", as these drugs may not be covered by the Plan.

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Penalties for Not Calling

If you receive certain injectable prescription drugs and do not pre-certify when required, your benefit under the Plan will be reduced by $250. This is called a pre-certification penalty. For example, if the Plan would normally pay $1,000 for coved charges, it would only pay $750 if you don't follow the pre- certification procedure. You are not required to pre-certify, and will not be penalized, when receiving emergency treatment.

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Step Therapy

Certain prescription drugs covered under the Prescription Plan will be subject to Step therapy Management. This is a medication management process which requires starting with the most proven, safest, and cost-effective medications prior to stepping up to newer and possible more expensive mediations. Convenience alone does not constitute a reason for stepping-up to another drug.

Specific Medications

Certain prescription drugs must be obtained through the Prescription Drug Plan and will not be available under the medical portion of the Plan. These medications are included in classes of drugs that are already available through the Prescription Plan.

A list of these medication, which is subject to change during the year, will be available on the INET at HRONLINE.

Quantity Level Limits (QLL)

Some prescription drugs may be subject to the Quantity Level Limits (QLL) program such as quantity and duration. QLL will determine the monthly drug dosage and/or the number of months the drug usage is usually needed to treat a particular condition.

QLL makes sure that the needed medication received is considered safe and is the quantity recommended by the drug manufacturer, the U.S. Food & Drug Administration (FDA) and clinical studies.

This is how the program works. At the pharmacy, you may be told that a refill has been requested too soon; that is, some medication should still be on hand. In this case, ask the pharmacist when the prescription can be refilled. If the prescription is written for a larger amount than the Plan covers:

- You may ask the pharmacist to dispense the amount covered by the Plan. You will be responsible for the appropriate co-payment or co-insurance.
- The pharmacist may ask the prescribing physician to change the prescription to a higher strength when one is available. For example, taking one 40 mg pill instead of two 20 mg pill. In this way, the Plan's quantity limit is met, and fewer co-payments of less co-insurance may need; or
- You may ask the pharmacist to dispense the full amount of the prescription. You will be responsible for the appropriate co-payment or co-insurance as well as the cost of any amount of the medication in excess of what is covered by the Plan.

An Example of How the Prescription Benefits Are Calculated (Plus Option example)

Here's an example that will show you how benefits are calculated. Let's assume you've gone to non-WellSpan Health pharmacy. If you need a prescription that will cost $50 for the generic version, $100 for the brand-name formulary version, and $150 for the brand-name non- formulary version of the drug, your costs would be calculated as follows:

	Generic	Formulary Brand-	Non-Formulary
Cost	$50.00	$100.00	$150.00
20% co-insurance	$10.00		
plus cost difference	$ 0.00		
35% co-insurance		$35.00	
plus cost difference		$50.00	
50% co-insurance			$75.00
plus cost difference			$100.00
Your Cost	**$10.00**	**85.00**	**$150.00(drug total cost)**

Benefit Limitation

The covered prescription drug charge for any one prescription will be limited to refills:

- Only up to the number of times specified by the prescribing physician; and
- Up to the time period permitted by law, but not more than one year from the date of order by the prescribing physician.

What is Covered?

To find if a particular prescription drug is covered or not covered by the Plan, call the Capital Rx Member Services Support phone number at (844) 265-1734 or visit Optum Rx's web site www.cap-rx.com. Any amount in excess of the prescription drug benefits (such as co- payments or co-insurance) is not generally covered under the medical benefits. Any expenses incurred under the prescription drug benefits do not apply towards the medical benefit deductible or out-of-pocket maximum.

Covered prescription drugs, medicines, or medications must be:

- Prescribed by a physician for treatment of a sickness or injury;
- Medically necessary; and
- Dispensed by a pharmacist.

Prescription Drug Schedule of Benefits

When you and your dependents are enrolled in the WellSpan Health Plan, you receive the prescription drug benefits outlined below. Remember, certain drugs require pre-authorization or pre-certification or can only be filled at a WellSpan Pharmacy!

*Capital Rx cannot process some drugs, devices, or aids – or cannot process it with a $0 co-payment. In those cases, a claim for an item or a claim for the Plan's Prescription Drug Plan co-payment/coinsurance must be submitted to the Medical Plan along with a physician prescription. See the section Covered Prescription Drugs for more information about this Plan benefit.

Covered Prescription Drugs

Covered prescription drugs include:

- Anti-neoplastic agents (oral and injectable);
- Anti-rejection drugs;
- Compounded medications as per the terms of the compounded Management Program;
- Contraceptive drugs and devices for women, including oral contraceptives, injectables, emergency contraceptives, devices, and *over-the counter* devices and drugs (requires a *physician's* prescription). Items may be covered under the Medical Plan if Capital Rx is unable to process the item at the $0 co-payment level;
- Diabetes supplies, including but not limited to, syringes, needles, swabs, blood monitors and kits, blood test strips, blood glucose calibration solutions, urine tests, lancets, and lancet devices;
- Depigmentation products used for skin conditions requiring a bleaching agent;
- Desi Drugs;
- Growth hormones - prior authorization is required;
- Immunizations for Adults or Children as recommended by the Centers for Disease Control
- Impotence drugs, limited to oral drugs;
- Injectable drugs and necessary syringes;
- Insulin;
- Iron supplements up to age one (1);
- Legend diagnostic testing and imaging supplies;
- Legend drugs, referring to medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to near the legend: "Caution: Federal law prohibits dispensing without prescription";
- Medications required to be covered under the Accountable Care Act (ACA);
- Ostomy supplies, including but not limited to, bags, wafers, deodorizers, clips, adhesive, and tape;
- Pediatric fluoride;
- Respiratory therapy supplies, such as aero chambers and spacers and peak flow meters;
- Tobacco cessation medications and products, including drugs and *over-the-counter* cessation aids (requires a *physician's* prescription). Items and drugs may be covered, or the Prescription Drug Plan co-payment may be covered under the Medical Plan if Capital Rx is unable to process the drug or item at the $0 co-payment level;
- Vitamins, limited to prenatal vitamins, therapeutic agents used for specific deficiencies and conditions; and,
- Other drugs which, under the applicable state law, may only be dispensed upon the written prescription of a qualified prescriber.

What Is Not Covered?

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Other exclusions and limitations are found in the medical plan section of this guide and apply to the prescription drug plan benefits unless they are specifically listed as covered.

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Administration

Any charge for the administration of a covered prescription drug

Adult Fluoride

Any charge for adult fluoride, regardless of reason

Consumed on Premises

Any charge for a drug or medication that is not purchased through a pharmacy and is consumed or administered at the place where it is dispensed.

Cosmetic Agents

Any charge for a drug or medication used for cosmetic reasons, unless related to restoring bodily function or to correct deformity resulting from sickness, trauma, congenital or developmental anomalies, or is for repair of damage from an accidental injury.

Excess Supply

Any portion of a prescription or refill that exceeds the:

- Day or Unit supply limit;
- Drug specific dispensing limit if any;
- Any drug specific age limit, if any; and
- Duration specific limit, if applicable.

Experimental and/or Investigational

Any drug, medication, or device that is either experimental/investigational or is not medically necessary.

The Plan Administrator has the sole discretion to determine what services and treatment are considered to be experimental, investigational, or medically necessary.

Fraudulent Use

Any fraudulent misuse of this benefit including prescription drugs purchased for consumption by someone other than for whom it was prescribed.

Gene Therapy

Any technique that modifies a person's genes via drug.

Hair Growth Agents

Drugs used to stimulate hair growth or eliminate baldness.

Homeopathic Legend Medications

Any homeopathic drug, supplement, or medication, regardless of reason or prescription.

Immunization Agents, Biological Sera and Blood Products

Administered on an outpatient basis.

Impotence

Any drug used to treat impotence, except those listed as covered.

Infertility

Any fertility drug, medication, or device. Refer to your medical plan option for possible benefits.

Inpatient

Prescription drugs that are to be taken by or administered to the patient, in whole or in part, while the patient is in a facility where drugs are ordinarily provided by the facility on an inpatient basis.

Lost or Wasted Medication

Lost or wasted medication will not be covered under this Plan except in limited cases. The Plan may require proof such as a police report, to support lost or stolen medication.

Medical Foods

Medical Foods are excluded from coverage (includes prescription vitamins/herbals not FDA approved)

Multiple Prescriptions

Multiple fills for the same drug or therapeutic equivalent medication prescribed by one or more physicians and dispensed by one or more retail pharmacies. This exclusion does not apply when referring a prescription according to Quantity Level Limits (QLL).

No Charge

Any charge for prescription drugs that may be properly received without charge under local, state, or federal programs.

No Prescription

Drugs, medicines, or medications that are lawfully obtainable without a prescription (over- the-counter), expect as listed as covered.

Not Medically Necessary

Legend drugs which are not recommended by a physician and/or not deemed to be medically necessary.

Nutritional Therapy

Any prescription directing enteral or parenteral administration of nutritional therapy.

Outside of the United States
Medications obtained outside of the United States are not covered under this Plan.

Over-The-Counter
Except as otherwise listed as covered.

Shipping and Handling
Any costs related to the mailing, sending or delivery of prescription drugs.

Therapeutic Devices, Appliances or Supplies
Except those items specifically listed as covered under the prescription drug benefits.

Unit Dosage Medications
Any drug packaged in unit doses (such as a "blister pack") that is prescribed as such for the convenience of the patient.

Vitamin and Dietary Supplements
Except those listed as specifically covered under the heading "What Is Covered".

Weight Loss
Any brand name drug used for weight loss, including those used to suppress appetite or control fat absorption.

- Brand name medications are not covered.

Filing Claims
If you use your medical identification card at network pharmacies, you do not need to file claims. Simply pay your share of the cost, and the PBM takes care of the rest.

Keep in mind that most pharmacies nationwide are part of the Prescription Benefit Manager network. However, if you need to us a pharmacy that is not part of the network – or you forgot your medical identification card – you will need to file a claim for reimbursement. In this case, you will pay the full retail cost of the drug up front and be reimbursed according to the negotiated discounted price of the drug rather than the retail price. Claim forms are available from WellSpan Health Human Resources or WellSpan Population Health Services.

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For important information on claims and appealing denied claims, see the headings "Claims Procedures" and "Appeal Procedures" under your medical plan option section of this guide.

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For more information about covered benefits and services under this Plan, please contact Capital Rx at (844)265-1734. You may also visit the Capital Rx web site at www.cap-rx.com.

About Quest Behavioral Health

When you enroll in any of the medical plan options offered by WellSpan Health, you automatically receive behavioral health benefits for mental health and substance use disorder care through Quest Behavioral Health. Quest offers an affordably priced network of state- licensed mental health providers and certified addictions counselors to help you with you or your family's specific needs.

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It is important to understand that if you choose an out-of-network provider for your care, you will pay a substantially larger part of the cost for that care.

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The Quest Behavioral Health network includes:

- Hospitals with inpatient psychiatric programs, some of which have inpatient services for children and adolescents; and
- Residential facilities providing inpatient substance use disorder services.

The Quest network also includes outpatient services provided by licensed specialists, including but not limited to:

- Psychologists and psychiatrists;
- Clinical social workers and professional counselors;
- Marriage and family therapists; and
- Certified addictions counselors.

Office visits for eligible mental health or substance use disorder services not provided by one of these specialists (for example, services provided by a family physician or pediatrician) may be covered under the medical plan option in which you are enrolled.

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Who is the Plan Administrator?

The Plan Administrator is the formally identified Plan Fiduciary and has the responsibility for final Plan determinations. The Plan Administrator manages the Plan on a day-to-day basis. The Plan Administrator for the WellSpan Medical Plan is WellSpan Health. The Claims Administrator is responsible for claims processing and other administrative duties related to the Plan, including assisting covered persons with claims and benefit issues. For more information about the Plan Administrator, see the sections "Administrative Information" and "Terms You Should Know

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How the Program Works

Trained and experienced Quest Behavioral Health staff is available 24 hours a day, seven days a week through a toll-free telephone number. To access your benefits through Quest for mental health or substance use disorder services, call the toll-free number listed below to speak with a Quest staff member. The Quest staff member will recommend the most appropriate service and direct you to a network provider to set up an appointment. Quest will follow up with your provider to ensure that you are receiving quality care. Contact Quest if you want to know if a provider or facility is in the network. You may also visit the Quest Behavioral Health website, www.questbh.com, for information about the network.

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In order to receive the best level of benefits for mental health or substance use disorder services through your Quest benefits, you or your provider must call the Quest toll-free number at (800) 364-6352. This ensures that you are receiving benefits from a network provider. You must pre-certify all non-emergency inpatient, intensive outpatient, partial hospitalization, psychological testing, residential services, Autism services, electroconvulsive therapy (ECT) services and Transcranial Magnetic Stimulation (TMS) services. If you do not pre- certify these services when provided by an out-of-network provider, you will have to pay a $250 penalty and benefits may be affected. If you are admitted as an inpatient on an emergency basis, you must notify Quest within 2 business days of the admission. There is no penalty for not pre-certifying urgent or emergency services.

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You must contact Quest directly when using an out-of-network provider for mental health and substance use disorder services. You will be responsible for submitting claims to Quest for those services.

The Quest Behavioral Health address and toll-free number is:

Quest Behavioral Health
PO Box 1032
York, PA 17405
(800) 364-6352

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When you receive your services from a WellSpan Network provider, your visit will be covered 100% after any required deductibles, co-payments or co-insurance. When you receive your services from a Quest Network provider that is not a WellSpan provider, your costs will be subject to your deductible, co-payments, and co-insurance. If you receive services from an out-of-network provider, your costs will include co-payments, an annual deductible and co- insurance. You will also be responsible for all costs over the Plan Allowance charge that a provider is reimbursed for the service.

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Out-of-Network Benefits

If you or your covered dependent permanently resides outside the Quest network service area, and you have a preferred provider in mind for mental health or substance use disorder services, the Quest staff may call the provider to attempt to negotiate a better rate for you. However, this treatment will still be considered out-of-network and you will still be responsible for the deductible, co-payment, co-insurance and any balance-billing the provider does. If you do not have a preferred provider, Quest staff will identify a potential provider using available resources.

If you reside within the Quest network service area but choose to go to an out-of-network facility or provider, you are responsible for the deductible, co-payments, co-insurance, and any balance over the Plan Allowance.

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You are responsible for pre-certifying services for out-of-network providers. If you do not pre-certify all non-emergency inpatient, intensive outpatient, partial hospitalization, electroconvulsive therapy services, autism services, residential services, psychological testing and Transcranial Magnetic Stimulation services, you will have to pay a $250 penalty and benefits may be affected. If you are admitted as an inpatient on an emergency basis, you must notify Quest within 2 business days of the admission. There is no penalty for not pre-certifying urgent or emergency services.

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Your Out-Of-Pocket Costs

Your out-of-pocket costs depend on the provider you see:

- If you use WellSpan Provider Network providers, your out-of-pocket costs include an annual deductible, co-payments, and co-insurance; or
- If you use Quest Network providers, your out-of-pocket costs include an annual deductible, co- payments, and co-insurance; or
- If you use out-of-network providers, your out-of-pocket costs include an annual deductible, co- payments, co-insurance, and any expenses that exceed the Plan Allowance.

Annual Deductible

A deductible is an amount you pay each year before benefits are paid. Each deductible must be met separately. These deductibles are listed in the Schedule of Benefits.

Deductibles applied under the mental health and substance use disorder benefits and the medical

benefits are combined, according to each benefit tier.

Co-Payments

A co-payment is a dollar amount that you must pay for certain services. Each time the service is received, it requires a new co-payment. Co-payments apply towards the out-of-pocket limit and cease when the out-of-pocket maximum is reached.

Under the WellSpan Medical Plan, co-payments are generally required for office visits, the emergency department, for certain facility charges, and therapies. Co-payment amounts vary dependent on the benefit tier and type of provider.

Co-Insurance

Co-insurance refers to the percentage you pay for covered services.

- If you use WellSpan Provider Network providers, your coverage pays a percentage after the deductible and co-payment is met;
- If you use Quest Network providers, your coverage pays a percentage for outpatient services and inpatient care, after the deductible and co-payment is met; and
- If you use out-of-network providers, please refer to "Behavioral Health Grid Appendix 3" in the front of this document. However, you will also be responsible for any amount over the Plan Allowance.

Out-of-Pocket Maximum

To protect you and your family from the cost of catastrophic claims, the Plan has calendar year out-of-pocket maximums. This means the amount you pay each calendar year for covered expenses is limited. Your out- of-pocket is the amount for which you are responsible after the Plan pays its normal co-insurance.

Amounts applied to your out-of-pocket maximums accumulate across the WellSpan medical and Quest Networks. Services received from WellSpan Provider Network providers and Quest Network providers both are credited towards the same out-of-pocket maximum.

The out-of-pocket maximum for out-of-network services is separate and does not accumulate with the network out-of-pocket.

Once an annual out-of-pocket maximum has been reached within the calendar year, the Plan will pay 100% of covered charges for the remainder of the calendar year, under that benefit level, subject to any

limitations.

Certain expenses do not count toward an out-of-pocket maximum, including:

- Your Plan contributions;
- Expenses over the Plan Allowance;
- Any penalties for not following pre-certification requirements; and
- Services that the Plan does not cover.

Out-of-pocket maximums accrued under the medical benefits and mental health and substance use disorder benefits are combined, according to each benefit tier.

Behavioral Health Services Per-Admission Inpatient Co-Payment (Applies to Plus Plan option only)

If you are admitted on an inpatient basis to a Quest network hospital or facility or an out-of- network facility for behavioral health services, you will need to pay a separate per-admission co-payment. If you are admitted to a facility as an inpatient more than once for the same condition within a 90-day period, you only must meet one per-admission co-payment. There is no co-payment for an admission to a WellSpan Provider Network facility.

You are also responsible for the per-admission co-payment when you are admitted to a partial hospitalization or intensive outpatient program.

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Claims for emergency hospital observation or admissions that occur at WellSpan or non-WellSpan facilities will be covered at the WellSpan Provider Network benefit level (subject to the Plan Allowance) and the pre-admission co-payment will not apply. This includes all services you or your dependent receives while an inpatient.

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Terms You Should Know

You can find a list of defined terms at the end of this guide, under the section "Terms You Should Know."

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What is Covered?

The following services are covered under the Quest Behavioral Health benefits at the level specified.
For expenses to be covered, they must be:

- Incurred while you are covered under the Plan;
- Medically necessary; and

- Provided by a covered health care provider or facility, where appropriate.

If you have any questions regarding a specific covered service, please call Quest Behavioral Health at (800) 364-6352.

Hospital Behavioral Health Services (Inpatient)

Inpatient is treatment including services, supplies, and medicines provided and used at a hospital or other qualified facility to a person admitted as a registered bed patient.

Partial Hospitalization Behavioral Health Services

Benefits include behavioral health services for partial hospitalization. Partial hospitalization is designed to increase or sustain the highest level of functioning and promote movement to the least restrictive level of care.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Intensive Outpatient Program Behavioral Health Services

Your benefits include intensive outpatient program (IOP) services, which is an intermediate level of behavioral health disorder care. The program can be a step-down treatment from a higher or more restrictive level of care or can be an appropriate level of care to provide intensive intervention.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Short-Term Residential Treatment Services for Eating Disorders

State licensed or certified short-term Residential Treatment Services for Eating Disorders are included as a covered benefit assuming that the disorder has been medically diagnosed by a licensed board-certified psychiatrist or licensed psychologist and pre-authorized by Quest Case Management. Only programs within the Quest network or those outside the network willing to enter into Single Case Agreements (SCAs) with Quest are eligible for reimbursement under Enhanced Tier and Core Tier of employee benefits.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Long Term Residential Programs

Long term residential programs for mental health or substance use disorders.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Outpatient Behavioral Health Services

Benefits cover services for behavioral health outpatient visits from an eligible behavioral health provider. Outpatient services are generally office visits that usually occur on a regular basis and can be on an individual, group, or family basis. These visits are typically for psychotherapy or medication management.

Outpatient Psychological Testing

Psychological testing is a covered charge when needed to aid in the evaluation of an individual with emotional, psychiatric or personality disorders.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Neuropsychological Assessments

Neuropsychological assessment is a more specific comprehensive assessment of cognitive processes and can be pre-authorized under certain diagnostic categories. Referrals for assessment and testing by a neuropsychologist to determine levels of cognitive functioning for brain injuries must be made by a physician after a medical examination.

Referrals from a physician can be made for conditions such as cognitive symptoms of concussion syndrome, early Alzheimer's or dementia or other brain diseases requiring an assessment of level of cognitive functioning for purposes of confirming or developing a differential diagnosis and treatment plan.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Biofeedback

A therapeutic modality performed by a licensed provider that uses a special machine to help clients become more aware of certain biological functions (e.g., muscle tension, temperature, etc.)

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT), a treatment that electrically induces seizures for the treatment of certain behavioral health disorders that have not responded well to medications and psychotherapy, is a covered charge.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Transcranial Magnetic Stimulation (TMS)

A non-invasive technique used to apply brief magnetic pulses to the brain by an FDA approved device in the treatment of major Depressive Disorder. The pulses are administered by passing high currents through an electromagnetic coil placed adjacent to the patient's scalp. The pulses induce an electrical field in the brain tissue activating neurons in the targeted brain structure. The goal is to lessen the duration or severity of depressive episodes. TMS is a covered benefit.

Keep in mind that services must be pre-certified! If you do not pre-certify out-of-network services, you will have to pay a $250 penalty and benefits may be affected.

Emergency Department Care/Crisis Evaluation

The benefits include coverage for Emergency Department treatment related to a mental health or substance use disorder disorders.

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Emergency services do not require pre-certification; however, in an emergency situation, you or a member of your family should call Quest immediately or as soon as reasonably possible. If your covered dependent is a student attending school outside the area covered by the Quest network and requires emergency treatment call (or have your dependent call) Quest's toll-free number at (800) 364-6352. Quest staff can help your covered dependent receive care from a behavioral health specialist in that area.

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Autism Spectrum Disorder

Services for autism spectrum disorder are ongoing in nature. The process begins with Diagnostic Testing that is pre-authorized by Quest. Once the child receives a diagnosis of ASD, the child is assessed by a clinician specifically trained in this area, and then a Treatment Plan is developed. That Treatment Plan must be approved by Quest. Once implemented, the child's progress is regularly monitored by Quest Care Management.

What Is Not Covered?

The following expenses are not covered services under the Quest Behavioral Health benefits. Your mental health and substance use disorder benefits are subject to the same exclusions listed previously under the WellSpan Medical Plan options unless the service is specifically listed in this section as covered. If you have any questions about a specific service, please contact Quest Behavioral Health toll-free at (800) 364- 6352.

Mental health or substance use disorder services not provided by a licensed mental health professional (psychiatrist, psychologist, clinical social worker, professional counselor, marriage and family therapy or certified addictions counselor) not covered by the Quest benefits may be covered by the medical plan option in which you are enrolled. Review your medical plan option for more information.

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Should this Plan pay benefits and it is later determined that these benefits should not have been paid based on the exclusions mentioned below, the Plan explicitly reserves the right to recover any and all benefits paid in error.

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Charges for the following are not covered:

Ambulance

Ambulance transportation to receive routine (non-emergency) assessment or treatment.

Child Custody Evaluations

Child custody evaluations, regardless of the reason ordered.

Cognitive Rehabilitation

Services for cognitive rehabilitation for the neurologically impaired. Services may be covered under the medical plan option in which you are enrolled.

Counseling Limitation

Services related to vocational or educational counseling, regardless of the reason ordered.

Court Ordered Services

Court ordered or legally required evaluations/treatment unless the medical necessity criteria of Quest Behavioral Health is also met.

Diagnosis Limitation (Other Conditions that may be a Focus of Clinical Attention)

Services when the primary diagnosis is any of the "V-codes" listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Disability Evaluations

Disability evaluations, regardless of the reason ordered.

Education Programs

Educational programs related to a diagnosis of mental retardation or learning disabilities.

Half-way Houses

Half-way houses for mental health disorders or substance use disorders.

Lethal Weapon Evaluations

Lethal Weapon evaluations, regardless of the reason ordered.

Marital Therapy

Marital therapy is not a covered service unless a provider determines one of the participants in treatment is suffering from a disorder listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth (DSM-5) and treatment with the other party is required.

Provider of Service Limitation

Mental health and substance use disorder services by professional providers who do not have a license to perform these services or professional providers not acting within the scope of his/her license.

Psychological Testing Limitation

Psychological testing for education/vocational evaluation, placement, assessment, or decision making.

Service Limitation Per Day

Therapy services or medication check-up services will be reimbursed on the same day when a covered person is in a partial hospitalization or intensive outpatient (IOP) program with an all- inclusive rate. Substance Use Disorders intensive outpatient (IOP) programs that require covered persons to receive a medication check up on the same day would be covered.

Similar Services

Two similar services billed on the same day may not be covered. For example, individual, group or family therapy cannot be billed on the same day.

Testing Limitation

Testing for learning disabilities, developmental delays, mental retardation or the mentally gifted.

Vocational and Educational Placement Testing

Vocational and Educational Placement testing are excluded from the standard psychological assessment which typically evaluates general cognitive, and personality functioning and is geared to diagnose psychiatric conditions.

Filing Claims

You do not need to file a claim when you use providers who are in the WellSpan Provider Network or Quest Behavioral Health Networks. Your network provider files them for you.

If you use out-of-network benefits, you must file your own claim, or make sure the provider's office files one for you. Claim forms are available in the Human Resources Department or from Quest Behavioral Health at www.questbh.com. You must attach an itemized bill for the services you received. The bill must include the:

- Plan name;
- Plan's group number (see your medical identification card);
- Employee's name;
- Patient's name;
- Identification number (see your medical identification card);
- Name, address and telephone number of the professional provider or facility who provided the care;
- NPI # and Tax ID # of the professional provider and/or facility who provided the care;
- Type of service provided, including diagnosis and procedure codes;
- Date the service was provided; and
- An itemized list of the charges.

Mail your completed claim form and itemized bill to:

Quest Behavioral Health

P.O. Box 1032
York, PA 17405

All claims should be submitted as soon as possible. No claims will be paid when filed 12 months or more after the date of service unless it was not reasonably possible to submit the claim within that time frame.

The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the covered person. The Plan reserves the right to have a covered person seek a second opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish you with a written notice of this denial. This written notice will contain the following information:

- The specific reason or reasons for the denial;
- Specific reference to those Plan provisions on which the denial is based;
- A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if you wish to submit a claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator will send written notice of such extension to you. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim.

Release of Medical Records and Medical Reviews

Generally, medical or pharmacy information may be used without obtaining authorization or consent for purposes of claims payment and other health care or prescription drug operations required by the Plan. However, in some circumstances, an authorization for the release of medical records may be required. If this is required, you or your dependent may be asked to sign an authorization permitting the disclosure of medical records for this purpose.

Expenses Incurred Outside the United States

If you or a dependent incurs covered medical expenses outside the United States, you must pay the bill and then file a claim.

The claim must be translated into English and the charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount in U.S. dollars. When submitting the claim, you must also include a receipt showing that the bill was paid in full.

General Rules

These general rules apply to the Plan's reasonable claim and appeal procedures:

- The initial claim, any request for review of adverse benefit determination and any request for external appeal must be made in writing, except for request for review of adverse benefit determinations relating to claims involving urgent care, which may also be made orally;
- The covered person must follow the claim and review procedures contained in this Plan Document carefully and completely and he/she must file a claim before any applicable deadlines. If this is not done, the covered person may give up important legal rights;
- A covered person's casual inquires, and questions will not be treated as claims or requests for a review or submissions to the external appeal process;
- The covered person may have a lawyer or other authorized representative help with the claim at his/her own expense (the Plan will require written authorization to verify that an individual has been authorized to act on the covered person's behalf except that for a claim involving urgent care, a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative);
- The covered person is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any adverse benefit determination. The covered person will also be allowed to review the claims file and present evidence and written testimony as part of the internal claim and appeal process; and
- The covered person must comply with any additional requirements for filing a claim (for example, completing forms and following claim filing deadlines) imposed by the Plan.

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Who is the Plan Administrator?

The Plan Administrator is the formally identified Plan Fiduciary and has the responsibility for final Plan determinations. The Plan Administrator manages the Plan on a day-to-day basis and answers questions about Plan details. The Plan Administrator for the WellSpan Medical Plan is WellSpan Health. The Claims Administrator is responsible for claims processing and other administrative duties related to the Plan. For more information about the Plan Administrator, see the sections "Administrative Information" and "Terms You Should Know."

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Plan's Failure to Follow Procedures

If the WellSpan Medical Plan fails to follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Exhaustion of Administrative Remedies

The exhaustion of the claim and review procedure (with the exception of the external claim review process) is mandatory for resolving every claim and dispute arising under this Plan prior to initiating legal action. In any legal action brought after the covered person has exhausted the administrative remedies, all determinations made by the Plan shall be afforded the maximum deference permitted by law.

Nonalienation

No benefit payable under the Program shall be subject in any manner to anticipating, assignment, or voluntary or involuntary alienation. A Participant or Beneficiary may not assign, alienate, sell, encumber, or transfer benefits to which they may become entitled under this Plan without the written consent of the Plan Administrator. To the extent allowed by law, the Plan will not accept any assignment to a health provider or facility for any reason, including, but not limited to, an assignment of:

- The benefits due under the Plan;
- The right to receive payment due under the Plan; and
- Any claim made for damages resulting from a violation or alleged violation of the terms of the Plan, including any breach of fiduciary duties under ERISA.

Notwithstanding anything to the contrary herein, any payments made by the Plan to a health provider do not grant the health provider rights under the Plan or ERISA.

Plan benefits may not be subject to attachment or garnishment by any of the Participant's creditors or to legal process.

Administrative Information About Your Benefits

This section of your guide contains important information about the administration and funding of the WellSpan Medical Plan. Some of the information is required under the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Participants Covered

Generally, the benefits described in this Plan Document/Summary Plan Description cover all full-time, part- time, PRN, occasional and per diem employees who are eligible for benefits as described. For more information about the Plan eligibility, please see the heading "Your Eligibility" in the section, "Participating in the Medical Plan Option."

Plan Sponsor and Plan Administration

Your benefit plan is sponsored by WellSpan Health, the Plan Administrator. The Plan options that make up your medical, behavioral health and prescription drug benefits program are subject to the overall administration of the Plan Administrator, according to the formal legal documents and any insurance contracts governing the Plan. The Plan Administrator is located at:

WellSpan Health
3350 Whiteford Road
York, PA 17402
(717)851-2400
IRS Employer Identification Number: 22-2517863

The Plan Administrator established the policies, practices, and procedures of this Plan. The Plan Administrator will administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental and/or investigational), to decide disputes which may arise relative to a covered person's rights and to decide questions of Plan interpretation and those of fact relating to the Plan.

The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator, in its discretion, determines that the covered person is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

- Administer the Plan in accordance with its terms;
- Determine all questions of eligibility, status, and coverage under the Plan;

- Interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
- Make factual findings;
- Decide disputes which may arise relative to a covered person's rights;
- Prescribe procedures for filing a claim for benefits and appeals of any denials;
- Keep and maintain the Plan Documents and all other records pertaining to the Plan;
- Appoint and supervise a third-party administrator to pay claims;
- Perform all necessary reporting as required by ERISA;
- Establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO;
- To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan's administration.

Agent for Service of Legal Process

If you want to take legal action for any reason related to a benefit claim, you may contact the Plan Administrator. Whenever you inquire or write about the Plan, be sure to use the IRS employer identification number and the Plan number.

Plan Administrator Compensation

The Plan Administrator services without compensation. However, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

WellSpan Medical Plan Information

Plan Name	Plan Number	Plan Year	Plan Type	Plan Funding	Claims Admin
WellSpan Medical Plan	501	January 1 – December 31	Medical	Self-insured. The Plan is funded through contributions from WellSpan Health and participating employees.	WellSpan Population Health Services PO Box 2347 York PA 17405
Prescription Drugs Benefits Capital Rx (for all medical plan options)	501	January 1 – December 31	Prescription Drug	Self-insured. The Plan is funded through contributions from WellSpan Health and participating employees.	Capital Rx 228 Park Avenue S. Suite 87234 New York, NY 10003
Mental Health and Substance Use Disorder benefits Quest Behavioral Health (for all medical plan options)	501	January 1 – December 31	Mental Health and Substance Use Disorder	Self-insured. The Plan is funded through contributions from WellSpan Health and participating employees	Quest Behavioral Health PO Box 1032 York, PA 17405

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan are called "fiduciaries," and they have the duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Claims Administrator is Not a Fiduciary

A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Plan is Not an Employment Contract

The Plan is not to be construed as a contract for or of employment

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

Misrepresentation

The WellSpan medical Plan reserves the right to verify your dependent's eligibility for coverage and may require other documentation in addition to a completed enrollment form. All payments from the Plan to you or a provider are contingent upon the accuracy of the personal and/or dependent information supplied by you. If you present fraudulent or intentional misrepresentations of material fact about yourself, your spouse, or your dependent child(ren), the Plan will take appropriate action, up to and including forfeiture of benefits and/or loss of coverage. Coverage may be rescinded (terminated retroactively)for:

- Non-payment contributions;
- An act, practice or omission that constitutes fraud; or
- An intentional misrepresentation of material fact.

Information concerning the Plan's dependent eligibility provisions are provided to you at the time of hire, including the Plan's Plan Document and Summary Plan Description, and during the annual open enrollment period. If your dependent is found not to be eligible for coverage because you enrolled an ineligible dependent or because you failed to notify the Plan when your dependent lost eligibility (for example, loss of benefits due to divorce or loss of dependent child status), the Plan will consider this to be an intentional misrepresentation of material fact and/or fraud.

The Plan shall be entitled to recover its damages, including legal fees, from the covered person, or from any other person responsible for misleading the Plan and from the person for whom the benefits were provided.

Important Information About all Plan Benefits

The following information applies to all Plan benefits:

HIPAA Privacy and Security Standards Compliance

The WellSpan Medical Plan will use Protected Health Information (PHI) to the extent of, and in accordance with, the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, 45 C.F.R. parts 160 through 164 ("HIPAA Privacy Rule)) and 456 C.F.R. parts 160, 162 and 164 ("HIPAA Security Standards"). Specifically, the Plan will use and disclose PHI for purposes related to healthcare

payment and health care operations. Additionally, the Plan will satisfy all obligations with respect to the security of Electronic Protected health Information. All permitted and required uses and disclosures will be consistent with the HIPAA Privacy and Security Standards Rules.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, Plan maximums and co-payments as determined for an individual's claim);
- Coordination of benefits (C.O.B.);
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;

- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating, and resolving payment disputes and responding to covered persons inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges; and
- Utilization review, including pre-certification, concurrent care, and retrospective review.

Health care operations include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, censuring, or placing a contract reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning- related analyses related to managing and operating the Plan, including formulary development and administration, development, or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan including, but not limited to:
    - Management activities relating the implementation of and compliance with HIPAA's administrative simplification requirements; or
    - Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers; and
    - Resolution of internal grievances.

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted by the Plan Document/Summary Plan Description or as required by law;

- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI in connection with any other benefit or health care plans of the Plan Sponsor unless authorized by the individual;
- Not use or disclose PHI in connection with any employment-related actions or decisions of the Plan Sponsor;
- Report to the Plan any PHI uses or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, records relating to the use and disclose of PHI received from the Plan available to the Health and Human Services Secretary for the purposes of determining the Plan's compliance with the HIPAA Privacy Rule; and

If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).In accordance with the HIPAA Privacy Rule, only the following employees or classes of employees under the control of the Plan Sponsor may be given access to PHI received from the Plan:

- Human Resources Department employees;
- The WellSpan Health Benefits Committee;
- Internal Audit Department employees;
- Finance Department employees; and
- The executive staff of WellSpan Health.

The list reflects employees, classes of employees, or other workforce members of the Plan Sponsor who receive individual's PHI relating to payment under, health care operation of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the WellSpan Medical Plan. These individuals will have access to PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanction (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of PHI in violation of, or noncompliance with, the provisions of the HIPAA Privacy Rule.

The Plan Sponsor will promptly report any such breach, violation or noncompliance to the WellSpan Medical Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or

noncompliance.

Where Electronic Protected Health Information (defined as any Protected Health information that is transmitted or maintained in any electronic media) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- The Plan Sponsor shall implement administrative, physical, and technical safeguards and appropriately protect confidentiality, integrity, and availability of the Electronic Protected Health Information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor shall ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected healthcare Information agrees to implement reasonable and appropriate security measures to protect such information; and
- The Plan Sponsor shall report, within a reasonable time, to the Plan any security incidents (defined in the Security Standards Rule as they attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system) of which it becomes aware.

Newborn's and Mother's Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health coverage may not generally restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal deliver; or
- Less than 96 hours following a cesarean section.

However, the Plan may pay for a shorter stay if the attending provider (e.g., a physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or the newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain pre-authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, your Plan may require that you obtain pre-certification. Please contact your Plan if you have questions.

Mastectomy Services

Your medical plan options provide coverage for a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications for all states of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

This coverage will be provided in consultation with the attending physician and patient. These benefits are subject to the same co-payment, deductible, and/or co-insurance amounts that apply to other benefits provided. If you have questions about benefit coverage, contact your Plan.

Other Information

Updating Your Benefit Records: Basic Information About You

Be sure to call the WellSpan Health Human Resources Department with any changes to your name, address, or marital status.

Basic Information About Your Dependents

You should also call Human Resources within 31 days if you marry, divorce, have or adopt a child, or if there is a death in your family which affects your benefits. Also be sure to call if your child becomes ineligible for coverage, or if you have a qualified life status change as described earlier in this guide in the "Participating in the Medical Plan Option" section.

About Your Benefit Rights: Your Right to Continue Certain Coverage Under Cobra

Under certain circumstances, you (or your dependents) may be able to obtain continued health care coverage for a period of time after your group health care coverage ends. You will be responsible for paying the full contribution Standard an additional administrative charge.

This continued coverage is available under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Full details on COBRA continued coverage are find in the "Participating in the Medical Plan Option" section.

Your Rights Under ERISA

As a participant in the WellSpan Medical Plan, you are entitled to certain rights and protections under

the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to receive information about the Plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that Plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, all documents governing the Plan. These include insurance contracts, collective bargaining agreements, and a c copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor. The Form 5500 may also be obtained from the Public Disclosure Room of the Employee Benefits Security Administration. You are entitled to examine these documents at the Plan Administrator's office and at other specified locations, such as worksites.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, the latest annual report (Form 5500), and the updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. It is important to review this Summary Plan Description and the documents governing the Plan regarding the rules for exercising your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for a benefit is denied or ignored, you are entitled to:

- Know why this was done
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps that you can take to enforce your rights. For example, you may file suit in federal court if:

- You request a copy of Plan documents or the latest annual report (Form 5500) and do not

receive them within 30 days. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless they were not sent for reasons beyond the control of the Plan Administrator;

- You have a claim for benefits that is denied or ignored, in whole or in part. You may also file suit in state court;
- You disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order; or
- The Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The Court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This could occur if the court finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, which is listed in your telephone directory. You may also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administrator
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Reservation of Rights

Notwithstanding anything in this Plan Document/Summary Plan Description or in any Plan contract, or other document to the contrary, WellSpan Health and its affiliated, subsidiary, and related entities reserve the right to change, modify, or terminate any WellSpan Health- sponsored employee benefit plan option, in whole or in part. If any Plan option or part of any Plan option is amended, suspended, or terminated, such actions will take place only by decision of a Director of Human Resources, Vice-President of Human Resources and/or the executive staff of WellSpan Health.

If a Plan Option is Terminated

Participants in the Plan have no Plan benefits after a Plan option termination or partial Plan option termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan option termination or partial Plan option termination and except as otherwise expressly provided, in writing, by WellSpan Health and its affiliated, subsidiary, and related companies.

A Final Comment

Always keep in mind these important points about your benefit plans and this guide:

- The written terms of the Plan Document/Summary Plan Description (SPD) will always govern
- This Plan Document/Summary Plan Description (SPD) does not constitute a contract of employment
- WellSpan Health and its affiliated, subsidiary, and related entities retain the right to amend or terminate the Plan or Plan options at any time and for any reason; and
- WellSpan Health and/or the Plan Administrator retain discretionary authority to interpret the Plan options and to require whatever documentation it deems necessary to properly adjudicate claims for benefits.

Terms You Should Know

This section provides a list of common Plan terms and definitions for the WellSpan medical Plan. These definitions may differ from definitions that other medical plans use. If you elect coverage under this Plan, you should review the terms carefully, so you are able to better understand your benefits.

The following definitions are not an indication that charges for particular treatments, supplies, or services are eligible for payment under the Plan; please refer to the appropriate sections of this document for that information.

Accidental Injury (Accident)

An accidental injury means physician harm caused by a sudden and unforeseen event at a specific time and place. It is independent of sickness, except for infection of a cut or wound.

Active Employee

An employee who is on the regular payroll of the employer, who is in a benefits eligible position, and who has begun to perform the duties of his or her job for the employer on a full-time, part- time, PRN, or per diem basis.

Adverse Benefit Determination

Occurs when your claim is denied, reduced, or the Plan does not make a payment (in whole or in part). This may happen if your claim is not paid because of your eligibility or because the services you received is considered to be experimental and/or not medically necessary. Also, any claim that is not paid at 100% is considered to have had an adverse benefit determination; this would include any amounts applied to your deductible or co-insurance, as well as any amount that exceeds a Plan limit.

Ambulatory Surgical Center

A licensed facility that:

- Is used mainly for performing outpatient surgery;
- Has a staff of Physicians;
- Provides continuous physician care and/or nursing care by Registered Nurses; and
- Does not provide for overnight stays.

Authorized Representative

This is a person(s) whom you decide may act on your behalf with regard to your group health coverage. This is not the same as an "assignment of benefits" that many providers ask patients to sign. If you designate an authorized representative, this person will have the authority to receive information about your claims any appeals, and request documents and information from your health plan. This means that notifications and other information that would normally go to you could now be sent to your authorized representative.

Your Plan must receive, in writing, notice from you indicating the name, contact information, and a statement written by you that says you are naming this person(s) as your authorized representative. When you decide that you no longer want this person to act as your authorized representative, you must again, notify the Plan in writing of that decision.

The only exception to this written notification requirement in naming an authorized representative is when you incur a claim involving urgent care, in which case, the Plan will permit a healthcare provider that has knowledge of your medical condition to act as your authorized representative.

Birthing Center

A freestanding health facility, place, professional office, or institution which is not a hospital or in a hospital, where births occur in a home-like atmosphere. The facility must be licensed and operated in accordance with the laws regarding birthing centers in the jurisdiction where the facility is located.

The birthing center must:

- Provide facilities for obstetrical delivery and short-term recovery after delivery;
- Provide care under the full0-time supervision of a physician and either a Registered Nurse or a Licensed Nurse Midwife; and
- Have a written agreement with a hospital in the same locality for the immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name Drug

Refers to a trade name drug.

Calendar Year

Calendar year means January 1st through December 31st of the same year.

Case Management

A multidisciplinary process that coordinates quality resources and facilities flexible, individualized treatment goals, in conjunction with the Plan. It may provide cost effective options for selected individuals with complex needs.

Claim

When you request a benefit consideration under the Plan, and you follow the Plan's filing procedures, it is called a claim. You may notify the Plan about a claim involving urgent care or pre- service claim either orally or in writing. Post-service claims are usually written claims since they are for services you have already received.

Claim Involving Urgent Care

If the Plan requires that you pre-certify a medical service before the Plan will make payment or will penalize you for not pre-certifying a medical service and it is the type of service that:

- Could seriously jeopardize the health and life of the patient or the ability of the patient to regain maximum function;
- In the opinion of a physician who understands the patient's medical condition, would conclude that the care requested is necessary to alleviate severe pain that cannot be managed without this treatment, or the physician determines that the service is a "claim involving urgent care," or
- The Plan determines that a person, with an average medical knowledge, would determine that the service is a "claim involving urgent care."

Your medical plan option does not require you to pre-certify emergency or urgent care (e.g., emergency admissions or emergency surgery); therefore, you will not have a claim involving urgent care. The only exception to this occurs under a concurrent care decision; if you or your physician wants to extend approved care, then there may be circumstances where that extension could be considered as a claim involving urgent care.

Claims Administrator

An entity, selected from time to time by the Plan Administrator, providing technical services and advise to the Plan Administrator in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-Insurance

Co-insurance refers to the percentage you pay for covered medical expenses. If you use a WellSpan Provider Network provider, there is no co-insurance, because services are paid at 100%.

If you use a provider from the CBC network, you will generally be responsible for co- insurance because most services are paid at a percentage.

However, if you use out-of-network providers, the Plan generally pays 50% and you pay all remaining charges.

Co-Payments

A co-payment is a dollar amount that you must pay for certain services. Each time the service is received, it requires a new co-payment. Co-payments apply towards the out-of-pocket limit and cease when the out-of-pocket maximum is reached.

Under the WellSpan Medical Plan, co-payments are generally required for office visits, the emergency department, for certain facility charges, and therapies. Co-payment amounts vary dependent on the benefit tier and type of provider.

Concurrent Care Decision

A concurrent care decision claim can occur in two ways. If the Plan has approved a course of treatment for you that is either provided over a period of time or is for a number of treatments and the Plan reduces or terminates the approval for the services before the end of the treatment. Or it can happen when you request that your course of treatment be extended beyond the original approved time period or number of treatments.

Cosmetic Services and Surgery (Cosmetic)

Medically unnecessary surgical and other procedures, usually, but not limited to, plastic surgery directed toward improving the person's appearance and self-esteem.

Covered Charge (Covered Service)

Means those medically necessary services or supplies that are covered under this Plan.

Covered Person

Covered person is an employee or dependent who is enrolled under the Plan.

Creditable coverage

Includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, or Medicare. Creditable coverage does not include coverage consisting solely of dental or vision benefits. Creditable coverage does not include coverage that was in place before a significant break in coverage of more than sixty-three (63) days.

Custodial Care

Care, including room and board needed to provide that care, which is given primarily for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care include help in walking and getting out of bed; assistance in bathing, dressing, and feeding; or supervision over medication which could normally be self-administered.

Deductibles

The calendar year deductibles are the amounts you pay each year before benefits are paid.

- If you are in the WellSpan Plus plan option - each Tier deductible must be satisfied individually before benefits are paid and each within a family must satisfy an individual deductible.
- If you are in the WellSpan Standard plan option - Each Tier deductible must be satisfied before benefits are payable. One person cannot satisfy more than their individual deductible; however, any combination of the family may satisfy the family deductible. Once the family deductible is met, benefits will be paid depending on the level of coverage.
- If you are in the WellSpan High Deductible plan option – Each Tier deductible must be satisfied either individually or per family before benefits are paid depending on your level of coverage.

Deductibles applied under the mental health and substance use disorder benefits and the medical benefits are combined, according to each benefit tier.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

Refers to a covered employee's spouse or child as defined in the "Participating in the Medical Plan Option" section of this guide.

Disability (Disabled)

Disability refers to, in the case of an active employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of accidental injury or sickness.

Disability refers to, in the case of a dependent child, the complete inability as a result of accidental injury or sickness, such as muscular dystrophy, mental retardation, or spinal cord injury, to perform the normal activities of a person of like age and gender in good health.

Doula

A non-medical professional who provides continuous, physical, emotional, and informational support to the pregnant person and their support team before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible.

Durable Medical Equipment (DME)

Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally, is not useful to a person I the absence of a sickness or injury; and
- Is appropriate for use in the home.

Embedded (Total Maximum Out-of-Pocket) (Generally only applies to High Deductible Plans)

The total maximum out-of-pocket refers to the specified dollar amount of deductible, coinsurance, copayments incurred for network covered services, covered medications, and any qualified medical expenses in a benefit period. When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, your program begins to pay 100% of all covered expenses and no additional coinsurance, copayments and deductible will be incurred for network covered services and covered medications in that benefit period.

The total maximum out-of-pocket does not include out of-network cost-sharing or amounts in excess of the plan allowance. However, if any covered family member has incurred an amount equal to the individual total maximum out-of-pocket, the benefits payable for covered services for that particular individual family member will be payable at 100% of the plan allowance during the remainder of the

benefit period.

Employee

Means a person who is directly involved in the regular business of and compensated for services, as reported in the individual's W-2 form, by the employer. This definition does not include leased employees.

Employer

WellSpan Health is the employer.

ERISA

ERISA is the federal Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational

Experimental and/or investigational means services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the individual case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight at the time services were rendered.

The Plan Administrator, in consultation with the Claims Administrator, must make an independent evaluation of the experimental/non-experimental standings of specific technologies, procedures and therapeutics. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
- If "reliable evidence" shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- If "reliable evidence" shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with a standard means of treatment or diagnosis.

then the drug, device, medical treatment, or procedure will be deemed experimental and/or investigational by the Plan.

Reliable evidence shall mean only:

- Published reports and articles in the peer-reviewed authoritative scientific and medical literature and/or standard evidence-based expert analysis of that literature; or
- The written protocol from the facility who published the study using the same drug, device, medical treatment, or procedure and which is consistent with the information in the written informed consent used by the publishing facility using the same drug, device, medical treatment, or procedure in persons with the same condition.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration.

If any of the entities used to determine the investigational status of a drug, device, supply, treatment, or any other medical service reverses, modifies, or established its policy for such expenses, and makes such changes retroactively, the Plan will not make payment for related retroactive incurred expenses. The Plan will not seek refund for its previous payments, or make payments for any previously denied expenses, affected by such retroactive changes.

Facility Provider (Facility)

An institution or other entity licensed where required and performing services within the scope of such license.

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For the purposes of the mental health and substance use disorder benefits outlined in the "Mental Health and Substance Use Disorder Benefits" section, facility providers are limited to those listed under the heading "About Quest Behavioral Health."

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Formulary

A formulary is a listing of preferred drugs that are chosen because of their clinical efficacy, quality, and cost-effectiveness. Formulary drugs have three special characteristics:

- Formulary drugs must be effective to be included on a formulary list, a drug must do the job for which it was prescribed;
- A formulary drug is "therapeutically" similar to another drug but does not always have the same chemical make-up. For example, different fillers may be used in drugs that are considered therapeutically equivalent; and
- Formulary drugs usually cost less. Generally, the drugs on a formulary list were chosen because they are effective in treating certain conditions and are lower in cost.

Generic Drug

A prescription drug which has an equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information (Genetic)

Means information about genes, gene products, and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, ad direct analysis of genes in chromosomes.

Home Health Care Agency (Home Health Care)

An organization that meets all of the following tests:

- Its main function is to provide home health care services and supplies, including:
  Part-time or intermittent nursing care by or under the supervision of a Registered Nurse Part-time or intermittent home health aide services (except general housekeeping services) Physical, occupational, and speech therapy, Medical supplies, and Laboratory services by or on behalf of a hospital;
- It is federally certified as a home health care agency; and
- It is licensed by the state in which it is located if licensing is provided.

Hospice Care Services and Supplies (Hospice)

Those services and supplies provided through a hospice agency and under a hospice care plan and include inpatient care in a hospice unit or other licensed facility provider, home care, and family counseling during the bereavement period.

Hospital

A facility which is engaged primarily in providing medical care and treatment of sick and injured persons which fully meets the following tests:

- It is accredited/certified by a Centers for Medicare and Medicaid Services (CMS) – authorized accreditation program; for example, by the Joint Commission on Accreditation of Healthcare Organizations;
- It is licensed by the state in which it is located;
- It is approved by Medicare as a hospital;

- It maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians;
- It continuously provides on the premises, 24-hour nursing services by or under the supervision of Registered Nurses; and
- It is operated continuously with organized facilities for operative surgery on the premises.

Injury

Injury means accidental physical harm to the body caused by unexpected external means.

Inpatient Care (Inpatient)

Inpatient is treatment including services, supplies, and medicines provided and used at a hospital or other qualified facility to a person admitted as a registered bed patient.

Leave of Absence

A leave of absence is a period of time during which the employee does not work for the employer, but which is of a stated duration and after which time the employee is expected to return to active work. A leave of absence shall otherwise be limited by the employer's standard personnel practices and policies.

Legend Drug

Means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription."

Lifetime

A word that appears in reference to benefit maximums and limitations as explained throughout this guide. Under no circumstances does lifetime mean during the lifetime of the covered person.

Maintenance Drug

A prescription drug that is generally prescribed for treatment of a long-term chronic sickness or injury.

Medicaid

Refers to the state program (with federal matching funds provided by Social Security under stipulated conditions) of public health assistance to persons, regardless of age, whose income and resources are insufficient to pay for health care.

Medical Emergency (Emergency)

The Plan defines the term "medical emergency" as an acute medical condition that manifests itself by acute symptoms (including severe pain) of sufficient severity that the absence of immediate medical attention could reasonably result in:

- Placing the patient's health in jeopardy;
- Causing other serious medical consequences;
- Causing serious impairment to bodily functions; and
- Causing serious dysfunction of any bodily organ or part.

Should a prudent layperson, who possesses an average knowledge of health and medicine, believe a serious medical condition exists, the emergency department visit is justified.

Medically Necessary (Medical Necessity)

Care and treatment that is:

- Recommended or approved by a physician or dentist;
- Is consistent with the patient's condition or accepted standards of good medical and dental practice;
- Is medically proven to be effective treatment for the condition at issue;
- Is not performed mainly for the convenience of the patient or provider of medical or dental services;
- Is not conducted for research purposes; and
- Is the most appropriate level of service, which can safely be provided to the patient.

All of the above criteria must be met in order for care to be considered medically necessary. The fact that a physician recommends or approves care or treatment does not in itself mean it is medically necessary. The Plan Administrator has discretionary authority to determine whether care or treatment is medically necessary.

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Charges that are greater than the charges for an alternative service or supply that could have safely and adequately diagnosed or treated you or your dependent's physical or mental condition will not be considered medically necessary under this Plan. Call the telephone number on the back of your medical identification card for more information about this provision or about a particular service, before the charge is incurred.

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Medicare

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Health Disorders (Mental Health)

The CDC defines mental illnesses as conditions that impact a person's thinking, mood, feelings, or behavior. These may be occasional or long-lasting and can affect one's ability to function and/or relate to others.

Network Provider (Network)

Refers to providers who have agreed to be part of the WellSpan Provider Network, Capital Blue Cross, or Quest Behavioral health Provider Organizations (PPOs) providing services to covered persons under the WellSpan Medical Plan. It also includes pharmacies that have contracted with the Prescription Benefit Manager (PBM), Capital Rx.

Non-Embedded (Family Deductible) (Usually used for High Deductible Health Plans Only)

The family deductible is a specified dollar amount of covered services that must be incurred by covered family members before the program begins to provide payment for benefits. For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, the entire family deductible must be satisfied in one benefit period by one or more family members. Benefits for any individual member of the family will not be payable until the family deductible has been satisfied. Once the family deductible is met, no further deductible amounts must be satisfied by any covered family member.

Notification of Adverse Benefit Determination

When there is an adverse benefit determination, the Plan must notify you of the claim decision and the reasons why the claim was denied, reduced, or not paid at 100%. In many cases, this notification will be called an “Explanation of Benefits” (EOB).

Nurse

A nurse is a licensed person holding the degree of Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of their license.

Obesity

Obesity means, in the case of an adult age twenty and older, a diagnosed condition in which the patient's Body Mass Index (BMI) is between 30 kg/M2 and 34.9 kg/M2 [BMI = weight (in kg) divided by height (in square meters)].

Obesity means, in the case of a child from age two through age nineteen, a diagnosed condition in which the patient's Body Mass Index (BMI)-For-Age percentile is between the 85th and 94th percentile (as determined by the Center for Disease Control weight charge for BMI-For-Age).

Out-Of-Network Provider (Out-Of-Network)

Means providers who have not agreed to be part of the WellSpan Provider Network, Capital Blue Cross, or Quest Behavioral Health Preferred Provider Organizations (PPOs) providing services to covered persons under the WellSpan Medical Plan or pharmacies that have not contracted with Capital Rx.

Out-of-Pocket Maximum

To protect you and your family from the cost of a catastrophic sickness or injury, the WellSpan Medical Plan has calendar year out-of-pocket maximums. This means the amount you pay each calendar year for covered expenses is limited. Your out-of-pocket is the amount for which you are responsible after the Plan pays its normal co-insurance.

Amounts applied to your out-of-pocket maximums accumulate across the Enhanced and Core Tiers. For example, amounts applied to a Core Tier out-of-pocket are also credited under the Enhanced Tier out-of-pocket maximum.

The out-of-pocket maximum for Out-of-Network is separate and does not accumulate with the Enhanced and Core Tiers.

Once an annual out-of-pocket maximum has been reached within the calendar year, the Plan will pay 100% of covered charges for the remainder of the calendar year, under that tier, subject to any benefit limitations.

Certain expenses do not count toward an out-of-pocket maximum, including:

- Your Plan contributions;
- Expenses over the Plan Allowance;
- Any penalties for not following pre-certification requirements; and
- Services that the Plan does not cover.

Out-of-pocket maximums accrued under the medical benefits and mental health and substance use disorder benefits are combined, according to each benefit tier. Out-of-pocket maximums for the High Deductible Health Plan include medical and behavioral health deductibles, co-insurance, and co-payments.

Outpatient Care (Outpatient)

Treatment, including services, supplies, and medicines provided and used:

- At a hospital under the direction of a physician to a person who is not admitted as a registered bed patient
- In a physician's office, a laboratory or x-ray facility, ambulatory surgical center; or
- In the patient's home.

Over-the-Counter (OTC) Drug

Refers to a drug product that does not require a prescription order under state or federal law.

Pharmacy

A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician

A person, who is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), is licensed and legally entitled to practice medicine in all of its branches, perform surgery, and dispense drugs.

Plan

When used in this guide, the term Plan is meant to be the WellSpan Medical Plan including the:

- WellSpan Medical Plan Option;
- Prescription Drug Benefits; and
- Mental Health and Substance Use Disorder Benefits

Plan Administrator

- The Plan Administrator, WellSpan Health, will interpret the Plan in accordance with its terms and their intended meaning, and benefits under the Plan will be paid only if the Plan Administrator, in its discretion, decides a participant or beneficiary is entitled to them. The Plan Administrator will have the discretion to make any findings of fact needed to administer the Plan or determine benefits claims and to construe ambiguous, unclear, or implied (but not stated) terms in any way it deems appropriate. The Plan Administrator's earlier exercise if its discretionary authority granted under the Plan shall not require it to exercise that authority in the same manner thereafter. If any Plan provision, on account of errors in

drafting, does not accurately reflect its intended meaning, as determined by the Plan Administrator in its sole discretion, the provision will be considered ambiguous and will be construed by the Plan Administrator in a manner consistent with the intended meaning. All actions taken, and determinations made in good faith by the Plan Administrator under this Plan Document/Summary Plan Description will be final and binding on all persons.

Plan Allowance

Defined:

- For a network provider (Enhanced Tier) – the contracted fee schedule; or
- For a network provider (Core Tier) – the contracted fee schedule; or
- For a non-network provider (Out of Network), the fee will generally be based on the Blue non-participating local provider allowance. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the plan allowance.

If the provider submits a charge that is lower than the Plan Allowance for a service, the Plan will reimburse the provider for the actual amount of the charge.

The Plan administrator has discretionary authority to decide whether a charge is in excess of the Plan Allowance. This means the Plan may use other methodologies and accepted sources (such as Medicare), to determine the Plan Allowance.

Plan Sponsor

Refers to an employer that established or maintains any employee benefit plan. WellSpan Health is the Plan Sponsor of the WellSpan Medical Plan.

Post-Service Claim

This includes all claims that are not considered to be claims involving urgent care or pre-service claims. This will generally include claims for which you have already received the medical services and a claim has been sent to the Plan for benefit consideration.

Pre-Authorization (Pre-Authorize)

Pre-authorization means the approval that must be obtained from the Plan prior to receiving certain prescription drugs. See the “Prescription Drug Benefits” section for a listing of those prescription drugs that require pre-authorization.

Pre-Certification (Pre-Certify)

Pre-certification means the approval that must be obtained from the Plan prior to certain non- medical emergency, non-urgent services. See the “Medical Management Services” heading under the medical plan section for a listing of services that require pre-certification.

Pregnancy (Maternity)

Refers to childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Means any of the following: A Food and Drug Administration (FDA) approved drug or medicine which, under federal law is required to bear the legend: "Caution: federal law prohibits dispensing without a prescription;" injectable insulin; and hypodermic needles or syringes, but only when dispensed upon a written prescription from a licensed physician. Such drugs must be medically necessary for the treatment of a sickness or injury.

Pre-Service Claim

If the Plan requires you to pre-certify or pre-approve a medical service before the Plan will make a payment or will penalize you for not pre-certifying, the claim is considered to be a pre- service claim. It is a claim for benefits for a service that you have not yet received. It only includes those services that are not considered to be claims involving urgent care.

Professional Provider (Provider)

A professional provider is a physician or other health care professional or facility that is licensed, registered, or certified as required by the state in which the services were received to provide a medical service or supply and who does so within the lawful scope of that license, registration, or certification.

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For the purposes of the mental health and substance use disorder benefits outlined in the "Mental Health and Substance Use Disorder Benefits" section, professional providers are limited to those listed under the heading "About Quest Behavioral Health

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Reconstructive Surgery

Surgery that is medically necessary to restore bodily function or to correct deformity resulting from sickness, trauma, congenital developmental anomalies, or therapeutic process.

Scientific and Medical Literature

Scientific and medical literature refers to those journals that publish articles written by researchers and are reviewed by their peers.

Sickness

Sickness is a person's illness, disease, or pregnancy.

Skilled Nursing Facility

A facility that fully meets the following criteria:

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from injury or sickness. The service must be provided by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse;
- It provides services to help restore patients to self-care in essential daily living activities;
- Its services are provided for compensation and are under the full-time supervision of a physician;
- It provides 24-hour nursing services by licensed nurses, under the direction of a full- time Registered Nurse;
- It maintains a complete medical record on each patient;
- It has an effective utilization review plan;
- It is not, other an incidentally, a place for rest, the aged, those with addictions to drugs and alcohol, mental retardation, custodial, educational care, or care of mental health disorders; and,
- It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, or any other similar name.

Spouse

Refers to the husband, wife, or same-sex partner of the employee under a legally valid existing marriage, according to the laws of the state in which the employee was married.

Substance Use Disorder (Drug and Alcohol)

Substance use disorder is a condition defined by regular, excessive, and/or compulsive drinking of alcohol and/or habitual dependence on drugs that results in a chronic disorder affecting physician health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint Dysfunction (TMJ)

The treatment of jaw joint disorders, including conditions of structure linking the jawbone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Urgent Care Center

A non-emergency facility that is not connected to an Emergency Department of a hospital. It sees patients, without an appointment, for injuries and sickness that require immediate care, but not serious enough to require the Emergency Department.

Waiting Period

This is the time period which must pass before an employee or dependent is effective for benefits under the Plan. If an employee or dependent enrolls on a special enrollment day, any period before such special enrollment is not a waiting period.

Walk-In Clinic

A health care clinic that treats uncomplicated minor illnesses and injuries and also provides preventative health care services. These clinics are also known as “retail clinics”, “convenient care clinics”, or “express clinics”.