2024 Medical

WellSpan Plus Plan

Note: changes to the Plan are in **blue**.

Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Capital Blue Cross Network	Out-of-Network Out-of-Network [4]
Annual Deductible [1]	$300 per person	$450 per person	$900 per person
Medical Out-of-Pocket Maximum [2] Includes deductible, copays, and coinsurance	**Individual:** $2,750 / **Family:** $4,750		**Individual:** $10,250 / **Family:** $20,250
Preventive Care Includes annual physical and well-child care	Plan pays 100% You pay 0%	Plan pays 100% You pay 0%	After deductible Plan pays 50%, You pay 50%
Office Visits (Primary Care (PCP), Specialist)	**PCP:** You pay $10, Plan pays remainder **Specialist:** You pay $30, Plan pays remainder	**PCP:** You pay $25, Plan pays remainder **Specialist:** You pay $40, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
WellSpan Online Urgent Care	$0 copay	N/A	N/A
Hospital Facility/Physician (Inpatient)	After deductible Plan pays 95%, You pay 5%	You pay $200 copay. After deductible Plan pays 80%, You pay 20%	You pay $250 copay. After deductible Plan pays 70%, You pay 30%
Ambulatory, Outpatient, Surgery, MRIs, MRAs, and CT and PET Scans (Facility)	After deductible Plan pays 95%, You pay 5%	You pay $250 copay. After deductible Plan pays 80%, You pay 20%	You pay $250 copay. After deductible Plan pays 50%, You pay 50%
Outpatient (Lab/Diagnostic)	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 80%, You pay 20%	After deductible Plan pays 50%, You pay 50%
Physical/Speech/Vision/Occupational Therapy	**Physical Therapy**: **$0 copay**, 95% coinsurance, deductible waived **Speech Therapy**: $10 copay, 95% coinsurance, deductible waived **Vision Therapy**: $10 copay, 95% coinsurance, deductible waived **Occupational Therapy:** $10 copay, 95% coinsurance, deductible waived	**Physical Therapy**: $30 co-payment, then 70% with no deductible **Speech Therapy:** $30 co-payment, then 70% with no deductible **Vision Therapy**: $30 co-payment, then 70% with no deductible **Occupational Therapy**: $30 co-payment, then 70% with no deductible	**Physical Therapy:** 50% after the deductible subject to the Plan Allowance **Speech Therapy**: 50% after the deductible subject to the Plan Allowance **Vision Therapy**: 50% after the deductible subject to the Plan Allowance **Occupational Therapy**: 50% after the deductible subject to the Plan Allowance
Urgent Care/Walk-In Clinics/Retail Clinics	**PCP:** You pay $25, Plan pays remainder **Specialist:** You pay $50, Plan pays remainder **Other Covered Services:** After deductible Plan pays 95%, You pay 5%	**PCP:** You pay $45, Plan pays remainder **Specialist:** You pay $60, Plan pays remainder **Other Covered Services:** After deductible Plan pays 80%, You pay 20%	After deductible Plan pays 50%, You pay 50%
Emergency Room [3]	You pay $200 (waived if admitted) Plan pays remainder	You pay $200 (waived if admitted) Plan pays remainder	You pay $200 (waived if admitted) Plan pays remainder

[1] Deductibles do not accumulate across networks. They include medical and behavioral health deductibles.
[2] Out-of-pocket maximums accumulate across Enhanced and Core networks only. They include medical and behavioral health deductibles, coinsurance, and copays.
[3] For non-emergency use of the Emergency Department, the room charge is not covered and all ancillary and physician services are covered at the applicable deductible and coinsurance rates.
[4] All out-of-network expenses are subject to usual, customary, and reasonable (UC&R) limits.

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WellSpan Plus Plan (Prescription Drug)

Type of Medication	Enhanced Network Retail (WellSpan Pharmacies and Other Select Pharmacies) Up to 34-day supply	Core Network Retail (Capital Rx Network Pharmacies) Up to 34-day supply	Mail Order or Retail[2] (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	Out-of-Network Pharmacy[3] Up to 34-day supply
Generic	You pay $10, Plan pays remainder	Plan pays 80%, You pay 20% ($10 minimum)	You pay $20, Plan pays remainder	Plan pays 80%, You pay 20% ($10 minimum)
Brand-Name Formulary	You pay $35 plus the amount above generic cost, Plan pays remainder	Plan pays 65%, You pay 35% plus the amount above generic cost ($35 minimum)	You pay $70 plus the amount above generic cost, Plan pays remainder	Plan pays 65%, You pay 35% plus the amount above generic cost ($35 minimum)
Brand-Name Non-Formulary	You pay $60 plus the amount above generic cost, Plan pays remainder	Plan pays 50%, You pay 50% plus the amount above generic cost ($60 minimum)	You pay $120 plus the amount above generic cost, Plan pays remainder	Plan pays 50%, You pay 50% plus the amount above generic cost ($60 minimum)
Specialty Drugs	You pay 20% up to a $150 maximum	Not Covered	Not Available	Not Covered
Prescription Out-of-Pocket Maximum[1] Includes deductible, coinsurance, and copays	**Individual:** $3,000 **Family:** $5,250		Included in the Enhanced and Core Network maximums	**Individual:** $10,250 **Family:** $20,250

[1] Prescription out-of-pocket maximum for pharmacy is separate from and in addition to, the medical/behavioral health out-of-pocket maximum.

[2] Prescription for a "maintenance" medication (a medication you take routinely for an ongoing health issue, such as high blood pressure, high cholesterol or asthma), MUST be fill at a WellSpan Pharmacy to receive coverage.

[3] All out-of-network expenses are subject to usual, customary, and reasonable (UC&R) limits.

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WellSpan Plus Plan (Behavioral Health)

Note: changes to the Plan are in **blue**.

Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Quest Network	Out-of-Network Out-of-Network [3]
Deductible [1]	$300 per person	$450 per person	$900 per person
Out-of-Pocket Maximum [2] Includes deductible, copays, and coinsurance	**Individual:** $2,750 / **Family:** $4,750		**Individual:** $10,250 / **Family:** $20,250
INPATIENT			
Hospitalization, Partial Hospitalization, and Intensive Outpatient Services	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 80%, You pay $200 + 20%	After deductible Plan pays 70%, You pay $250 + 30%
Professional Fees (Inpatient)	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 80%, You pay 20%	After deductible Plan pays 50%, You pay 50%
OUTPATIENT			
Outpatient Visits (per visit)	You pay $10, Plan pays remainder	You pay $25, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
Autism (per visit)	You pay $10, Plan pays remainder	You pay $25, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
Psychological Testing (Outpatient diagnostic)	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 80%, You pay 20%	After deductible Plan pays 50%, You pay 50%
Transcranial Magnetic Stimulation	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 80%, You pay 20%	After deductible Plan pays 50%, You pay 50%
EMERGENCY			
Emergency Department/Crisis Evaluation	You pay $200 (waived if admitted), Plan pays 100%	You pay $200 (waived if admitted), Plan pays 100%	**ER:** You pay $200 (waived if admitted), Plan pays 100% **Non-Emergency:** After deductible Plan pays 50%, You pay 50%
Electroconvulsive Therapy	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 80%, You pay 20%	After deductible Plan pays 50%, You pay 50%

[1] Deductibles do not accumulate across networks. They include medical and behavioral health deductibles.
[2] Out-of-pocket maximums accumulate across Enhanced and Core networks only. They include medical and behavioral health deductibles, coinsurance, and copays.
[3] All out-of-network claims are subject to adjustments for usual, customary, and reasonable (UC&R) charges. The plan does not pay benefits for amounts above UC&R.

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