

2024 Medical WellSpan Standard 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	Individual: \$550 / Family: \$1,100	Individual: \$1,200 / Family: \$2,400	Individual: \$2,050 / Family: \$4,050
Medical Out-of-Pocket Maximum ² Includes deductible, copays, and coinsurance	Individual: \$4,500 / Family: \$8,250		Individual: \$6,750 / Family: \$12,750
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 \$20, Plan pays remainder Specialist: You pay \$40, Plan pays remainder	PCP: You pay \$30, Plan pays remainder Specialist: You pay \$45, 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 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
Ambulatory, Outpatient, Surgery, MRIs, MRAs, and CT and PET Scans (Facility)	After deductible Plan pays 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
Outpatient (Lab/Diagnostic)	After deductible Plan pays 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
Physical/Speech/Vision/Occupational Therapy	Physical Therapy: \$10 copay, 90% coinsurance , deductible waived Speech Therapy: \$10 copay, 90% coinsurance , deductible waived Vision Therapy: \$10 copay, 90% coinsurance , deductible waived Occupational Therapy: \$10 copay, 90% 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 \$30, Plan pays remainder Specialist: You pay \$60, Plan pays remainder Other Covered Services: After deductible Plan pays 90%, You pay 10%	PCP: You pay \$50, Plan pays remainder Specialist: You pay \$80, Plan pays remainder Other Covered Services: After deductible Plan pays 70%, You pay 30%	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.

WellSpan Standard 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 70%, You pay 30%	You pay \$20, Plan pays remainder	Plan pays 70%, You pay 30%
Brand-Name Formulary	You pay \$40 plus the amount above generic cost, Plan pays remainder	Plan pays 65%, You pay 35% plus the amount above generic cost (\$40 minimum per script)	You pay \$80 plus the amount above generic cost, Plan pays remainder	Plan pays 65%, You pay 35% plus the amount above generic cost (\$40 minimum per script)
Brand-Name Non-Formulary	You pay \$65 plus the amount above generic cost, Plan pays remainder	Plan pays 50%, You pay 50% plus the amount above generic cost (\$65 minimum per script)	You pay \$130 plus the amount above generic cost, Plan pays remainder	Plan pays 50%, You pay 50% plus the amount above generic cost (\$65 minimum per script)
Specialty Drugs	You pay 20% up to a \$150 maximum	Not Covered	Not Available	Not Covered
Prescription Out-of-Pocket Maximum¹ Includes deductible, coinsurance, and copays	Individual: \$3,000 Family: \$5,250		Included in the Enhanced and Core Network maximums	Individual: \$6,750 Family: \$12,750

¹ Prescription out-of-pocket maximum for WellSpan Pharmacy and Capital Rx Pharmacies (Enhanced and Core) is separate from and in addition to the medical 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.

WellSpan Standard Plan (Behavioral Health)



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	Individual: \$550 / Family: \$1,100	Individual: \$1,200 / Family: \$2,400	Individual: \$2,050 / Family: \$4,050
Out-of-Pocket Maximum ² Includes deductible, copays, and coinsurance	Individual: \$4,500 / Family: \$8,250		Individual: \$6,750 / Family: \$12,750
INPATIENT			
Hospitalization, Partial Hospitalization, and Intensive Outpatient Services	After deductible Plan pays 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
Professional Fees (Inpatient)	After deductible Plan pays 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
OUTPATIENT			
Outpatient Visits (per visit)	You pay \$20, Plan pays remainder	You pay \$30, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
Autism (per visit)	You pay \$20, Plan pays remainder	You pay \$30, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
Psychological Testing (Outpatient diagnostic)	After deductible Plan pays 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
Transcranial Magnetic Stimulation	After deductible Plan pays 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	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 90%, You pay 10%	After deductible Plan pays 70%, You pay 30%	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.