

# 2025 Medical PPO Standard Plan



Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Capital Blue Cross Network	Out-of-Network Out-of-Network <sup>4</sup>
<b>Annual Deductible<sup>1</sup></b>	<b>Individual: \$550 / Family: \$1,100</b>	<b>Individual: \$1,200 / Family: \$2,400</b>	<b>Individual: \$2,050 / Family: \$4,050</b>
<b>Medical Out-of-Pocket Maximum<sup>2</sup></b> Includes deductible, copays, and coinsurance	<b>Individual: \$4,500 / Family: \$8,250</b>		<b>Individual: \$6,750 / Family: \$12,750</b>
<b>Preventive Care</b> 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%
<b>Office Visits</b> (Primary Care (PCP), Specialist)	<b>PCP:</b> You pay \$20, Plan pays remainder <b>Specialist:</b> You pay \$40, Plan pays remainder	<b>PCP:</b> You pay \$30, Plan pays remainder <b>Specialist:</b> You pay \$45, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
<b>WellSpan Online Urgent Care</b>	\$0 copay	N/A	N/A
<b>Hospital Facility/Physician</b> (Inpatient)	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>Ambulatory, Outpatient, Surgery, MRIs, MRAs, and CT and PET Scans</b> (Facility)	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>Outpatient</b> (Lab/Diagnostic)	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>Physical/Speech/Vision/Occupational Therapy</b>	<b>Physical Therapy:</b> \$10 copay, 95% coinsurance, deductible waived <b>Speech Therapy:</b> \$10 copay, 95% coinsurance, deductible waived <b>Vision Therapy:</b> \$10 copay, 95% coinsurance, deductible waived <b>Occupational Therapy:</b> \$10 copay, 95% coinsurance, deductible waived	<b>Physical Therapy:</b> \$30 co-payment, then 70% with no deductible <b>Speech Therapy:</b> \$30 co-payment, then 70% with no deductible <b>Vision Therapy:</b> \$30 co-payment, then 70% with no deductible <b>Occupational Therapy:</b> \$30 co-payment, then 70% with no deductible	<b>Physical Therapy:</b> 50% after the deductible subject to the Plan Allowance <b>Speech Therapy:</b> 50% after the deductible subject to the Plan Allowance <b>Vision Therapy:</b> 50% after the deductible subject to the Plan Allowance <b>Occupational Therapy:</b> 50% after the deductible subject to the Plan Allowance
<b>Urgent Care/Walk-In Clinics/Retail Clinics</b>	<b>PCP:</b> You pay \$30, Plan pays remainder <b>Specialist:</b> You pay \$60, Plan pays remainder <b>Other Covered Services:</b> After deductible Plan pays 95%, You pay 5%	<b>PCP:</b> You pay \$50, Plan pays remainder <b>Specialist:</b> You pay \$80, Plan pays remainder <b>Other Covered Services:</b> After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>Emergency Room<sup>3</sup></b>	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

<sup>1</sup> Deductibles do not accumulate across networks. They include medical and behavioral health deductibles.

<sup>2</sup> Out-of-pocket maximums accumulate across Enhanced and Core networks only. They include medical and behavioral health deductibles, coinsurance, and copays.

<sup>3</sup> 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.

<sup>4</sup> All out-of-network expenses are subject to usual, customary, and reasonable (UC&R) limits.

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 <sup>2</sup> (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	Out-of-Network Pharmacy <sup>3</sup> Up to 34-day supply
<b>Generic</b>	You pay \$10, Plan pays remainder	Plan pays 70%, You pay 30%	You pay \$20, Plan pays remainder	Plan pays 70%, You pay 30%
<b>Brand-Name Formulary</b>	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)
<b>Brand-Name Non-Formulary</b>	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)
<b>Specialty Drugs</b>	You pay 20% up to a \$150 maximum	Not Covered	Not Available	Not Covered
<b>Prescription Out-of-Pocket Maximum<sup>1</sup></b> Includes deductible, coinsurance, and copays	<b>Individual: \$3,000</b> <b>Family: \$5,250</b>		Included in the Enhanced and Core Network maximums	<b>Individual: \$6,750</b> <b>Family: \$12,750</b>

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> All out-of-network expenses are subject to usual, customary, and reasonable (UC&R) limits.

# 2025 Medical PPO 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 <sup>3</sup>
<b>Deductible<sup>1</sup></b>	<b>Individual: \$550 / Family: \$1,100</b>	<b>Individual: \$1,200 / Family: \$2,400</b>	<b>Individual: \$2,050 / Family: \$4,050</b>
<b>Out-of-Pocket Maximum<sup>2</sup></b> Includes deductible, copays, and coinsurance	<b>Individual: \$4,500 / Family: \$8,250</b>		<b>Individual: \$6,750 / Family: \$12,750</b>
<b>INPATIENT</b>			
<b>Hospitalization, Partial Hospitalization, and Intensive Outpatient Services</b>	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>Professional Fees (Inpatient)</b>	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>OUTPATIENT</b>			
<b>Outpatient Visits (per visit)</b>	You pay \$20, Plan pays remainder	You pay \$30, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
<b>Autism (per visit)</b>	You pay \$20, Plan pays remainder	You pay \$30, Plan pays remainder	After deductible Plan pays 50%, You pay 50%
<b>Psychological Testing (Outpatient diagnostic)</b>	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>Transcranial Magnetic Stimulation</b>	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%
<b>EMERGENCY</b>			
<b>Emergency Department/Crisis Evaluation</b>	You pay \$200 (waived if admitted), Plan pays 100%	You pay \$200 (waived if admitted), Plan pays 100%	<b>ER:</b> You pay \$200 (waived if admitted), Plan pays 100% <b>Non-Emergency:</b> After deductible Plan pays 50%, You pay 50%
<b>Electroconvulsive Therapy</b>	After deductible Plan pays 95%, You pay 5%	After deductible Plan pays 70%, You pay 30%	After deductible Plan pays 50%, You pay 50%

<sup>1</sup> Deductibles do not accumulate across networks. They include medical and behavioral health deductibles.

<sup>2</sup> Out-of-pocket maximums accumulate across Enhanced and Core networks only. They include medical and behavioral health deductibles, coinsurance, and copays.

<sup>3</sup> 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.