



# Health & Wellness

## 2021 MEDICAL: WellSpan Plus Plan

| Feature   | Enhanced Network<br>WellSpan Provider Network and<br>Other Select Providers and Facilities  | Core Network<br>Legacy Summit:<br>PPO Blue Network (Highmark)<br>Legacy WellSpan:<br>Aetna Signature Administrators Network                                    | Out-of-Network<br>Out-of-Network <sup>4</sup>                           |
|---|---|--|---|
|   |   |  |   |
| <b>Annual Deductible<sup>1</sup></b> (per person)   | \$150   | \$300  | \$800   |
| <b>Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family)<br><i>Includes deductible, copays, and coinsurance</i> | \$2,750/\$4,750   |  | \$10,250/\$20,250   |
| <b>Preventive Care</b><br><i>Includes annual physical and well-child care</i>                                       | Plan pays 100%<br>You pay 0%  | Plan pays 100%<br>You pay 0%   | After deductible plan pays 50%<br>You pay 50%                           |
| <b>Office Visits</b><br>• Primary Care<br>• Specialist  | Plan pays 100%, you pay 0%<br>You pay \$25/Plan pays remainder  | You pay \$20/Plan pays remainder<br>You pay \$35/Plan pays remainder   | After deductible plan pays 50%<br>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 100%<br>You pay 0%   | You pay \$200 copay, then after<br>deductible plan pays 80%/You pay 20%  | You pay \$250 copay, then after<br>deductible plan pays 70%/You pay 30% |
| <b>Ambulatory, Outpatient, Surgery, MRIs,<br/>MRAs, and CT and PET Scans</b> (facility)                             | After deductible plan pays 100%<br>You pay 0%   | You pay \$200 copay, then after<br>deductible plan pays 80%/You pay 20%  | You pay \$250 copay, then after<br>deductible plan pays 50%/You pay 50% |
| <b>Outpatient</b> (Lab/Diagnostic)  | After deductible plan pays 100%<br>You pay 0%   | After deductible plan pays 80%<br>You pay 20%  | After deductible plan pays 50%<br>You pay 50%                           |
| <b>Massage Therapy<sup>6</sup></b>  | \$15 copay then Plan pays 100% up to a \$500<br>maximum per calendar year <sup>5</sup>  | Not covered  | Not covered   |
| <b>Urgent Care/Walk-In Clinics/Retail Clinics</b>   | PCP: Plan pays 100%/You pay 0%<br>Specialist: You pay \$25/Plan pays remainder<br>Other covered services:<br>After deductible plan pays 100%/You pay 0% | PCP: You pay \$20/Plan pays remainder<br>Specialist: You pay \$35/Plan pays remainder<br>Other covered services:<br>After deductible plan pays 80%/You pay 20% | After deductible plan pays 50%<br>You pay 50%                           |
| <b>Emergency Room<sup>3</sup></b>   | You pay \$150 (waived if admitted)<br>Plan pays remainder   | You pay \$150 (waived if admitted)<br>Plan pays remainder  | You pay \$150 (waived if admitted)<br>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.

<sup>5</sup> Only covered when services are obtained at a WellSpan Center for Mind Body & Health and at select locations.

<sup>6</sup> \$15 copay for massage therapy is not eligible for FSA reimbursement, unless it is deemed medically necessary.

## 2021 WellSpan Plus Plan: Prescription Drug Benefits

| Type of Medication   | Enhanced Network<br>Retail<br>(WellSpan Pharmacies and<br>Other Select Pharmacies)<br>Up to 34-day supply | Core Network<br>Retail*<br>(Optum Rx Network<br>Pharmacies)<br>Up to 34-day supply   | Mail Order or Retail<br>(WellSpan Pharmacies Only)<br>35-100 day supply for<br>Maintenance Drugs | Out-of-Network<br>Pharmacy**<br>Up to 34-day supply                                  |
|--|---|--|--|--|
| <b>Generic</b>   | You pay \$10<br>Plan pays remainder   | Plan pays 80%<br>You pay 20% (\$10 minimum)  | You pay \$20<br>Plan pays remainder  | Plan pays 80%<br>You pay 20% (\$10 minimum)  |
| <b>Brand-Name Formulary</b>  | You pay \$25 plus the amount<br>above generic cost<br>Plan pays remainder                                 | Plan pays 75%<br>You pay 25% plus the amount<br>above generic cost<br>(\$25 minimum) | You pay \$50 plus the amount<br>above generic cost<br>Plan pays remainder                        | Plan pays 75%<br>You pay 25% plus the amount<br>above generic cost<br>(\$25 minimum) |
| <b>Brand-Name Non-Formulary</b>  | You pay \$50 plus the amount<br>above generic cost<br>Plan pays remainder                                 | Plan pays 55%<br>You pay 45% plus the amount<br>above generic cost<br>(\$50 minimum) | You pay \$100 plus the amount<br>above generic cost<br>Plan pays remainder                       | Plan pays 55%<br>You pay 45% plus the amount<br>above generic cost<br>(\$50 minimum) |
| <b>Prescription Out-of-Pocket Maximum</b><br>(Individual/Family)<br>includes deductible, coinsurance, and copays | \$2,750/\$4,750   |  | Included in the Enhanced and<br>Core Network maximums  | \$10,250/\$20,250  |

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

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

## 2021 WellSpan Plus Plan: Behavioral Health Benefits

| Feature  | Enhanced Network<br>WellSpan Provider Network and<br>Other Select Providers and Facilities | Core Network<br>Quest Network                         | Out-of-Network<br>Out-of-Network <sup>3</sup>  |
|--|--|---|--|
| Deductible <sup>1</sup> (per person)   | \$150  | \$300   | \$800  |
| Out-of-Pocket Maximum <sup>2</sup> (Individual/Family)                         | \$2,750/\$4,750  |   | \$10,250/\$20,250  |
| Inpatient  |  |   |  |
| Hospitalization, Partial Hospitalization,<br>and Intensive Outpatient Services | After deductible plan pays 100%<br>You pay 0%  | After deductible plan pays 80%<br>You pay \$200 + 20% | After deductible plan pays 70%<br>You pay \$250 + 30%  |
| Professional Fees (Inpatient)  | After deductible plan pays 100%<br>You pay 0%  | After deductible plan pays 80%<br>You pay 20%         | After deductible plan pays 50%<br>You pay 50%  |
| Outpatient   |  |   |  |
| Outpatient Visits  | Plan pays 100%<br>You pay 0%   | You pay \$20<br>Plan pays remainder                   | After deductible plan pays 50%<br>You pay 50%  |
| Psychological Testing (Outpatient diagnostic)                                  | After deductible plan pays 100%<br>You pay 0%  | After deductible plan pays 80%<br>You pay 20%         | After deductible plan pays 50%<br>You pay 50%  |
| Emergency  |  |   |  |
| Emergency Department/Crisis Evaluation   | You pay \$150 (waived if admitted)<br>Plan pays 100%                                       | You pay \$150 (waived if admitted)<br>Plan pays 100%  | ER: You pay \$150/Plan pays 100%<br>Non-Emergency: After deductible plan<br>pays 50%/You pay 50% |
| Electroconvulsive Therapy  | After deductible plan pays 100%<br>You pay 0%  | After deductible plan pays 80%<br>You pay 20%         | After deductible plan pays 50%<br>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 (UCR) charges. The plan does not pay benefits for amounts above UCR.

## 2021 MEDICAL: WellSpan Standard Plan

| Feature   | Enhanced Network<br>WellSpan Provider Network and<br>Other Select Providers and Facilities   | Core Network<br>Legacy Summit:<br>PPO Blue Network (Highmark)<br>Legacy WellSpan:<br>Aetna Signature Administrators Network  | Out-of-Network<br>Out-of-Network <sup>4</sup>             |
|---|--|--|---|
|   |  |  |   |
| <b>Annual Deductible<sup>1</sup></b> (Individual/Family)  | \$500/\$1,000  | \$1,050/\$2,050  | \$2,050/\$4,050   |
| <b>Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family)<br><i>Includes deductible, copays, and coinsurance</i> | \$4,250/\$7,750  |  | \$6,750/\$12,750  |
| <b>Preventive Care</b><br><i>Includes annual physical and well-child care</i>                                       | Plan pays 100%<br>You pay 0%   | Plan pays 100%<br>You pay 0%   | After deductible plan pays 50%<br>You pay 50%             |
| <b>Office Visits</b><br>• Primary Care<br>• Specialist  | You pay \$20/Plan pays remainder<br>You pay \$40/Plan pays remainder   | You pay \$30/Plan pays remainder<br>You pay \$45/Plan pays remainder   | After deductible plan pays 50%<br>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 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%  | After deductible plan pays 50%<br>You pay 50%             |
| <b>Ambulatory, Outpatient, Surgery, MRIs, MRAs, and CT and PET Scans</b> (facility)                                 | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%  | After deductible plan pays 50%<br>You pay 50%             |
| <b>Outpatient</b> (Lab/Diagnostic)  | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%  | After deductible plan pays 50%<br>You pay 50%             |
| <b>Urgent Care/Walk-In Clinics/Retail Clinics</b>   | PCP: You pay \$20/Plan pays remainder<br>Specialist: You pay \$40/Plan pays remainder<br><b>Other covered services:</b><br>After deductible plan pays 90%<br>You pay 10% | PCP: You pay \$30/Plan pays remainder<br>Specialist: You pay \$45/Plan pays remainder<br><b>Other covered services:</b><br>After deductible plan pays 70%<br>You pay 30% | After deductible plan pays 50%<br>You pay 50%             |
| <b>Emergency Room<sup>3</sup></b>   | You pay \$150 (waived if admitted)<br>Plan pays remainder  | You pay \$150 (waived if admitted)<br>Plan pays remainder  | You pay \$150 (waived if admitted)<br>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.

## 2021 WellSpan Standard Plan: Prescription Drug Benefits

| Type of Medication   | Enhanced Network<br>Retail<br>(WellSpan Pharmacies and<br>Other Select Pharmacies)<br>Up to 34-day supply | Core Network<br>Retail*<br>(Optum Rx Network<br>Pharmacies)<br>Up to 34-day supply | Mail Order or Retail<br>(WellSpan Pharmacies Only)<br>35-100 day supply for<br>Maintenance Drugs | Out-of-Network<br>Pharmacy**<br>Up to 34-day supply                |
|--|---|--|--|--|
| <b>Generic</b>   | You pay \$10<br>Plan pays remainder   | Plan pays 70%<br>You pay 30%   | You pay \$20<br>Plan pays remainder  | Plan pays 70%<br>You pay 30%                                       |
| <b>Brand-Name Formulary</b>  | You pay \$25 plus the amount<br>above generic cost<br>Plan pays remainder                                 | Plan pays 65%<br>You pay 35% plus the amount<br>above generic cost                 | You pay \$50 plus the amount<br>above generic cost<br>Plan pays remainder                        | Plan pays 65%<br>You pay 35% plus the amount<br>above generic cost |
| <b>Brand-Name Non-Formulary</b>  | You pay \$50 plus the amount<br>above generic cost<br>Plan pays remainder                                 | Plan pays 50%<br>You pay 50% plus the amount<br>above generic cost                 | You pay \$100 plus the amount<br>above generic cost<br>Plan pays remainder                       | Plan pays 50%<br>You pay 50% plus the amount<br>above generic cost |
| <b>Prescription Out-of-Pocket Maximum</b><br>(Individual/Family)<br>includes deductible, coinsurance, and copays | \$2,750/\$4,750   |  | Included in the Enhanced and<br>Core Network maximums  | \$6,750/\$12,750   |

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

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

## 2021 WellSpan Standard Plan: Behavioral Health Benefits

| Feature  | Enhanced Network<br>WellSpan Provider Network and<br>Other Select Providers and Facilities | Core Network<br>Quest Network                        | Out-of-Network<br>Out-of-Network <sup>3</sup>  |
|--|--|--|--|
| Deductible <sup>1</sup> (Individual/Family)                                    | \$500/\$1,000  | \$1,050/\$2,050                                      | \$2,050/\$4,050  |
| Out-of-Pocket Maximum <sup>2</sup> (Individual/Family)                         | \$4,250/\$7,750  |  | \$6,750/\$12,750   |
| Inpatient  |  |  |  |
| Hospitalization, Partial Hospitalization,<br>and Intensive Outpatient Services | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%        | After deductible plan pays 50%<br>You pay 50%  |
| Professional Fees (Inpatient)  | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%        | After deductible plan pays 50%<br>You pay 50%  |
| Outpatient   |  |  |  |
| Outpatient Visits  | You pay \$20<br>Plan pays remainder  | You pay \$30<br>Plan pays remainder                  | After deductible plan pays 50%<br>You pay 50%  |
| Psychological Testing (Outpatient diagnostic)                                  | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%        | After deductible plan pays 50%<br>You pay 50%  |
| Emergency  |  |  |  |
| Emergency Department/Crisis Evaluation   | You pay \$150 (waived if admitted)<br>Plan pays 100%                                       | You pay \$150 (waived if admitted)<br>Plan pays 100% | ER: You pay \$150/Plan pays 100%<br>Non-Emergency: After deductible plan<br>pays 50%/You pay 50% |
| Electroconvulsive Therapy  | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%        | After deductible plan pays 50%<br>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 (UCR) charges. The plan does not pay benefits for amounts above UCR.

## 2021 MEDICAL: WellSpan High Deductible Plan

| Feature   | Enhanced Network  | Core Network  | Out-of-Network   |
|---|---|---|--|
|   | WellSpan Provider Network and<br>Other Select Providers and Facilities  | Legacy Summit:<br>PPO Blue Network (Highmark)<br>Legacy WellSpan:<br>Aetna Signature Administrators Network   | Out-of-Network <sup>4</sup>  |
| <b>Annual Deductible<sup>1</sup></b> (Individual/Family)  | \$1,400/\$2,800   |   | \$2,800/\$5,600  |
| <b>Integrated Out-of-Pocket Maximum<sup>2</sup></b><br>(Individual/Family Embedded)<br><i>Includes medical, behavioral health and<br/>prescription deductibles, coinsurances and copays</i> | \$5,500/\$9,500   |   | \$13,800/\$27,600  |
| <b>Preventive Care</b><br><i>Includes annual physical and well-child care</i>   | Plan pays 100%<br>You pay 0%  | Plan pays 100%<br>You pay 0%  | After deductible plan pays 50%<br>You pay 50%                              |
| <b>Office Visits</b><br>• Primary Care<br>• Specialist  | After deductible<br>You pay \$10/Plan pays remainder<br>You pay \$30/Plan pays remainder  | After deductible<br>You pay \$30/Plan pays remainder<br>You pay \$40/Plan pays remainder  | After deductible plan pays 50%<br>You pay 50%                              |
| <b>Hospital Facility/Physician</b> (Inpatient)  | After deductible plan pays 90%<br>You pay 10%   | After deductible plan pays 70%<br>You pay 30%   | After deductible plan pays 50%<br>You pay 50%                              |
| <b>Ambulatory, Outpatient, Surgery, MRIs,<br/>MRAs, and CT and PET Scans</b> (facility)   | After deductible plan pays 90%<br>You pay 10%   | After deductible plan pays 70%<br>You pay 30%   | After deductible plan pays 50%<br>You pay 50%                              |
| <b>Outpatient</b> (Lab/Diagnostic)  | After deductible plan pays 90%<br>You pay 10%   | After deductible plan pays 70%<br>You pay 30%   | After deductible plan pays 50%<br>You pay 50%                              |
| <b>Urgent Care/Walk-In Clinics/Retail Clinics</b>   | PCP: After deductible you pay \$10<br>Plan pays remainder<br>Specialist: After deductible you pay \$30<br>Plan pays remainder<br>Other covered services:<br>After deductible plan pays 90%<br>You pay 10% | PCP: After deductible you pay \$30<br>Plan pays remainder<br>Specialist: After deductible you pay \$40<br>Plan pays remainder<br>Other covered services:<br>After deductible plan pays 70%<br>You pay 30% | After deductible plan pays 50%<br>You pay 50%                              |
| <b>Emergency Room<sup>3</sup></b>   | After deductible you pay \$150 (waived if<br>admitted)/Plan pays remainder  | After deductible you pay \$150 (waived if<br>admitted)/Plan pays remainder  | After deductible you pay \$150 (waived if<br>admitted)/Plan pays remainder |

<sup>1</sup> Deductibles accumulate across Enhanced and Core networks only. They include medical, prescription, and behavioral health deductibles. All covered family members contribute toward the family deductible.

<sup>2</sup> Out-of-pocket maximums accumulate across Enhanced and Core networks only. They include medical, prescription drug, 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.

## 2021 WellSpan High Deductible Plan: Prescription Drug Benefits

### Preventive Drugs

Preventive drugs are covered with no deductible in the High Deductible Medical Plan option when using in-network pharmacies (WellSpan Pharmacy — Enhanced or Optum Rx — Core networks). Certain ACA approved medications and generic drugs on the preventive list are \$0. Click here for a list of Preventive drugs, as determined by Optum Rx. *Note: Brand-name preventive drugs will have a copay/coinsurance you will be responsible for, but the deductible will be waived.*

### Non-Preventive Drugs

| Type of Medication  | Enhanced Network<br>Retail<br>(WellSpan Pharmacies and<br>Other Select Pharmacies)<br>Up to 34-day supply | Core Network<br>Retail*<br>(Optum Rx Network<br>Pharmacies)<br>Up to 34-day supply  | Mail Order or Retail<br>(WellSpan Pharmacies Only)<br>35-100 day supply for<br>Maintenance Drugs    | Out-of-Network<br>Pharmacy**<br>Up to 34-day supply                                 |
|---|---|---|---|---|
| <b>Generic</b>  | After deductible you pay \$10<br>Plan pays remainder  | After deductible plan pays 70%<br>You pay 30%                                       | After deductible you pay \$20<br>Plan pays remainder  | After deductible plan pays 70%<br>You pay 30%                                       |
| <b>Brand-Name Formulary</b>   | After deductible you<br>pay \$30 plus the amount<br>above generic cost<br>Plan plan pays remainder        | After deductible plan pays 65%<br>You pay 35% plus the amount<br>above generic cost | After deductible you<br>pay \$60 plus the amount<br>above generic cost<br>Plan plan pays remainder  | After deductible plan pays 65%<br>You pay 35% plus the amount<br>above generic cost |
| <b>Brand-Name Non-Formulary</b>   | After deductible you<br>pay \$55 plus the amount<br>above generic cost<br>Plan plan pays remainder        | After deductible plan pays 50%<br>You pay 50% plus the amount<br>above generic cost | After deductible you<br>pay \$110 plus the amount<br>above generic cost<br>Plan plan pays remainder | After deductible plan pays 50%<br>You pay 50% plus the amount<br>above generic cost |
| <b>Integrated Out-of-Pocket Maximum*</b><br>(Individual/Family Embedded)<br><i>Includes medical, behavioral health and<br/>prescription deductibles, coinsurances, and copays</i> | \$5,500/\$9,500   |   | Included in the Enhanced and<br>Core Network maximums   | \$13,800/\$27,600*  |

\* Out-of-pocket maximums accumulate across Enhanced and Core only. They include medical, prescription, and behavioral health deductibles, coinsurance, and copays.

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



## 2021 WellSpan High Deductible Plan: Behavioral Health Benefits

| Feature  | Enhanced Network<br>WellSpan Provider Network and<br>Other Select Providers and Facilities | Core Network<br>Quest Network  | Out-of-Network<br>Out-of-Network <sup>3</sup>   |
|--|--|--|---|
| <b>Deductible<sup>1</sup></b> (Individual/Family)  | \$1,400/\$2,800  |  | \$2,800/\$5,600   |
| <b>Integrated Out-of-Pocket Maximum<sup>2</sup></b><br>(Individual/Family)<br><i>Includes medical, behavioral health and<br/>prescription deductibles, coinsurances and copays</i> | \$5,500/\$9,500  |  | \$13,800/\$27,600   |
| <b>Inpatient</b>   |  |  |   |
| <b>Hospitalization, Partial Hospitalization,<br/>and Intensive Outpatient Services</b>   | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%                            | After deductible plan pays 50%<br>You pay 50%   |
| <b>Professional Fees</b> (Inpatient)   | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%                            | After deductible plan pays 50%<br>You pay 50%   |
| <b>Outpatient</b>  |  |  |   |
| <b>Outpatient Visits</b>   | After deductible you pay \$10<br>Plan pays remainder                                       | After deductible you pay \$30<br>Plan pays remainder                     | After deductible plan pays 50%<br>You pay 50%   |
| <b>Psychological Testing</b> (Outpatient diagnostic)   | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%                            | After deductible plan pays 50%<br>You pay 50%   |
| <b>Emergency</b>   |  |  |   |
| <b>Emergency Department/Crisis Evaluation</b>  | After deductible you pay \$150<br>(waived if admitted)<br>Plan pays 100%                   | After deductible you pay \$150<br>(waived if admitted)<br>Plan pays 100% | <b>ER:</b> After deductible you pay \$150<br>(waived if admitted)/Plan pays 100%<br><b>Non-Emergency:</b> After deductible<br>plan pays 50%/You pay 50% |
| <b>Electroconvulsive Therapy</b>   | After deductible plan pays 90%<br>You pay 10%  | After deductible plan pays 70%<br>You pay 30%                            | After deductible plan pays 50%<br>You pay 50%   |

<sup>1</sup> Deductibles accumulate across Enhanced and Core networks only. They include medical, prescription, and behavioral health deductibles. All covered family members contribute toward the family deductible.

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

<sup>3</sup> All out-of-network claims are subject to adjustments for usual, customary, and reasonable (UCR) charges. The plan does not pay benefits for amounts above UCR.