



Health & Wellness

As of 10.05.22

2023 MEDICAL: WellSpan Plus Plan

2023 changes are marked 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 Deductible¹ (per person)	\$200	\$350	\$800
Medical Out-of-Pocket Maximum² (Individual/Family) <i>Includes deductible, copays, and coinsurance</i>	\$2,750/\$4,750		\$10,250/\$20,250
Preventive Care <i>Includes annual physical and well-child care</i>	Plan pays 100% You pay 0%	Plan pays 100% You pay 0%	After deductible Plan pays 50% You pay 50%
Office Visits • Primary Care • Specialist	You pay \$10 /Plan pays remainder You pay \$30/Plan pays remainder	You pay \$25/Plan pays remainder 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, then after deductible Plan pays 80%/You pay 20%	You pay \$250 copay, then 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, then after deductible Plan pays 80%/You pay 20%	You pay \$250 copay, then 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%
Massage Therapy⁶	\$15 copay then Plan pays 100% up to a \$500 maximum per calendar year ⁵	Not covered	Not covered
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 Room³	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.
⁵ Only covered when services are obtained at a WellSpan Center for Mind Body & Health and at select locations.
⁶ \$15 copay for massage therapy is not eligible for FSA reimbursement, unless it is deemed medically necessary.

IMPORTANT! New for 2023

If you have a prescription for a “maintenance” medication (a medication you take routinely for an ongoing health issue, such as high blood pressure, high cholesterol or asthma), you **MUST** fill it through a WellSpan onsite pharmacy to receive coverage.

You can fill the first two fills at a retail network pharmacy, such as CVS or Giant, but afterward all remaining fills must be filled through WellSpan onsite pharmacies. Otherwise, you will be responsible for paying the full price.

2023 WellSpan Plus Plan: Prescription Drug Benefits**2023 changes are marked in blue**

Type of Medication	Enhanced Network Retail (WellSpan Pharmacies and Other Select Pharmacies) Up to 34-day supply	Core Network Retail (Optum Rx Network Pharmacies) Up to 34-day supply	Mail Order or Retail (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	Out-of-Network Pharmacy** 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* (individual/Family) includes deductible, coinsurance, and copays	\$3,000/\$5,250		Included in the Enhanced and 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.

2023 WellSpan Plus Plan: Behavioral Health Benefits

2023 changes are marked 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 (per person)	\$200	\$350	\$800
Out-of-Pocket Maximum ² (Individual/Family)	\$2,750/\$4,750		\$10,250/\$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	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 (TMS)	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/Plan pays 100% (waived if admitted) 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.

2023 MEDICAL: WellSpan Standard Plan

2023 changes are marked 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 Deductible¹ (Individual/Family)	\$550/\$1,100	\$1,200/\$2,400	\$2,050/\$4,050
Medical Out-of-Pocket Maximum² (Individual/Family) <i>Includes deductible, copays, and coinsurance</i>	\$4,500/\$8,250		\$6,750/\$12,750
Preventive Care <i>Includes annual physical and well-child care</i>	Plan pays 100% You pay 0%	Plan pays 100% You pay 0%	After deductible Plan pays 50% You pay 50%
Office Visits • Primary Care • Specialist	You pay \$20/Plan pays remainder You pay \$40/Plan pays remainder	You pay \$30/Plan pays remainder 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%
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 Room³	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.

IMPORTANT! New for 2023

If you have a prescription for a “maintenance” medication (a medication you take routinely for an ongoing health issue, such as high blood pressure, high cholesterol or asthma), you **MUST** fill it through a WellSpan onsite pharmacy to receive coverage.

You can fill the first two fills at a retail network pharmacy, such as CVS or Giant, but afterward all remaining fills must be filled through WellSpan onsite pharmacies. Otherwise, you will be responsible for paying the full price.

2023 WellSpan Standard Plan: Prescription Drug Benefits**2023 changes are marked in blue**

Type of Medication	Enhanced Network Retail (WellSpan Pharmacies and Other Select Pharmacies) Up to 34-day supply	Core Network Retail (Optum Rx Network Pharmacies) Up to 34-day supply	Mail Order or Retail (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	Out-of-Network Pharmacy** 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 Maximum* (Individual/Family) includes deductible, coinsurance, and copays	\$3,000/\$5,250		Included in the Enhanced and 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.

2023 WellSpan Standard Plan: Behavioral Health Benefits

2023 changes are marked 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 (Individual/Family)	\$550/\$1,100	\$1,200/\$2,400	\$2,050/\$4,050
Out-of-Pocket Maximum ² (Individual/Family)	\$4,500/\$8,250		\$6,750/\$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	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 (TMS)	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.

2023 MEDICAL: WellSpan High Deductible Plan

2023 changes are marked 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 Deductible¹ (Individual/Family)	\$1,500/\$3,000			\$2,800/\$5,600
Integrated Out-of-Pocket Maximum² (Individual/Family Embedded) <i>Includes medical, behavioral health and prescription deductibles, coinsurances and copays</i>	\$6,000/\$12,000			\$13,800/\$27,600
Preventive Care <i>Includes annual physical and well-child care</i>	Plan pays 100% You pay 0%		Plan pays 100% You pay 0%	After deductible Plan pays 50% You pay 50%
Office Visits • Primary Care • Specialist	After deductible You pay \$10/Plan pays remainder You pay \$30/Plan pays remainder		After deductible You pay \$30/Plan pays remainder You pay \$40/Plan pays remainder	After deductible Plan pays 50% You pay 50%
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%
Urgent Care/Walk-In Clinics/Retail Clinics	PCP: After deductible you pay \$30 Plan pays remainder Specialist: After deductible you pay \$60 Plan pays remainder Other covered services: After deductible Plan pays 90% You pay 10%		PCP: After deductible you pay \$50 Plan pays remainder Specialist: After deductible 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 Room³	After deductible you pay \$200 (waived if admitted)/Plan pays remainder		After deductible you pay \$200 (waived if admitted)/Plan pays remainder	After deductible you pay \$200 (waived if admitted)/Plan pays remainder

¹ 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.

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

IMPORTANT! New for 2023

If you have a prescription for a “maintenance” medication (a medication you take routinely for an ongoing health issue, such as high blood pressure, high cholesterol or asthma), you **MUST** fill it through a WellSpan onsite pharmacy to receive coverage.

You can fill the first two fills at a retail network pharmacy, such as CVS or Giant, but afterward all remaining fills must be filled through WellSpan onsite pharmacies. Otherwise, you will be responsible for paying the full price.

2023 WellSpan High Deductible Plan: Prescription Drug Benefits

2023 changes are marked in blue

Type of Medication	Enhanced Network Retail (WellSpan Pharmacies and Other Select Pharmacies) Up to 34-day supply	Core Network Retail (Optum Rx Network Pharmacies) Up to 34-day supply	Mail Order or Retail (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	Out-of-Network Pharmacy** Up to 34-day supply
Generic	After deductible you pay \$10 Plan pays remainder	After deductible plan pays 70% You pay 30%	After deductible you pay \$20 Plan pays remainder	After deductible Plan pays 70% You pay 30%
Brand-Name Formulary	After deductible you pay \$40 plus the amount above generic cost Plan pays remainder	After deductible Plan pays 65% You pay 35% plus the amount above generic cost (minimum \$40 per script)	After deductible you pay \$80 plus the amount above generic cost Plan pays remainder	After deductible Plan pays 65% You pay 35% plus the amount above generic cost (minimum \$40 per script)
Brand-Name Non-Formulary	After deductible you pay \$65 plus the amount above generic cost Plan pays remainder	After deductible Plan pays 50% You pay 50% plus the amount above generic cost (minimum \$65 per script)	After deductible you pay \$130 plus the amount above generic cost Plan pays remainder	After deductible Plan pays 50% You pay 50% plus the amount above generic cost (minimum \$65 per script)
Specialty Drugs	You pay 20% with a \$150 maximum	Not Covered	Not Available	Not Covered
Integrated Out-of-Pocket Maximum* (Individual/Family Embedded) <i>Includes medical, behavioral health and prescription deductibles, coinsurances, and copays</i>	\$6,000/\$12,000		Included in the Enhanced and 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.

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.*

2023 WellSpan High Deductible Plan: Behavioral Health Benefits

2023 changes are marked 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
Deductible¹ (Individual/Family)	\$1,500/\$3,000		\$2,800/\$5,600
Integrated Out-of-Pocket Maximum² (Individual/Family) <i>Includes medical, behavioral health and prescription deductibles, coinsurances and copays</i>	\$6,000/\$12,000		\$13,800/\$27,600
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	After deductible you pay \$10 Plan pays remainder	After deductible you pay \$30 Plan pays remainder	After deductible Plan pays 50% You pay 50%
Autism	After deductible you pay \$10 Plan pays remainder	After deductible 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 (TMS)	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	After deductible you pay \$200 (waived if admitted) Plan pays 100%	After deductible you pay \$200 (waived if admitted) Plan pays 100%	ER: After deductible 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 accumulate across Enhanced and Core networks only. They include medical, prescription, and behavioral health deductibles. All covered family members contribute toward the family deductible.

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