



Health & Wellness

2020 MEDICAL: WellSpan Plus Plan

Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Aetna Signature Administrators Network	Out-of-Network Out-of-Network ⁴
Annual Deductible¹ (per person)	None	\$300	\$800
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	Plan pays 100%, you pay 0% You pay \$25/Plan pays remainder	You pay \$20/Plan pays remainder You pay \$35/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)	Plan pays 100% You pay 0%	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)	Plan pays 100% You pay 0%	You pay \$200 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)	Plan pays 100% You pay 0%	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: Plan pays 100%/You pay 0% Specialist: You pay \$25/Plan pays remainder Other covered services: Plan pays 100%/You pay 0%	PCP: You pay \$20/Plan pays remainder Specialist: You pay \$35/Plan pays remainder Other covered services: Plan pays 80%/You pay 20%	After deductible plan pays 50% You pay 50%
Emergency Room³	You pay \$100 (waived if admitted) Plan pays remainder	You pay \$100 (waived if admitted) Plan pays remainder	You pay \$100 (waived if admitted) Plan pays remainder

¹ Deductibles accumulate across Tiers 1 and 2 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 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.

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.

2020 MEDICAL: WellSpan Standard Plan

Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Aetna Signature Administrators Network	Out-of-Network Out-of-Network ⁴
Annual Deductible¹ (per person)	None	\$1,050/\$2,050	\$2,050/\$4,050
Out-of-Pocket Maximum² (Individual/Family) <i>Includes deductible, copays, and coinsurance</i>	\$4,250/\$7,750		\$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 \$10/Plan pays remainder You pay \$35/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)	Plan pays 80% You pay 20%	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)	Plan pays 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%
Outpatient (Lab/Diagnostic)	Plan pays 80% You pay 20%	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 \$10/Plan pays remainder Specialist: You pay \$35/Plan pays remainder Other covered services: Plan pays 80%/ You pay 20%	PCP: You pay \$30/Plan pays remainder Specialist: You pay \$45/Plan pays remainder Other covered services: Plan pays 70%/ You pay 30%	After deductible plan pays 50% You pay 50%
Emergency Room³	You pay \$100 (waived if admitted) Plan pays remainder	You pay \$100 (waived if admitted) Plan pays remainder	You pay \$100 (waived if admitted) Plan pays remainder

¹ Deductibles accumulate across Tiers 1 and 2 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 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.

2020 MEDICAL: WellSpan High Deductible Plan

Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Aetna Signature Administrators Network	Out-of-Network Out-of-Network ⁴
Annual Deductible¹ (Individual/Family)	\$1,400/\$2,800		\$2,800/\$5,600
Out-of-Pocket Maximum² (Individual/Family) <i>Includes deductible, copays, and coinsurance</i>	\$6,900/\$13,800		\$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 80% You pay 20%	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 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%
Outpatient (Lab/Diagnostic)	After deductible plan pays 80% You pay 20%	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 \$10 Plan pays remainder Specialist: After deductible you pay \$30 Plan pays remainder Other covered services: After deductible plan pays 80%/You pay 20%	PCP: After deductible you pay \$30/ Plan pays remainder Specialist: After deductible you pay \$40/ Plan pays remainder Other covered services: Plan plays 70%/You pay 30%	After deductible plan pays 50% You pay 50%
Emergency Room³	You pay \$100 (waived if admitted) Plan pays remainder	You pay \$100 (waived if admitted) Plan pays remainder	You pay \$100 (waived if admitted) Plan pays remainder

¹ Deductibles accumulate across Tiers 1 and 2 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 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.

2020 WellSpan Plus Plan: Prescription Drug Benefits

Type of Medication	Enhanced Network Retail (WellSpan Pharmacy) 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 \$25 + amount over generic cost Plan pays remainder	Plan pays 75% You pay 25% + amount over generic cost (\$25 minimum)	You pay \$50 + amount over generic cost Plan pays remainder	Plan pays 75% You pay 25% + amount over generic cost (\$25 minimum)
Brand-Name Non-Formulary	You pay \$50 + amount over generic cost Plan pays remainder	Plan pays 55% You pay 45% + amount over generic cost (\$50 minimum)	You pay \$100 + amount over generic cost Plan pays remainder	Plan pays 55% You pay 45% + amount over generic cost (\$50 minimum)
Prescription Out-of-Pocket Maximum (Individual/Family) includes deductible, coinsurance and copays	\$2,750/\$4,750		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.

2020 WellSpan Standard Plan: Prescription Drug Benefits

Type of Medication	Enhanced Network Retail (WellSpan Pharmacy) 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 \$25 + amount above generic cost Plan pays remainder	Plan pays 65% You pay 35% + amount over generic cost	You pay \$50 + amount above generic cost Plan pays remainder	Plan pays 65% You pay 35% + amount over generic cost
Brand-Name Non-Formulary	You pay \$50 + amount above generic cost Plan pays remainder	Plan pays 50% You pay 50% + amount above generic cost	You pay \$100 + amount above generic cost Plan pays remainder	Plan pays 50% You pay 50% + amount above generic cost
Prescription Out-of-Pocket Maximum (Individual/Family) includes deductible, coinsurance and copays	\$2,750/\$4,750		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.

2020 WellSpan High Deductible Plan: Prescription Drug Benefits

Preventive Drugs

Preventive drugs are covered at 100% (no copay, coinsurance or deductible) in the High Deductible Medical Plan option when using in-network pharmacies (WellSpan Pharmacy - Enhanced or Optum Rx - Core networks). Click here for a list of Preventive drugs, as determined by Optum Rx.

Non-Preventive Drugs

Type of Medication	Enhanced Network Retail (WellSpan Pharmacy) 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 \$20 Plan pays remainder	After deductible plan pays 70% You pay 30%	After deductible you pay \$40 Plan pays remainder	After deductible plan pays 70% You pay 30%
Brand-Name Formulary	After deductible you pay \$35 +amount over generic costs Plan plan pays remainder	After deductible plan pays 65% You pay 35% + amount of generic cost	After deductible you pay \$70 +amount over generic costs Plan plan pays remainder	After deductible plan pays 65% You pay 35% + amount of generic cost
Brand-Name Non-Formulary	After deductible you pay \$60 +amount over generic costs Plan plan pays remainder	After deductible plan pays 50% You pay 50% + amount of generic cost	After deductible you pay \$120 +amount over generic costs Plan plan pays remainder	After deductible plan pays 50% You pay 50% + amount of generic cost
Prescription Out-of-Pocket Maximum (Individual/Family) includes deductible, coinsurance and copays	\$6,900/\$13,800		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.

2020 WellSpan Plus: Behavioral Health Benefits

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)	None	\$300	\$800
Out-of-Pocket Maximum ² (Individual/Family)	\$2,750/\$4,750		\$10,250/\$20,250
Inpatient			
Hospitalization, Partial Hospitalization, and Intensive Outpatient Services	Plan pays 100% You pay 0%	After deductible plan pays 80% You pay \$200 + 20%	After deductible plan pays 70% You pay \$250 + 30%
Professional Fees (Inpatient)	Plan pays 100% You pay 0%	After deductible plan pays 80% You pay 20%	After deductible plan pays 50% You pay 50%
Outpatient			
Outpatient Visits	Plan pays 100% You pay 0%	You pay \$20 Plan pays remainder	After deductible plan pays 50% You pay 50%
Psychological Testing (Outpatient diagnostic)	Plan pays 100% You pay 0%	After deductible plan pays 80% You pay 20%	After deductible plan pays 50% You pay 50%
Emergency			
Emergency Department/Crisis Evaluation	You pay \$100 (waived if admitted) Plan pays 100%	You pay \$100 (waived if admitted) Plan pays 100%	ER: You pay \$100/Plan pays 100% Non-Emergency: After deductible plan pays 50%/You pay 50%
Electroconvulsive Therapy	Plan pays 100% You pay 0%	Plan pays 90% You pay \$20 + 10%	After deductible plan pays 50% You pay 50%

¹ Deductibles accumulate across Tiers 1 and 2 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 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 (UCR) charges. The plan does not pay benefits for amounts above UCR.

2020 WellSpan Standard: Behavioral Health Benefits

Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Quest Network	Out-of-Network Out-of-Network ³
Deductible¹ (per person)	None	\$1,050/\$2,050	\$2,050/\$4,050
Out-of-Pocket Maximum² (Individual/Family)	\$4,250/\$7,750		\$6,750/\$12,750
Inpatient			
Hospitalization, Partial Hospitalization, and Intensive Outpatient Services	Plan pays 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%
Professional Fees (Inpatient)	Plan pays 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%
Outpatient			
Outpatient Visits	You pay \$10 + 20% Plan pays 80%	You pay \$30 + 30% Plan pays 70%	After deductible plan pays 50% You pay 50%
Psychological Testing (Outpatient diagnostic)	Plan pays 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%
Emergency			
Emergency Department/Crisis Evaluation	You pay \$100 (waived if admitted) Plan pays 100%	You pay \$100 (waived if admitted) Plan pays 100%	ER: You pay \$100/Plan pays 100% Non-Emergency: After deductible plan pays 50%/You pay 50%
Electroconvulsive Therapy	Plan pays 80% You pay 20%	Plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%

¹ Deductibles accumulate across Tiers 1 and 2 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 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 (UCR) charges. The plan does not pay benefits for amounts above UCR.

2020 WellSpan High Deductible: Behavioral Health Benefits

Feature	Enhanced Network WellSpan Provider Network and Other Select Providers and Facilities	Core Network Quest Network	Out-of-Network Out-of-Network ³
Deductible¹ (per person)	\$1,400/\$2,800		\$2,800/\$5,600
Out-of-Pocket Maximum² (Individual/Family)	\$6,900/\$13,800		\$13,800/\$27,600
Inpatient			
Hospitalization, Partial Hospitalization, and Intensive Outpatient Services	After deductible plan pays 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%
Professional Fees (Inpatient)	After deductible plan pays 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%
Outpatient			
Outpatient Visits	After deductible plan pays 80% You pay \$10 + 20%	After deductible plan pays 70% You pay \$30 + 30%	After deductible plan pays 50% You pay 50%
Psychological Testing (Outpatient diagnostic)	After deductible plan pays 80% You pay 20%	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 \$100 (waived if admitted) Plan pays 100%	After deductible you pay \$100 (waived if admitted) Plan pays 100%	ER: After deductible you pay \$100 (waived if admitted)/Plan pays 100% Non-Emergency: After deductible plan pays 50%/You pay 50%
Electroconvulsive Therapy	After deductible plan pays 80% You pay 20%	After deductible plan pays 70% You pay 30%	After deductible plan pays 50% You pay 50%

¹ Deductibles accumulate across Tiers 1 and 2 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 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 (UCR) charges. The plan does not pay benefits for amounts above UCR.