



# Health & Wellness

## 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 <sup>4</sup>
<b>Annual Deductible<sup>1</sup></b> (per person)	\$200	\$350	\$800
<b>Medical Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family) <i>Includes deductible, copays, and coinsurance</i>	\$2,750/\$4,750		\$10,250/\$20,250
<b>Preventive Care</b> <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%
<b>Office Visits</b> • Primary Care • Specialist	You pay <b>\$10</b> /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%
<b>WellSpan Online Urgent Care</b>	\$0 copay	N/A	N/A
<b>Hospital Facility/Physician</b> (Inpatient)	After deductible Plan pays <b>95%</b> You pay <b>5%</b>	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%
<b>Ambulatory, Outpatient, Surgery, MRIs, MRAs, and CT and PET Scans</b> (facility)	After deductible Plan pays <b>95%</b> You pay <b>5%</b>	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%
<b>Outpatient</b> (Lab/Diagnostic)	After deductible Plan pays <b>95%</b> You pay <b>5%</b>	After deductible Plan pays 80% You pay 20%	After deductible Plan pays 50% You pay 50%
<b>Massage Therapy<sup>6</sup></b>	\$15 copay then Plan pays 100% up to a \$500 maximum per calendar year <sup>5</sup>	Not covered	Not covered
<b>Urgent Care/Walk-In Clinics/Retail Clinics</b>	PCP: You pay \$25/Plan pays remainder Specialist: You pay \$50/Plan pays remainder <b>Other covered services:</b> After deductible Plan pays <b>95%</b> /You pay <b>5%</b>	PCP: You pay \$45/Plan pays remainder Specialist: You pay \$60/Plan pays remainder <b>Other covered services:</b> After deductible Plan pays 80%/You pay 20%	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.

<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.

**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	<b>Enhanced Network</b> Retail (WellSpan Pharmacies and Other Select Pharmacies) Up to 34-day supply	<b>Core Network</b> Retail (Optum Rx Network Pharmacies) Up to 34-day supply	<b>Mail Order or Retail</b> (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	<b>Out-of-Network Pharmacy**</b> Up to 34-day supply
<b>Generic</b>	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)
<b>Brand-Name Formulary</b>	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)
<b>Brand-Name Non-Formulary</b>	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)
<b>Specialty Drugs</b>	<b>You pay 20% up to a \$150 maximum</b>	<b>Not Covered</b>	<b>Not Available</b>	<b>Not Covered</b>
<b>Prescription Out-of-Pocket Maximum*</b> (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 <sup>3</sup>
<b>Deductible<sup>1</sup></b> (per person)	\$200	\$350	\$800
<b>Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family)	\$2,750/\$4,750		\$10,250/\$20,250
<b>Inpatient</b>			
<b>Hospitalization, Partial Hospitalization, and Intensive Outpatient Services</b>	After deductible Plan pays <b>95%</b> You pay <b>5%</b>	After deductible Plan pays 80% You pay \$200 + 20%	After deductible Plan pays 70% You pay \$250 + 30%
<b>Professional Fees</b> (Inpatient)	After deductible Plan pays <b>95%</b> You pay <b>5%</b>	After deductible Plan pays 80% You pay 20%	After deductible Plan pays 50% You pay 50%
<b>Outpatient</b>			
<b>Outpatient Visits</b> (per visit)	You pay <b>\$10</b> Plan pays remainder	You pay \$25 Plan pays remainder	After deductible Plan pays 50% You pay 50%
<b>Autism</b>	You pay <b>\$10</b> Plan pays remainder	You pay \$25 Plan pays remainder	After deductible Plan pays 50% You pay 50%
<b>Psychological Testing</b> (Outpatient diagnostic)	After deductible Plan pays <b>95%</b> You pay <b>5%</b>	After deductible Plan pays 80% You pay 20%	After deductible Plan pays 50% You pay 50%
<b>Transcranial Magnetic Stimulation (TMS)</b>	After deductible Plan pays <b>95%</b> You pay <b>5%</b>	After deductible Plan pays 80% You pay 20%	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/Plan pays 100% (waived if admitted) <b>Non-Emergency:</b> After deductible Plan pays 50%/You pay 50%
<b>Electroconvulsive Therapy</b>	After deductible plan pays <b>95%</b> You pay <b>5%</b>	After deductible Plan pays 80% You pay 20%	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.

## 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 <sup>4</sup>
<b>Annual Deductible<sup>1</sup></b> (Individual/Family)	\$550/\$1,100	\$1,200/\$2,400	\$2,050/\$4,050
<b>Medical Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family) <i>Includes deductible, copays, and coinsurance</i>	\$4,500/\$8,250		\$6,750/\$12,750
<b>Preventive Care</b> <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%
<b>Office Visits</b> • 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%
<b>WellSpan Online Urgent Care</b>	\$0 copay	N/A	N/A
<b>Hospital Facility/Physician</b> (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%
<b>Ambulatory, Outpatient, Surgery, MRIs, MRAs, and CT and PET Scans</b> (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%
<b>Outpatient</b> (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%
<b>Urgent Care/Walk-In Clinics/Retail Clinics</b>	PCP: You pay \$30/Plan pays remainder Specialist: You pay \$60/Plan pays remainder <b>Other covered services:</b> After deductible Plan pays 90% You pay 10%	PCP: You pay \$50/Plan pays remainder Specialist: 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.

**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	<b>Enhanced Network</b> Retail (WellSpan Pharmacies and Other Select Pharmacies) Up to 34-day supply	<b>Core Network</b> Retail (Optum Rx Network Pharmacies) Up to 34-day supply	<b>Mail Order or Retail</b> (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	<b>Out-of-Network Pharmacy**</b> 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>	<b>You pay 20% up to a \$150 maximum</b>	<b>Not Covered</b>	<b>Not Available</b>	<b>Not Covered</b>
<b>Prescription Out-of-Pocket Maximum*</b> (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 <sup>3</sup>
<b>Deductible<sup>1</sup></b> (Individual/Family)	\$550/\$1,100	\$1,200/\$2,400	\$2,050/\$4,050
<b>Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family)	\$4,500/\$8,250		\$6,750/\$12,750
<b>Inpatient</b>			
<b>Hospitalization, Partial Hospitalization, and Intensive Outpatient Services</b>	After deductible Plan pays 90% You pay 10%	After deductible Plan pays 70% You pay 30%	After deductible Plan pays 50% You pay 50%
<b>Professional Fees</b> (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%
<b>Outpatient</b>			
<b>Outpatient Visits</b> (per visit)	You pay \$20 Plan pays remainder	You pay \$30 Plan pays remainder	After deductible Plan pays 50% You pay 50%
<b>Autism</b>	You pay \$20 Plan pays remainder	You pay \$30 Plan pays remainder	After deductible Plan pays 50% You pay 50%
<b>Psychological Testing</b> (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%
<b>Transcranial Magnetic Stimulation (TMS)</b>	After deductible Plan pays 90% You pay 10%	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 90% You pay 10%	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.

## 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 <sup>4</sup>
<b>Annual Deductible<sup>1</sup></b> (Individual/Family)	\$1,500/\$3,000		\$2,800/\$5,600
<b>Integrated Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family Embedded) <i>Includes medical, behavioral health and prescription deductibles, coinsurances and copays</i>	\$6,000/\$12,000		\$13,800/\$27,600
<b>Preventive Care</b> <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%
<b>Office Visits</b> • 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%
<b>Hospital Facility/Physician</b> (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%
<b>Ambulatory, Outpatient, Surgery, MRIs, MRAs, and CT and PET Scans</b> (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%
<b>Outpatient</b> (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%
<b>Urgent Care/Walk-In Clinics/Retail Clinics</b>	PCP: After deductible you pay \$30 Plan pays remainder Specialist: After deductible you pay \$60 Plan pays remainder <b>Other covered services:</b> 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 <b>Other covered services:</b> After deductible Plan plays 70% You pay 30%	After deductible Plan pays 50% You pay 50%
<b>Emergency Room<sup>3</sup></b>	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

<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.

**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	<b>Enhanced Network</b> Retail (WellSpan Pharmacies and Other Select Pharmacies) Up to 34-day supply	<b>Core Network</b> Retail (Optum Rx Network Pharmacies) Up to 34-day supply	<b>Mail Order or Retail</b> (WellSpan Pharmacies Only) 35-100 day supply for Maintenance Drugs	<b>Out-of-Network Pharmacy**</b> Up to 34-day supply
<b>Generic</b>	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%
<b>Brand-Name Formulary</b>	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)
<b>Brand-Name Non-Formulary</b>	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)
<b>Specialty Drugs</b>	<b>You pay 20% with a \$150 maximum</b>	<b>Not Covered</b>	<b>Not Available</b>	<b>Not Covered</b>
<b>Integrated Out-of-Pocket Maximum*</b> (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 <sup>3</sup>
<b>Deductible<sup>1</sup></b> (Individual/Family)	\$1,500/\$3,000		\$2,800/\$5,600
<b>Integrated Out-of-Pocket Maximum<sup>2</sup></b> (Individual/Family) <i>Includes medical, behavioral health and prescription deductibles, coinsurances and copays</i>	\$6,000/\$12,000		\$13,800/\$27,600
<b>Inpatient</b>			
<b>Hospitalization, Partial Hospitalization, and Intensive Outpatient Services</b>	After deductible Plan pays 90% You pay 10%	After deductible Plan pays 70% You pay 30%	After deductible Plan pays 50% You pay 50%
<b>Professional Fees</b> (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%
<b>Outpatient</b>			
<b>Outpatient Visits</b>	After deductible you pay \$10 Plan pays remainder	After deductible you pay \$30 Plan pays remainder	After deductible Plan pays 50% You pay 50%
<b>Autism</b>	After deductible you pay \$10 Plan pays remainder	After deductible you pay \$30 Plan pays remainder	After deductible Plan pays 50% You pay 50%
<b>Psychological Testing</b> (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%
<b>Transcranial Magnetic Stimulation (TMS)</b>	After deductible Plan pays 90% You pay 10%	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>	After deductible you pay \$200 (waived if admitted) Plan pays 100%	After deductible you pay \$200 (waived if admitted) Plan pays 100%	<b>ER:</b> After deductible 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 90% You pay 10%	After deductible Plan pays 70% You pay 30%	After deductible Plan pays 50% 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 (UC&R) charges. The plan does not pay benefits for amounts above UC&R.