CALIFORNIA

# 2020 EP Cares™ Medical Plan Options

## This is a brief overview of in-network benefits. See plan documents for details.

In the unlikely event of a discrepancy between this summary and the plan documents, the plan documents will prevail.

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| PLAN | Local+ IN $5,900 HDHP | Local+ IN $4,500 | Open Access+ $4,500 HDHP | Open Access+ $2,500 | Open Access+ IN $1,000 | Open Access+ $750 |
|---|---|---|---|---|---|---|
| **COVERAGE TYPE** | **EPO HDHP** | **EPO** | **PPO HDHP** | **PPO** | **EPO** | **PPO** |
| **CALENDAR YEAR DEDUCTIBLE*** | $5,900 | $4,500 | $4,500 | $2,500 | $1,000 | $750 |
| **OUTPATIENT (Employee Pays)** | | | | | | |
| **Preventive Benefits** | $0 DW | $0 DW | $0 DW | $0 DW | $0 DW | $0 DW |
| **MDLive Telemedicine Visits** | $45 copay * | $35 copay | $45 copay * | $30 copay | $25 copay | $35 copay |
| **Office Visits** | 30% | $35 copay DW | 20% | $30 copay DW | $25 copay DW | $35 copay DW |
| **Specialist Visits** | 30% | $70 copay DW | 20% | $50 copay DW | $50 copay DW | $60 copay DW |
| **OTHER SERVICES (Employee Pays)** | | | | | | |
| **In-Network Coinsurance** | 30% | 30% | 20% | 30% | 20% | 30% |
| **Maximum Out-of-Pocket** | $6,550 | $6,350 | $6,350 | $6,350 | $5,850 | $5,000 |
| **Rx (Employee Pays)** | | | | | | |
| **Deductible** | combined w/med | $0 | combined w/med | $0 | $0 | $0 |
| **Tier 1** | 30% | $15 copay | 20% | $15 copay | $15 copay | $20 copay |
| **Tier 2** | 40% | $50 copay | 20% | $30 copay | $30 copay | $40 copay |
| **Tier 3** | 50% | 30% | 20% | $50 copay | $45 copay | 30% |

* Calendar Year Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. All services are subject to the deductible unless otherwise noted by DW (deductible waived).
* = The full cost of the services for MD Live Telemedicine Visits is shown. For these visits, you do not need to satisfy your calendar year deductible first. You just pay the amount of the copay at the time of service. The amount paid applies toward meeting the deductible.

# Rates

| PLAN | Local+ IN $5,900 HDHP | Local+ IN $4,500 | Open Access+ $4,500 HDHP | Open Access+ $2,500 | Open Access+ IN $1,000 | Open Access+ $750 |
|---|---|---|---|---|---|---|
| **COVERAGE TYPE** | **EPO HDHP** | **EPO** | **PPO HDHP** | **PPO** | **EPO** | **PPO** |
| **TOTAL PREMIUM**** | | | | | | |
| **Employee Only** | $293 | $371 | $385 | $527 | $533 | $557 |
| **Employee + Spouse** | $817 | $980 | $1,014 | $1,385 | $1,408 | $1,470 |
| **Employee + Child(ren)** | $708 | $851 | $879 | $1,207 | $1,223 | $1,276 |
| **Employee + Family** | $1,151 | $1,380 | $1,427 | $1,954 | $1,981 | $2,074 |

** Figures represent full monthly premiums without employer subsidy applied.

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# 2020 Dental Plan Options* & Rates

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| | DENTAL PLAN OPTIONS | | |
|---|---|---|---|
| **COVERAGE TYPE** | **PPO** | | **HMO** |
| | **In-Network** | **Out-of-Network** | **In-Network Only** |
| **COST-SHARES** | | | |
| **Deductible** | $50 x3 (max) | $50 x3 (max) | None |
| **Preventive Care** | No Charge | 20% after deductible | see fee schedule |
| **Basic Restorative Care** | 20% after deductible | 40% after deductible | see fee schedule |
| **Major Restorative Care** | 50% after deductible | 60% after deductible | $130 +up (see fee schedule) |
| **Orthodontics** | Not Covered | Not Covered | $1,220 +up (child)<br>$1,720 +up (adult) |
| **MAXIMUMS** | | | |
| **Annual Maximum** | $1,500 | $1,000 | None |

| MONTHLY DENTAL PLAN RATES | | |
|---|---|---|
| **COVERAGE TYPE** | **PPO** | **HMO** |
| **Employee** | $47.58 | $14.36 |
| **Employee + Spouse** | $97.08 | $28.72 |
| **Employee + Child(ren)** | $102.34 | $28.72 |
| **Employee + Family** | $155.55 | $46.68 |

* HMO Dental may not be available in all areas.

# 2020 Vision Plan & Rates**

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| | VISION PLAN OPTION | | |
|---|---|---|---|
| **COVERAGE TYPE** | **PPO** | | |
| | **Frequency** | **In-Network** | **Out-of-Network** |
| **COST-SHARES** | | | |
| **Routine Eye Exam** | 12 months | $10 | Up to $45 allowance |
| **Materials Copay** | 12 months | $10 | N/A |
| **Eyeglass Lenses Allowance** | 12 months | Covered 100% after copay | Up to $32 (single)<br>Up to $80 (lenticular) |
| **Frame Retail Allowance** | 24 months | Up to $130 | $71 |
| **Contact Lens Allowance** (in lieu of eyeglass lenses and frames) | 12 months | Up to $150 | Up to $120 |

| MONTHLY VISION PLAN RATES | |
|---|---|
| **COVERAGE TYPE** | **PPO** |
| **Employee** | $11.73 |
| **Employee + Spouse** | $23.43 |
| **Employee + Child(ren)** | $23.67 |
| **Employee + Family** | $37.79 |

** Additional discounts on in-network services/accesories/additional pairs of glasses are detailed in the plan summary.

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