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.



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	РРО	EPO	РРО
CALENDAR YEAR DEDUCTIBLE*	\$5,900	\$4,500	\$4,500	\$2,500	\$1,000	\$750
OUTPATIENT (Employee Pays)	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	\$O	\$O	\$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	РРО
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.

2020 Dental Plan Options* & Rates



	DENTAL PLAN OPTIONS				
COVERAGE TYPE	Ρ	НМО			
	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) \$1,720 +up (adult)		
MAXIMUMS					
Annual Maximum	\$1,500	\$1,000	None		
		S			
COVERAGE TYPE	P	НМО			
Employee	\$4	\$14.36			
Employee + Spouse	\$9	\$28.72			
Employee + Child(ren)	\$10	\$28.72			

\$155.55

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Now offering

Life Insurance and Aflac Accident Advantage starting at \$23/mo.



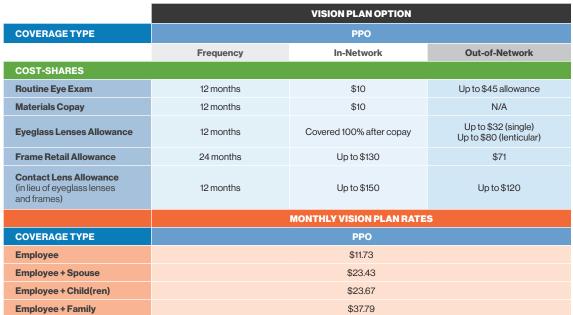


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* HMO Dental may not be available in all areas.

Employee + Family

2020 Vision Plan & Rates**



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

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\$46.68

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