ep Cares Medical Plan Options

CALIFORNIA 2022

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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	Open Access+ $250
COVERAGE TYPE	**EPO HDHP**	**EPO**	**PPO HDHP**	**PPO**	**EPO**	**PPO**	**PPO**
CALENDAR YEAR DEDUCTIBLE*	$5,900	$4,500	$4,500	$2,500	$1,000	$750	$250
OUTPATIENT (Employee Pays)							
Preventive Benefits	$0 DW	$0 DW	$0 DW	$0 DW	$0 DW	$0 DW	$0 DW
Office Visits	30%	$35 copay DW	20%	$30 copay DW	$25 copay DW	$35 copay DW	$20 copay DW
Specialist Visits	30%	$70 copay DW	20%	$50 copay DW	$50 copay DW	$60 copay DW	$20 copay DW
OTHER SERVICES (Employee Pays)							
In-Network Coinsurance	30%	30%	20%	30%	20%	30%	10%
Maximum Out-of-Pocket	$6,550	$6,350	$6,350	$6,350	$5,850	$5,000	$3,000
Rx (Employee Pays)							
Deductible	combined w/med	$0	combined w/med	$0	$0	$0	$0
Tier 1	30%	$15 copay	20%	$15 copay	$15 copay	$20 copay	$10 copay
Tier 2	40%	$50 copay	20%	$30 copay	$30 copay	$40 copay	$20 copay
Tier 3	50%	30%	20%	$50 copay	$45 copay	30%	$35 copay

* 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).

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	Open Access+ $250
COVERAGE TYPE	**EPO HDHP**	**EPO**	**PPO HDHP**	**PPO**	**EPO**	**PPO**	**PPO**
TOTAL MONTHLY PREMIUM**							
Employee Only	$351	$444	$461	$632	$638	$667	$819
Employee + Spouse	$979	$1,174	$1,215	$1,659	$1,686	$1,761	$2,279
Employee + Child(ren)	$848	$1,019	$1,053	$1,445	$1,464	$1,529	$1,972
Employee + Family	$1,379	$1,653	$1,710	$2,340	$2,373	$2,484	$3,209

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

ep Cares Dental & Vision Plans

2022

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Dental

	PLAN OPTIONS*		
COVERAGE TYPE	**PPO**		**HMO**
	In-Network	**Out-of-Network**	**In-Network Only**
Deductible	$50 x3 (max)	$50 x3 (max)	None
Preventive Care	No Charge	20%	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)
Annual Maximum Benefit	$1,500	$1,000	N/A

	MONTHLY RATES	
COVERAGE TYPE	**PPO**	**HMO**
Employee	$49.65	$15.24
Employee + Spouse	$101.31	$30.48
Employee + Child(ren)	$106.80	$30.48
Employee + Family	$162.33	$49.55

* HMO Dental may not be available in all areas.

Vision

	PLAN OPTION**		
COVERAGE TYPE	**PPO**		
	Frequency	**In-Network**	**Out-of-Network**
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) Up to $80 (lenticular)
Frame Retail Allowance	24 months	Up to $130	Up to $71
Contact Lens Allowance (in lieu of eyeglass lenses and frames)	12 months	Up to $150	Up to $120

	MONTHLY RATES
COVERAGE TYPE	**PPO**
Employee	$11.14
Employee + Spouse	$22.24
Employee + Child(ren)	$22.47
Employee + Family	$35.88

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

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- **Lump Sum Critical Illness**
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