epc BENEFITS RESOURCES, INC.

## 2026 - 2027 Comparison Medical/Rx Plan Offerings

| | Deductibles apply unless otherwise noted.<br>Copays are not applied to deductible.<br>Coinsurance is applied to deductible. | 2027 PLATINUM POS | 2027 GOLD POS | 2027 SILVER POS | 2027 GOLD HDHP | 2027 BRONZE HDHP |
|---|---|---|---|---|---|---|
| | Recommended Employer Contributions to HSA | | | N/A | Recommend<br>$1,000 Individual/$2,000 Family | Recommend<br>$1,000 Individual/$2,000 Family |
| | Medical Plan Annual Deductibles: Individual/Two-Person/Family | $550/$1,100/$1,550 | $1,150/$2,300/$3,000 | $1,850/$3,700/$5,350 | $3,500/$7,000<br>Combined Medical & Rx Deductible | $6,200/$12,400<br>Combined Medical & Rx Deductible |
| | Prescription Drug Plan Annual Deductibles: Individual/Two-Person/Family | $0/$0/$0 | $250/$500/$600 | $300/$600/$800 | | |
| | Co-Insurance: (after deductible) Plan pays/Individual pays | 90%/10% | 80%/20% | 70%/30% | 80%/20% | 60%/40% |
| | Maximum out-of-pocket (in-network services only, including deductible, co-pays, and co-insurance, combined Medical/Rx): Individual/Two-Person/Family | $3,500/$7,000/<br>$7,000 | $5,500/$11,000/<br>$11,000 | $7,000/$14,000/<br>$14,000 | $7,000/$14,000 | $7,000/$14,000 |
| | Wellness and Preventive Care Visits (Not subject to deductible)<br>See Preventive Care Schedule for list of covered services. | $0 | $0 | $0 | $0 | $0 |
| | 98point6: On-demand primary care via private, secure in-app messaging | $0 | $0 | $0 | $0 | $0 |
| IN-NETWORK | Primary Care Visit | $25 | $25 | $30 | 20% | 40% |
| | Retail Clinic | $35 | $40 | $50 | 20% | 40% |
| | MinuteClinic * (CVS & Target) | $0 | $0 | $0 | 20%** | 40%** |
| | Specialist Visit | $55 | $65 | $65 | 20% | 40% |
| | Urgent Care | $55 | $65 | $65 | 20% | 40% |
| | Emergency room services (per visit) (deductible does not apply for POS plans) | $300 | $500 | $500 | 20% | 40% |
| | Freestanding Outpatient Diagnostic facility (Diagnostic Imaging) | 5%<br>(Deductible Waived) | 10% | 15% | 10% | 20% |
| | Outpatient Diagnositic Imaging (HOPDs)<br>(CT Scan, MRI, Diagnostic) | 10% | 20% | 30% | 20% | 40% |
| | Outpatient Hospital Surgical Services (HOPDs) | 10% | 20% | 30% | 20% | 40% |
| | Hospital Inpatient (including maternity) | 10% after<br>$250 Co-Pay | 20% after<br>$250 Co-Pay | 30% after<br>$250 Co-Pay | 20% after<br>$250 Co-Pay | 40% after<br>$250 Co-Pay |
| | Inpatient Mental Health/Substance Abuse | 10% after<br>$250 Co-Pay | 20% after<br>$250 Co-Pay | 30% after<br>$250 Co-Pay | 20% after<br>$250 Co-Pay | 40% after<br>$250 Co-Pay |
| | Outpatient Mental Health/Substance Abuse (office and professional services) | $55 Co-Pay | $65 Co-Pay | $65 Co-Pay | 20% | 40% |
| | Habilitative Services (with limitations) | 10% | 20% | 30% | 20% | 40% |
| | Rehabilitative and Therapy Services (for Medical Necessity) Maximum 30 Visits | 10% | 20% | 30% | 20% | 40% |
| | Chiropractic Services (Institute Limits-35 annually in and out of network combined) | 50% | 50% | 50% | 50% | 30% |

| | PRESCRIPTION DRUG BENEFITS (All coinsurance and co-pays are effective after deductible is met) | | | | | |
|---|---|---|---|---|---|---|
| | Deductibles apply unless otherwise noted. | 2027 PLATINUM POS | 2027 GOLD POS | 2027 SILVER POS | 2027 GOLD HDHP | 2027 BRONZE HDHP |
| SHORT-TERM | Generic Drug | **$15** for Generic<br>up to a 30-Day Supply | **$15** for Generic<br>up to a 30-Day Supply | **$15** for Generic<br>up to a 30-Day Supply | 20%<br>(Plan pays 80%) | 40%<br>(Plan pays 60%) |
| | Formulary Brand*** | $45<br>up to a 30-Day Supply | $50<br>up to a 30-Day Supply | $55<br>up to a 30-Day Supply | | |
| | Non-Formulary Brand*** | $90<br>up to a 30-Day Supply | $100<br>up to a 30-Day Supply | $110<br>up to a 30-Day Supply | | |
| LONG-TERM | Generic Drug | $30<br>up to a 90-Day Supply | $35<br>up to a 90-Day Supply | $35<br>up to a 90-Day Supply | 20%<br>(Plan pays 80%) | 40%<br>(Plan pays 60%) |
| | Formulary Brand*** | $90<br>up to a 90-Day Supply | $105<br>up to a 90-Day Supply | $110<br>up to a 90-Day Supply | | |
| | Non-Formulary Brand*** | $180<br>up to a 90-Day Supply | $210<br>up to a 90-Day Supply | $220<br>up to a 90-Day Supply | | |
| SPECIALTY | **Generic Drug** | Participant pays 20% up to a max $750 per 30-Day Supply | Participant pays 20% up to a max $750 per 30-Day Supply | Participant pays 20% up to a max $750 per 30-Day Supply | Participant pays 20% up to a max $750 per 30-Day Supply | Participant pays 40% up to a max $750 per 30-Day Supply |
| | **Formulary Brand*** ** | | | | | |
| | **Non-Formulary Brand*** ** | | | | | |

| | OUT-OF-NETWORK MEDICAL BENEFITS - All providers will be considered In Network - Subject to Verification of Plan Acceptance | | | | | |
|---|---|---|---|---|---|---|
| | **Deductibles apply unless otherwise noted.** | **2027 PLATINUM POS** | **2027 GOLD POS** | **2027 SILVER POS** | **2027 GOLD HDHP** | **2027 BRONZE HDHP** |
| OUT-OF-NETWORK | Medical Plan Annual Deductibles: Individual/Two-Person/Family | N/A | N/A | N/A | N/A | N/A |
| | Co-Insurance: (after deductible)<br>Plan pays/Individual pays | N/A | N/A | N/A | N/A | N/A |
| | Maximum out-of-pocket (out-of-network services only, including deductible, co-pays, and co-insurance, combined Medical/Rx): Individual/Two-Person/Family | N/A | N/A | N/A | N/A | N/A |
| | Wellness and preventive care visits | N/A | N/A | N/A | N/A | N/A |
| | Primary Care Visit | N/A | N/A | N/A | N/A | N/A |
| | Specialist Visit | N/A | N/A | N/A | N/A | N/A |
| | Urgent Care | N/A | N/A | N/A | N/A | N/A |
| | Emergency Room Services (per visit) (Deductible does not apply for POS plans) | N/A | N/A | N/A | N/A | N/A |
| | Retail Clinic | N/A | N/A | N/A | N/A | N/A |
| | Outpatient Surgery/Outpatient Services (CT scan, MRI, Diagnostic) (after deductible) | N/A | N/A | N/A | N/A | N/A |
| | Hospital Inpatient (including maternity) | N/A | N/A | N/A | N/A | N/A |
| | Inpatient Mental Health/Substance Abuse (check for parity) | N/A | N/A | N/A | N/A | N/A |
| | Outpatient Mental Health/Substance Abuse (Office and professional services) | N/A | N/A | N/A | N/A | N/A |
| | Therapy and Rehabilitation Services (for Medical Necessity) Limit: 30 visits | N/A | N/A | N/A | N/A | N/A |
| | Habilitative Services (with limitations) | N/A | N/A | N/A | N/A | N/A |
| | Chiropractic Services (Institute Limits-35 annually in and out of network combined) | N/A | N/A | N/A | N/A | N/A |

*** MinuteClinic standard services were formerly covered under retail clinic benefit.**
****Eligible members enrolled in high-deductible plans must meet their deductible. However, services are provided at a lower program cost than standard retail clinic fees. Once the deductible has been met, members will be able to access MinuteClinic services at no cost-share.**
*****Mandatory Generic requirement in place. If a member chooses a brand name medication when there is a generic available, member will be charged the brand name copay + an ancillary fee (cost difference between the brand and generic).**