This Summary of Benefits and Coverage (SBC) shows you how you and the plan will share the cost for covered health care services.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.epc.org/benefits or call 1-800-925-2272. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 800-318-2596 to request a copy.

General Provisions		
Important Questions	**Answers**	**Why this Matters**
What is the overall medical plan deductible?	$1,050 individual / $2,100 two person /$2,950 family if in-network. For out-of-network, $2,000 individual / $4,000 two person / $6,000 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, when using an in-network provider the network deductible does not apply, and you will only pay the co-pay or coinsurance for office visits, preventive care services, emergency room care, outpatient mental health, outpatient substance abuse, hospice service. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may still apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific medical services?	No.	There are no other deductibles related to specific medical services other than the stated in-network and out-of-network deductibles.
What is the out-of-pocket limit for this plan?	$5,100 individual / $10,200 two person / $10,200 family in-network. For out-of-network, $6,300 individual / $12,600 two person / $12,600 family.	The out-of-pocket limit is the most you could pay in a year for covered services (includes deductible, coinsurance, copays, prescription drug copays, and other qualified medical expenses). If you have other family members in this plan, they must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out–of–pocket limit?	In-network/Out-of-network: Premiums paid, balance-billed charges, and health care covered and paid for by this plan do not apply to your total maximum out-of-pocket.	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use an in-network provider?	Yes. For a list of network providers, see www.meritain.com or call: 1-800-925-2272.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (called balance billed-charges). Be aware your network provider might use an out-of-network provider for some services (such as lab work). **Check with your provider before you use such services.**
Do I need a referral to see a specialist?	No, not under the EPC plan.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a deductible applies.

Office / Clinic / Urgent Care Visits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
Provider Co-Pays At-a-glance	Telemedicine **(98point6)** On-demand 24/7 primary care virtual visits via secure in-app messaging from your phone or smart device.	$0 co-pay	Not covered.	With 98point6, U.S board-certified physicians diagnose and treat acute and chronic illnesses, answer health-related questions, including mental health, outline care options, and order any necessary prescriptions or lab tests.
	Primary care visit to treat an injury or illness	$20 co-pay/office visit or virtual visit	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to the preventive schedule for additional information.
	Retail clinic visit	$35 co-pay/visit		
	Urgent care center visit	$45 co-pay/visit		
	Specialist office visit	$60 co-pay/visit		
	Emergency room visit	$250 co-pay visit		Co-pay waived if admitted as an inpatient
	Virtual visit originating site fee when your doctor connects you virtually to a specialist facility	20% coinsurance	40% coinsurance	

For virtual visit where available, stated co-pay will apply.

Preventive Care Services				
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, and Other Important Information**
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If you visit a health care provider's office or clinic	**Preventive care – routine adult:** • Physical exams • Immunizations • Gynecological exams (i.e., Pap test) • Mammograms (annual routine) • Mammograms (medically necessary) • Certain diagnostic services and procedures **Preventive care – routine pediatric:** • Physical exams • Immunizations • Certain diagnostic services and procedures See full preventive list at https://epc.org/benefits/2023medicalplans/	No charge for preventive care services (Deductible does not apply)	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information. In-Network/Out-of-network: Preventive care services are not subject to the deductible.

Prescription Drug Coverage: Refer to the Descripion Drug Plan Document for drug coverage and co-pay information.

Emergency Services				
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, and Other Important Information**
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If you need immediate medical attention or have an inpatient / hospital stay	Emergency room services	$250 copay/visit		Co-pay waived if admitted as an inpatient
	Physician / surgeon fee	20% coinsurance	40% coinsurance	Precertification may be required.
	Facility fee (i.e., hospital room)	20% coinsurance after $250 co-pay per admission	40% coinsurance after $250 co-pay per admission	Precertification may be required.
	Medical Transportation (Emergency and non-emergency)	20% coinsurance	40% coinsurance	
Hospital and Medical / Surgical Expenses (including maternity)				
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, and Other Important Information**
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If you have hospital/surgical expenses	Hospital inpatient services	20% coinsurance with $250 copay per admission	40% coinsurance with $250 copay per admission	Precertification may be required.
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician / surgeon fees			
	Hospital outpatient services			
	Medical Care (including inpatient visits and consultations) / Surgical expenses			

If you are pregnant	Maternity (non-preventive facility and professional services)	20% coinsurance	40% coinsurance	Precertification may be required.
	Maternity office visits (non-preventive)	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) In-Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth / delivery professional services Maternity (non-preventive facility and professional services)	20% coinsurance	40% coinsurance	
	Childbirth / delivery facility services	20% coinsurance after $250 co-pay per admission	40% coinsurance after $250 co-pay per admission	Precertification may be required.

Therapy and Rehabilitation Services				
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, and Other Important Information**
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If have therapy and rehabilitation health needs	Rehabilitation services (Speech, respiratory, physical, occupational)	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: 30 visits per benefit period limit to physical, speech, and occupational. Precertification may be required.
	Habilitative services for congenital conditions related to Cerebral Palsy, Down Syndrome, and Spina Bifida	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: maximum of 135 visits per benefit period for dependent child up to age 16, with congenital disabilities specific to the listed conditions. Only services performed on an outpatient basis are covered. Precertification may be required
	Other therapy services (Cardiac rehab, infusion therapy, chemotherapy, radiation therapy and dialysis)	20% coinsurance	40% coinsurance	Precertification may be required.
	Spinal manipulations	50% coinsurance	50% coinsurance	Precertification may be required.
Mental Health / Substance Abuse Services				
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, and Other Important Information**
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If you have mental health, behavioral health, or substance abuse needs	Inpatient mental health services Inpatient detoxification / rehabiliation	20% coinsurance after $250 co-pay per admission	40% coinsurance after $250 co-pay per admission	Precertification may be required.
	Outpatient mental health services (includes virtual behavioral health visits) Outpatient substance abuse services	$60 copay/visit	40% coinsurance	Precertification may be required.

Other Services				
Common Medical Eveny	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, and Other Important Information**
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If you need help recovering, have a test or other special health needs	Allergy extracts and injections	20% coinsurance	40% coinsurance	Precertification may be required.
	Dental services related to accidental injury			
	Diagnostic services: Advanced imaging (MRI, CAT, PET scan, etc.)			
	Basic diagnostic services (standard imaging, diagnostic medical, bloodwork, x-ray, allergy testing			
	Durable medical equipment, orthotics, and prosthetics			
	Transplant services			
	Private duty nursing			
	Infertility counseling, testing, and treatment (includes correction of physical or medical problem associated with infertility)	20% coinsurance	40% coinsurance	$5,000 lifetime benefit
	Home health care	20% coinsurance	40% coinsurance	60 visits per benefit period aggregate with visiting nurse
	Skilled nursing facility care	20% coinsurance	40% coinsurance	Combined network and out-of-network: 60 days per benefit period. Precertification may be required.
	Hospice service	No charge for hospice services (Deductible does not apply)		Out-of-network: Not subject to deductible. Precertification may be required.

In all cases, your total out-of-pocket expense will not exceed the maximum allowable amount out-of-pocket limit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.meritain.com.
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

EPC Prescription Drug Plan

When you enroll in the Medical Plan, you will be enrolled in the Prescription Drug Plan, which is administered by Express Scripts. To receive the highest level of benefits, prescription drugs must be obtained from a Pharmacy in their national pharmacy network or directly via the Express Scripts Mail Service or Specialty Pharmacy.

Prescriptions dispensed for acute care (short-term) medications and initial fills of maintenance (long-term) medications may be obtained through any retail pharmacy for up to a 30-day supply. Short-term drugs include antibiotics and other medications that you take for short periods of time. Long-term drugs, also called maintenance medications, are those you take on an ongoing basis, such as drugs that treat high blood pressure, cholesterol, or chronic diseases. Maintenance medications are only available under the Smart90 program. For those using Specialty Medications, these are dispensed through Accredo Health Group, Inc. ESI's preferred Specialty Pharmacy under the Specialty Medication program. Each program is described below.

Prescription Drug Plan Annual Deductible

Plan Participants are responsible for paying the following deductibles before the Plan starts paying for prescription coverage. After the deductible is met, plan participants will be responsible for the applicable co-payment for all prescriptions filled. If the cost of the prescription is less than the stated co-payment then you will only be responsible for the actual cost.

Gold POS Plan Annual Rx Deductible:	Individual	Two-Person	Family
	$200	$400	$500

Co-Payments for up to a 30-day supply of Short-Term Medications

Participant pays 100% until full deductible is met, then is only responsible for the co-payment. If the cost of the prescription is less than the stated co-payment then you will only be responsible for the actual cost.

Gold POS Plan Short Term Co-payments:	Generic	Formulary Brand	Non-Formulary Brand
	$10	$45	$90

Long-Term Maintenance Medications Smart90 Program

The Express Scripts Smart90 Program allows you to pay less for each 90-day supply of maintenance medications than you would pay for three 30-day supplies at non-participating retail pharmacies. If you are currently receiving home delivery through the Express Scripts Mail Order Pharmacy, you do not need to do

anything further for those prescriptions. For new and existing prescriptions of maintenance medications, you may receive up to two 30-day courtesy fills at any retail pharmacy that is not participating in Smart90 and pay the 30-day retail co-pay as stated above for each fill. However, you will receive notice from Express Scripts upon your first fill that you will need to move the prescription to a participating Smart90 network pharmacy prior to your third fill or the refill will be denied.

You can conveniently fill your maintenance prescriptions under the Smart90 program either by home delivery through the Express Scripts Mail Order Pharmacy or at any Walgreens or Walgreens-owned retail pharmacy in the Smart90 network. If you are not currently using a Smart90 participating pharmacy, you will need to obtain a new prescription from your doctor. Make sure your physician writes the prescription for a 90-day supply with up to a year's refills (if allowed).

Co-Payment for up to a 90-day supply of Long-Term Maintenance Medications

Participant pays 100% until full deductible is met, then is only responsible for the co-payment. If the cost of the prescription is less than the stated co-payment then you will only be responsible for the actual cost.

Gold POS Plan Long Term Co-payments:	Generic	Formulary Brand	Non-Formulary Brand
	$25	$95	$190

You can review your Smart90 Program options by logging in to *www.expressscripts.com* or calling 866-890-1419. If you are a first-time visitor to the website, take a minute to register (be sure you have your member ID number handy). You can also use the Express Scripts mobile app to locate a participating pharmacy.

Specialty Medications

Specialty Medications are high-cost medications dispensed **exclusively** by Accredo Health Group, Inc., ESI's preferred Specialty Pharmacy. To determine if a medication is part of the Specialty Program, review the list of impacted medications on the ESI website, call the number on your ESI ID card, or call Accredo at 800-922-8279. Under this program, specialty medications ordered for you or a covered family member by your physician or prescriber that are on the list will be covered *only* when ordered through Accredo and will not be covered through Meritain Health or when obtained from an outpatient clinic, a home infusion company, a doctor's office, or from another pharmacy. For a new prescription of a listed Specialty Medication, an initial fill may be permitted from another provider to allow time for you and your physician to transfer the prescription to Accredo. Please note that this program does not affect medications supplied by an emergency room or during an inpatient hospital stay. Due to the high cost and special handling required of these specialty medications, each fill is limited to a maximum of a 30-day supply.

Co-Insurance for up to a 30-day supply of Specialty Medications dispensed through Accredo
Participant pays 100% until full deductible is met, then is only responsible for the coinsurance.

Gold POS Plan Co-Insurance for Specialty Medications:	Generic	Formulary Brand	Non-Formulary Brand
	Member pays 20% of specialty medication cost, up to a		
	$500 Maximum per 30-day supply.		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer.
- For grievances and appeals regarding your drug coverage, call the number on the back of your pharmacy card or visit www.express-scripts.com.

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Insurance or benefit administration may be provided by Meritain Health which are an independent subsidiary of Aetna. Health care plans are subject to terms of the benefit agreement.

To find more information about Meritian Health's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to www.meritain.com; or for a paper copy, call 1-800-925-2272.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .

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