EPC
Benefit Resources, Inc.

2024 Medical/Rx Plan Offerings **Effective January 1, 2024**

	Deductibles apply unless otherwise noted. Copays are not applied to deductible. Coinsurance is applied to deductible.	2024 PLATINUM POS	2024 GOLD POS	2024 SILVER POS	2024 GOLD HDHP	2024 BRONZE HDHP
IN-NETWORK	Recommended Employer Contributions to HSA	N/A	N/A	N/A	Recommend $1,000 Individual/$2,000 Family	Recommend $1,000 Individual/$2,000 Family
	Medical Plan Annual Deductibles: Individual/Two-Person/Family	$500/$1000/$1,450	$1,100/$2,200/$2,950	$1,850/$3,700/$5,350	$3,200/$6,400 Combined Medical & Rx Deductible	$6,200/$12,400 Combined Medical & Rx Deductible
	Prescription Drug Plan Annual Deductibles: Individual/Two-Person/Family	$0/$0/$0	$200/$400/$500	$250/$500/ $700		
	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	$3,000/$6,000/ $6,000	$5,200/$10,400/ $10,400	$6,850/$13,700/ $13,700	$6,850/$13,700	$6,850/$13,700
	Wellness and Preventive Care Visits (Not subject to deductible) 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
	Primary Care Visit	$25	$25	$30	20%	40%
	Retail Clinic	$35	$40	$50	20%	40%
	MinuteClinic *	$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)	$225	$300	$300	20%	40%
	Freestanding outpatient diagnostic facility (Diagnostic Imaging)	5% (Deductible Waived)	10%	15%	10%	20%
	Outpatient Surgery/Outpatient Services (CT Scan, MRI, Diagnostic)	10%	20%	30%	20%	40%
	Hospital inpatient (including maternity)	10% after $250 Co-Pay	20% after $250 Co-Pay	30% after $250 Co-Pay	20% after $250 Co-Pay	40% after $250 Co-Pay
	Inpatient Mental Health/Substance Abuse	10% after $250 Co-Pay	20% after $250 Co-Pay	30% after $250 Co-Pay	20% after $250 Co-Pay	40% after $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%	40%

	PRESCRIPTION DRUG BENEFITS (All coinsurance and co-pays are effective after deductible is met)					
	Deductibles apply unless otherwise noted.	**2024 PLATINUM POS**	**2024 GOLD POS**	**2024 SILVER POS**	**2024 GOLD HDHP**	**2024 BRONZE HDHP**
SHORT-TERM	Generic Drug	$10 for Generic for 30-Day Supply	$10 for Generic for 30-Day Supply	$10 for Generic for 30-Day Supply	20% (Plan pays 80%)	40% (Plan pays 60%)
	Formulary Brand	$40 for 30-Day Supply	$45 for 30-Day Supply	$50 for 30-Day Supply		
	Non-Formulary Brand	$80 for 30-Day Supply	$90 for 30-Day Supply	$100 for 30-Day Supply		
LONG-TERM	Generic Drug	$20 for 90-Day Supply	$25 for 90-Day Supply	$25 for 90-Day Supply	20% (Plan pays 80%)	40% (Plan pays 60%)
	Formulary Brand	$80 for 90-Day Supply	$95 for 90-Day Supply	$100 for 90-Day Supply		
	Non-Formulary Brand	$160 for 90-Day Supply	$190 for 90-Day Supply	$200 for 90-Day Supply		
SPECIALTY	Generic Drug	Participant pays 20% up to a max $500 per 30-Day Supply	Participant pays 20% up to a max $500 per 30-Day Supply	Participant pays 20% up to a max $500 per 30-Day Supply	Participant pays 20% up to a max $500 per 30-Day Supply	Participant pays 40% up to a max $500 per 30-Day Supply
	Formulary Brand					
	Non-Formulary Brand					

OUT-OF-NETWORK

OUT-OF-NETWORK MEDICAL BENEFITS					
Deductibles apply unless otherwise noted.	**2024PLATINUM POS**	**2024 GOLD POS**	**2024 SILVER POS**	**2024 GOLD HDHP**	**2024 BRONZE HDHP**
Medical Plan Annual Deductibles: Individual/Two-Person/Family	$1,350/$2,700/ $4,050	$2,000/$4,000/ $6,000	$3,800/$7,600/ $11,400	$3,200/$6,400 Combined Medical & Rx Deductible	N/A
Co-Insurance: (after deductible) Plan pays/Individual pays	60%/40%	60%/40%	60%/40%	60%/40%	Not Covered
Maximum out-of-pocket (out-of-network services only, including deductible, co-pays, and co-insurance, combined Medical/Rx): Individual/Two-Person/Family	$4,200/$8,400/ $8,400	$6,300/$12,600/ $12,600	$7,900/$15,800/ $15,800	$6,750/$13,500	Not Covered
Wellness and preventive care visits	40%	40%	40%	40%	Not Covered
Primary Care Visit	40%	40%	40%	40%	Not Covered
Specialist Visit	40%	40%	40%	40%	Not Covered
Urgent Care	40%	40%	40%	40%	Not Covered
Emergency Room Services (per visit) (Deductible does not apply for POS plans)	$225	$300	$300	20%	40%
Retail Clinic	40%	40%	40%	40%	Not Covered
Outpatient Surgery/Outpatient Services (CT scan, MRI, Diagnostic) (after deductible)	40%	40%	40%	40%	Not Covered
Hospital Inpatient (including maternity)	40% after $250 Co-Pay	40% after $250 Co-Pay	40% after $250 Co-Pay	40% after $250 Co-Pay	Not Covered
Inpatient Mental Health/Substance Abuse (check for parity)	40% after $250 Co-Pay	40% after $250 Co-Pay	40% after $250 Co-Pay	40% after $250 Co-Pay	Not Covered
Outpatient Mental Health/Substance Abuse (Office and professional services)	40%	40%	40%	40%	Not Covered
Therapy and Rehabilitation Services (for Medical Necessity) Limit: 30 visits	40%	40%	40%	40%	Not Covered
Habilitative Services (with limitations)	40%	40%	40%	40%	Not Covered
Chiropractic Services (Institute Limits-35 annually in and out of network combined)	50%	50%	50%	50%	Not Covered

*** 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.**