EPC
Benefit Resources, Inc.

2019 Medical/Rx Plan Offerings

Effective January 1, 2019

	MEDICAL/RX BENEFITS	2019 PLATINUM	2019 GOLD	2019 GOLD HDHP	2019 SILVER	2019 BRONZE HDHP
IN-NETWORK	Required Employer Contributions to HSA	N/A	N/A	$1,000 Individual/ $2,000 Family	N/A	Employer Discretion
	Medical Plan Annual Deductibles: Individual/Two-Person/Family Prescription Drug Plan Annual Deductibles: Individual/Two-Person/Family	$450/$900/ $1,350 *$100/$200/ $300*	$900/$1,800/ $2,700 *$100/$200/ $300*	*$2,950/$5,900 Combined Medical & Rx Deductible*	*$1,700/$3,400/ $5,100* *$200/$400/ $600*	*$6,050/$12,100 Combined Medical & Rx Deductible*
	Co-Insurance: (after deductible) Plan pays/Individual pays	90%/10%	80%/20%	80%/20%	70%/30%	60%/40%
	Maximum out-of-pocket (in-network services only, including deductible, co-pays, and co-insurance, combined Medical/Rx): Individual/Two-Person/Family	*$2,800/$5,600/ $5,600*	*$5,100/$10,200/ $10,200*	$6,750/$13,500	*$6,750/$13,500/ $13,500*	$6,750/$13,500
	Wellness and preventive care visit (in-network, per *Preventive Care Schedule*) (no co-pay)	100%	100%	100%	100%	100%
	TELADOC (medical consultations through audio/visual devices)	*$15*	*$15*	80%	*$15*	60%
	Primary Care Visit, Co-Pay (co-pay not credited towards annual deductible)	*$20*	*$20*	80%	*$20*	60%
	Retail Clinic	*$30*	$35	80%	*$40*	60%
	Specialist Visit (co-pay not credited towards annual deductible)	$50	$50	80%	$50	60%
	Urgent Care (co-pay not credited towards annual deductible)	*$40*	$40	80%	*$45*	60%
	Emergency room services (per visit) (deductible does not apply for PPO plans)	$150	$150	80%	$150	60%
	Outpatient surgery/Outpatient services (CT scan, MRI, diagnostic) (after deductible)	90%	80%	80%	70%	60%
	Hospital inpatient (including maternity)	90% after $250 Co-Pay	80% after $250 Co-Pay	80% after $250 Co-Pay	70% after $250 Co-Pay	60% after $250 Co-Pay
	Inpatient Mental health/Substance Abuse	90% after $250 Co-Pay	80% after $250 Co-Pay	80% after $250 Co-Pay	70% after $250 Co-Pay	60% after $250 Co-Pay
	Outpatient Mental Health/Substance Abuse (office and professional services)	90%	80%	80%	70%	60%
	Habilitative Services (with limitations)	90%	80%	80%	70%	60%
	Rehabilitative & Therapy Services (for Medical Necessity) *Max 30 Visits*	90%	80%	80%	70%	60%
	Chiropractic Services	50%	50%	50%	50%	30%

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	PRESCRIPTION DRUG BENEFITS *(All coinsurance and co-pays are effective after deductible is met)*	2019 PLATINUM	2019 GOLD	2019 GOLD HDHP	2019 SILVER	2019 BRONZE HDHP
Short-Term Med	Generic Drug, Co-Pay	$10 for Generic	$10 for Generic	80% (Participant pays 20%)	$10 for Generic	60% (Participant pays 40%)
	Formulary Brand, Co-Pay	$40 for 30-Day Supply	$40 for 30-Day Supply		$40 for 30-Day Supply	
	Non-Formulary Brand, Co-Pay	$80 for 30-Day Supply	$80 for 30-Day Supply		$80 for 30-Day Supply	
Long-Term Maintenance	Generic Drug, Co-Pay	$20 for 90-Day Supply	$20 for 90-Day Supply	80% (Participant pays 20%)	$20 for 90-Day Supply	60% (Participant pays 40%)
	Formulary Brand, Co-Pay	$80 for 90-Day Supply	$80 for 90-Day Supply		$80 for 90-Day Supply	
	Non-Formulary Brand, Co-Pay	$160 for 90-Day Supply	$160 for 90-Day Supply		$160 for 90-Day Supply	
SPECIALTY Acreedo	Generic Drug, Co-Pay	Participant pays 20% up to a max of $500 per 30-Day Supply	Participant pays 20% up to a max of $500 per 30-Day Supply	Participant pays 20% up to a max of $500 per 30-Day Supply	20% up to a max of $500 per 30-Day Supply	Participant pays 40% up to a max of $500 per 30-Day Supply
	Formulary Brand, Co-Pay					
	Non-Formulary Brand, Co-Pay					

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	OUT-OF-NETWORK MEDICAL BENEFITS	2019 PLATINUM	2019 GOLD	2019 GOLD HDHP	2019 SILVER	2019 BRONZE HDHP
OUT-OF-NETWORK	Medical Plan Annual Deductibles: Individual/Two-Person/Family	$1,350/$2,700/ $4,050	$2,000/$4,000/ $6,000	*$2,950/$5,900*	*$3,800/$7,600/ $11,400*	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*	*$6,750/$13,500*	*$7,900/$15,800/ $15,800*	Not Covered.
	Wellness and preventive care visit (in-network, per *Preventive Care Schedule*) (no co-pay)	60%	60%	60%	60%	Not Covered.
	TELADOC (medical consultations through audio/visual devices)	N/A	N/A	N/A	N/A	Not Covered.
	Primary Care Visit, Co-Pay (co-pay not credited towards annual deductible)	60%	60%	60%	60%	Not Covered.
	Specialist Visit, Co-Pay (co-pay not credited towards annual deductible)	60%	60%	60%	60%	Not Covered.
	Urgent Care, co-pay (co-pay not credited towards annual deductible)	60%	60%	60%	60%	Not Covered.
	Emergency Room Services (per visit) (deductible does not apply for PPO plans)	$150	$150	60%	$150	60%
	Retail Clinic	60%	60%	60%	60%	Not Covered.
	Outpatient Surgery/Outpatient Services (CT scan, MRI, diagnostic) (after deductible)	60%	60%	60%	60%	Not Covered.
	Hospital Inpatient (including maternity)	60% after $250 Co-Pay	60% after $250 Co-Pay	60% after $250 Co-Pay	60% after $250 Co-Pay	Not Covered.
	Inpatient Mental Health/Substance Abuse	60% after $250 Co-Pay	60% after $250 Co-Pay	60% after $250 Co-Pay	60% after $250 Co-Pay	Not Covered.
	Outpatient Mental Health/Substance Abuse (office and professional services)	60%	60%	60%	60%	Not Covered.
	Therapy & Rehabilitation Services (for Medical Necessity) (Limit 30 visits)	60%	60%	60%	60%	Not Covered.
	Chiropractic Services	50%	50%	50%	50%	Not Covered.