2025 Medical Plans At-a-Glance

Plan Feature	EPO HP-NETWORK PLAN OR EPO NETWORK PLAN	HSA PLAN	PPO PLAN
Where available	Click here for access to a list of EPO HP-Network locations	Nationwide except HI	Nationwide except HI
Annual Deductible • Team Member • Family	Embedded $1,500 $4,500	Aggregate $2,000 $4,000[1]	Embedded $1,000 $2,000
Annual Out-of-Pocket Max • Team Member • Family	Embedded $5,000 $15,000	Embedded $6,000 $12,000	Embedded $4,000 $8,000
	NETWORK ONLY YOU PAY	**IN-NETWORK YOU PAY**	**IN-NETWORK YOU PAY**
Preventive Care	$0[3]	$0[3]	$0[3]
Teladoc Telemedicine Visit • Medical • Mental Health • Dermatology • Nutrition	 $20 per visit $20 per visit $20 per visit $20 per visit	 $20 per visit $20 per visit $20 per visit $20 per visit	 $20 per visit $20 per visit $20 per visit $20 per visit
Office Visit • PCP • Specialist	 $20 copay[3] $40 copay[3]	 20%[2] 20%[2]	 20%[2] 20%[2]
Urgent Care	$40 copay[3]	20%[2]	20%[2]
Emergency Room	$200 copay + 30%[2]	20%[2]	$200 copay + 20%[2]
Diagnostic Testing	PCP office: $20 copay[3] Specialist office: $40 copay[3]	20%[2]	20%[2]
Outpatient X-Ray and Lab	PCP office: $20 copay[3] Specialist office: $40 copay[3]	20%[2]	20%[2]
Hospitalization • Inpatient Semi-Private Room • Inpatient Physician	 30%[2] 30%[2]	 20%[2] 20%[2]	 20%[2] 20%[2]
Outpatient Treatment (Physical, Occupational & Speech Therapy)	$40 copay[3]	20%[2]	20%[2]
Mental Health/Substance Abuse • Inpatient • Outpatient	 30%[2] $20 copay[3] (Outpatient psychotherapy)	 20%[2] 20%[2]	 20%[2] 20%[2]
Pharmacy Retail	**30-day supply**	**30-day supply**	**30-day supply**
• Annual Deductible Applies • Pharmacy Out-of-Pocket Max	No Combined with medical	Yes Combined with medical	No Combined with medical
• Specified Preventive Drugs[3,4] • Generic • Brand Preferred • Brand Non-Preferred	N/A $10 copay 20% (min $30, max $90) 30% (min $60, max $120)	100% covered[3,4,5] $10 copay 20%[2] (min $30, max $90) 30%[2] (min $60, max $120)	N/A $10 copay 20% (min $30, max $90) 30% (min $60, max $120)
Pharmacy Retail/Mail Order	**90-day supply**	**90-day supply**	**90-day supply**
• Specified Preventive Drugs[3,4] • Generic • Brand Preferred • Brand Non-Preferred	N/A $30 copay 20% (min $90, max $270) 30% (min $180, max $360)	100% covered[3,4,5] $30 copay 20%[2] (min $90, max $270) 30%[2] (min $180, max $360)	N/A $30 copay 20% (min $90, max $270) 30% (min $180, max $360)

1) The family deductible must be met before any person receives benefits.
2) Coinsurance you pay after you meet the annual deductible unless otherwise noted.
3) Annual deductible waived.
4) As specified in essential health drug list.
5) Includes additional preventive drugs based on a formulary.