

2024 Benefits Summary



Envision Healthcare offers a variety of health and welfare benefit options to help protect your health and promote your wellbeing. This summary provides a brief overview of available options.

Medical

The Company offers five medical plan options so that you can choose the plan that best meets your needs. The plans are administered by Aetna, which utilizes the Aetna Choice POS II Provider network.

- POS Select
- POS Primary
- HSA Select
- HSA Primary
- HSA Base

POS plans include lower deductibles and out-of-pocket expenses for which you will pay higher payroll deductions.

The HSA Select, Primary and Base Plans include higher deductibles and out-of-pocket amounts—but lower payroll deductions and the opportunity to establish an HSA, which in some cases includes Company contributions.

Company-Paid Healthcare Support Resources*

Health Advocate: Your first point of contact for everything related to your medical, prescription, dental and vision needs. Health Advocate can resolve claims and billing issues, explain health conditions, diagnoses and treatments, research treatment options and much more.

Expert second opinions are available at no charge to all team members and their covered family members from leading providers across the country. The 2nd.MD team coordinates all the details so that you can focus on one thing—getting the best care possible.

Surgery Plus*: This benefit provides pre-planned surgical services at significantly reduced out-of-pocket cost to you. SurgeryPlus supplements your medical coverage and has its own network of high-quality providers.

Aetna Smart Compare*: Easily locate cost-effective providers with superior quality ratings and outcomes.

* For those enrolled in an Aetna medical plan

Dental

The Company offers three dental plan options administered by Delta Dental:

- **DHMO Plan:** In-network benefits only; most services subject to a flat copay; includes coverage for orthodontia.
- **PPO Base Plan:** In-network or out-of-network benefits; deductible and coinsurance apply.
- **PPO Buy-Up Plan:** In-network or out-of-network benefits; deductible and coinsurance apply; includes coverage for orthodontia.

Vision

The Company offers two vision plan options, administered by EyeMed:

- **Standard Plan:** Choice of in-network or out-of-network benefits; pays up to an allowance amount for covered services.
- **Premier Plan:** Choice of in-network or out-of-network benefits; pays a higher allowance amount for covered services.

Health Savings Account (HSA)

Team members who enroll in a high deductible health plan have the opportunity to contribute pre-tax dollars to a Health Savings Account with Fidelity Investments.

For 2024, the IRS HSA contribution limits are \$4,150 if you enroll just yourself in medical coverage and \$8,300 if you enroll other eligible family members. If you will be age 55 or older in 2024, you may make an additional HSA catch-up contribution of up to \$1,000.

Flexible Spending Accounts (FSA)

Your Healthcare Flexible Spending Accounts (HCFSA), Dependent Care Flexible Spending Account (DCFSA) and Commuter Benefit Plans are administered by MyChoice® Accounts. The best part is, MyChoice Accounts can be managed directly on EnvisionHealthcareBenefits.com or through the **MyChoice® Mobile App**.

The Company offers four Flexible Spending Accounts (FSAs):

- **Health Care FSA:** If you are not enrolled in a HSA Medical Plan, you may use pre-tax dollars to pay for eligible medical, prescription, dental and vision expenses. The contribution limit is \$3,200.*
- **Limited Purpose Health Care FSA:** If you are enrolled in an HSA Medical Plan, you may use pre-tax dollars to pay for eligible dental and vision expenses. The contribution limit is \$3,200.*
- **Dependent Care FSA:** You can contribute pre-tax dollars for dependent day care and/or after school care for eligible children under age 13 and elderly dependents who live with you. The contribution limit is \$5,000.
- **Commuter Benefit Plan:** Set aside pre-tax dollars for qualified transit, vanpooling and parking expenses. You can use up to \$315 monthly for transit and vanpooling expenses and up to \$315 monthly for parking expenses.*

*Please note: The contribution and spending limits listed are proposed for 2024 and subject to change per the IRS. Please visit EnvisionHealthcareBenefits.com to view final limits.

Life and Accidental Death & Dismemberment (AD&D) Insurance

Life Insurance and Accidental Death and Dismemberment (AD&D) insurance protects you and your family from financial hardship in the event of serious illness, injury or death. This coverage is administered by New York Life Insurance Company.

- **Basic Life/AD&D:** The Company provides Basic Life Insurance coverage of \$50,000. Vice Presidents and above receive two times their benefit salary up to \$2,000,000.
- **Employee Supplemental Life/AD&D:** You may elect up to \$1,000,000 (\$2,000,000 for Vice Presidents and above) of combined Basic and Supplemental Life insurance.
- **Dependent Supplemental Life:** You can also elect life and/or AD&D insurance for your family.

Short Term (STD) and Long Term Disability (LTD) & Parental Leave

Disability coverage replaces a portion of your pay if a serious non-work related illness, injury or pregnancy keeps you from working.

- **Company-Paid STD:** This benefit will be provided at no cost to you and will replace 50% of your income should you find yourself unable to work due to a medical condition. It starts after 14 days of absence and continues for 13 weeks with a maximum weekly benefit of \$3,500.
- **Voluntary STD:** In addition to company-paid STD, you may elect buy-up coverage for a combined weekly benefit of 65% up to \$4,550.
- **Voluntary LTD:** Replaces 60% of income after 90 consecutive days of disability.
- Two weeks of Company Paid Parental Leave

Voluntary Benefits

Envision offers many voluntary benefits that provide supplemental coverage to reduce your financial risk and/or increase your personal security.

Accident Insurance • Critical Illness Insurance • Hospital Indemnity Insurance • Identity Theft Protection • Legal Services

Employee Assistance Program (EAP)

The Employee Assistance Program through TELUS Health (formerly LifeWorks) is a company-paid program designed to provide professional help in dealing with personal concerns that impact you or your family at home or at work.

2024 Envision Medical Coverage Options



The following table provides a side-by-side comparison of the benefits available under each medical plan. This summary is an overview of benefits and not a contract. For a detailed listing of benefits, go to [EnvisionHealthcareBenefits.com](https://www.EnvisionHealthcareBenefits.com) or see the official plan documents.

	POS Select	POS Primary	HSA Select	HSA Primary	HSA Base
Deductible	In-Network: \$600 individual \$1,200 family Out-of-Network: \$1,200 individual \$2,400 family (embedded)	In-Network: \$1,100 individual \$2,200 family Out-of-Network: \$2,200 individual \$4,400 family (embedded)	In-Network: \$1,600 individual \$3,200 family Out-of-Network: \$3,200 individual \$6,400 family (non-embedded)	In-Network: \$3,200 individual \$6,200 family Out-of-Network: \$6,200 individual \$12,400 family (embedded)	In-Network: \$6,650 individual \$13,300 family Out-of-Network: \$13,300 individual \$26,600 family (embedded)
Coinsurance (Plan Pays)	In-Network: 90% Out-of-Network: 70%	In-Network: 80% Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 70% Out-of-Network: 60%	In-Network: 100% Out-of-Network: 80%
Out-of-Pocket Maximum¹	In-Network: \$3,300 individual \$6,600 family Out-of-Network: \$12,000 individual \$24,000 family	In-Network: \$4,300 individual \$8,600 family Out-of-Network: \$16,000 individual \$32,000 family	In-Network: \$4,300 individual \$8,600 family Out-of-Network: \$16,000 individual \$32,000 family	In-Network: \$6,300 individual \$12,600 family Out-of-Network: \$24,000 individual \$48,000 family	In-Network: \$6,650 individual \$13,300 family Out-of-Network: \$25,800 individual \$51,600 family
HSA Contribution²	N/A	N/A	\$500 individual \$1,000 family	\$300 individual \$600 family	N/A
Office Visit (PCP/Specialist)	In-Network: \$25 PCP / \$50 SPC (deductible waived) Out-of-Network: 70%	In-Network: \$30 PCP / \$60 SPC (deductible waived) Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 70% Out-of-Network: 60%	In-Network: 100% Out-of-Network: 80%
Telemedicine CVS Virtual Care	\$0 copay (deductible waived)	\$0 copay (deductible waived)	In-Network: \$0 copay (deductible waived)	In-Network: \$0 copay (deductible waived)	In-Network: \$0 copay (deductible waived)
Inpatient Hospital	In-Network: 90% Out-of-Network: 70%	In-Network: 80% Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 70% Out-of-Network: 60%	In-Network: 100% Out-of-Network: 80%
Outpatient Surgery	In-Network: 90% Out-of-Network: 70%	In-Network: 80% Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 70% Out-of-Network: 60%	In-Network: 100% Out-of-Network: 80%
Emergency Room	In-Network: \$200 copay Out-of-Network: \$200 copay	In-Network: \$250 copay Out-of-Network: \$250 copay	In-Network: 80% Out-of-Network: 80%	In-Network: 70% Out-of-Network: 70%	In-Network: 100% Out-of-Network: 100%
Urgent Care	In-Network: \$50 copay (deductible waived) Out-of-Network: 70%	In-Network: \$60 copay (deductible waived) Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 70% Out-of-Network: 60%	In-Network: 100% Out-of-Network: 80%
Mental Health/Substance Abuse Inpatient	In-Network: 90% Out-of-Network: 70%	In-Network: 80% Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 70% Out-of-Network: 60%	In-Network: 100% Out-of-Network: 80%
Mental Health/Substance Abuse Outpatient	In-Network: \$25 PCP / \$50 SPC (deductible waived) Out-of-Network: 70%	In-Network: \$30 PCP / \$60 SPC (deductible waived) Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 70% Out-of-Network: 60%	In-Network: 100% Out-of-Network: 80%

¹ Deductibles, coinsurance and copays (where applicable) accumulate toward the medical out-of-pocket maximum.

² The Company HSA contribution is available only to employees in salary bands I and II.

2024 Envision Prescription Coverage Option

POS Select	POS Primary	HSA Select	HSA Primary	HSA Base
Generic: \$10 copay Brand Formulary: \$50 copay Brand Non-Formulary: \$75 copay Specialty: 20% coinsurance* (Not subject to deductible but expenses paid by you count toward your medical plan's annual out-of-pocket maximum.)	Generic: \$15 copay Brand Formulary: \$60 copay Brand Non-Formulary: \$80 copay Specialty: 20% coinsurance* (Not subject to deductible but expenses paid by you count toward your medical plan's annual out-of-pocket maximum.)	20% coinsurance after deductible	Generic: 20% coinsurance after deductible Brand Formulary: 30% coinsurance after deductible Brand Non-Formulary: 50% coinsurance after deductible Specialty: 30% coinsurance after deductible	100% coverage after deductible

Note: Coinsurance you pay for prescription drugs applies to the out-of-pocket maximum under all medical plans. A coupon or a cost paid by the drug manufacturer will not apply.

*\$0 copay for PrudentRx medications; 30% coinsurance will be assessed if you opt out of program offering.

Dental Plan Overview

	DHMO Plan	Delta Dental Base Plan		Delta Dental Buy-Up Plan	
	In-Network Only	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible	N/A	\$50 individual \$150 family		\$50 individual \$150 family	
Calendar Year Maximum	No maximum	\$1,000 per person		\$2,000 per person	
Preventive & Diagnostic Services (routine exams, X-rays, cleanings)	Based on Fee Schedule	100% (no deductible)		100% (no deductible)	
Basic/Restorative Services (fillings, extractions, periodontal, endodontics)	Based on Fee Schedule	80% (after deductible)		80% (after deductible)	
Major (bridgework, crowns, dentures)	Based on Fee Schedule	50% (after deductible)		50% (after deductible)	
Orthodontia (for adults and children)	Based on Fee Schedule	Orthodontia not covered		50% (after deductible)— separate lifetime maximum applies	
Lifetime Maximum for Orthodontia	Covered	Orthodontia not covered		\$2,000 per person	

* You are responsible for charges exceeding the Maximum Plan Allowance (MPA) if you use an out-of-network provider. MPA charges are based on the usual and customary fees charged in your geographic area.

Vision Plan Overview

	Base Plan		Buy-Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Exam (12 Months)	\$20 Copay	\$40 Copay	\$10 Copay	\$50 Allowance
Standard Plastic Lenses (12 months)				
Single	\$25 Copay	\$30 Allowance	\$10 Copay	\$40 Allowance
Bifocal	\$25 Copay	\$50 Allowance	\$10 Copay	\$60 Allowance
Trifocal	\$25 Copay	\$65 Allowance	\$10 Copay	\$80 Allowance
Standard Progressive	\$80 Copay	\$50 Allowance	\$35 Copay	\$60 Allowance
Lens Options				
Tint	\$10 Copay	\$5 Allowance	\$0 Copay	\$5 Allowance
Frames (24 months for Standard Plan; 12 months for Premier Plan)				
Frames Benefit	\$150 Allowance	\$105 Allowance	\$200 Allowance	\$130 Allowance
Contact Lenses (12 months)				
Elective	\$150 Allowance	\$105 Allowance	\$200 Allowance	\$130 Allowance
Medically Necessary	\$0	\$210	\$0	\$210