

## 2024 MEDICAL PLAN COMPARISON

Contributions/Deductibles	<a href="http://www.aetna.com">Core Medical (www.aetna.com)</a>	<a href="http://www.aetna.com">High Deductible Medical (www.aetna.com)</a>	<a href="http://www.kp.org">Kaiser HMO (www.kp.org)</a>									
<b>Per-Pay-Period Contributions</b> <ul style="list-style-type: none"> <li>• Employee Only</li> <li>• Employee + One</li> <li>• Family</li> </ul>	\$ 65.54 \$ 131.08 \$ 196.62	\$ 24.00 \$ 48.00 \$ 72.00	\$ 48.00 \$ 96.00 \$ 153.69									
<b>Health Savings Account (HSA)</b> <ul style="list-style-type: none"> <li>• Maximum Contribution</li> <li>• Catch-up Contribution for Age 55+</li> </ul>	Not permitted – Per IRS rules. Not permitted – Per IRS rules.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 50%;"><u>Employee Only</u></td> <td style="text-align: center; width: 50%;"><u>Employee + One/Family</u></td> </tr> <tr> <td style="text-align: center;">\$4,150</td> <td style="text-align: center;">\$8,300</td> </tr> <tr> <td style="text-align: center;">\$1,000</td> <td style="text-align: center;">\$1,000</td> </tr> </table>	<u>Employee Only</u>	<u>Employee + One/Family</u>	\$4,150	\$8,300	\$1,000	\$1,000	Not permitted – Per IRS rules. Not permitted – Per IRS rules.			
<u>Employee Only</u>	<u>Employee + One/Family</u>											
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<b>Flexible Spending Account (FSA)</b> <ul style="list-style-type: none"> <li>• Maximum Contribution for Healthcare FSA</li> </ul>	\$3,200  Regular FSA provisions apply.	\$3,200  Limited Purpose FSA only Before deductible: limited to dental, vision and certain preventive drugs and services.  After deductible: used like a regular FSA for all qualified health care expenses.	\$3,200  Regular FSA provisions apply.									
<b>Annual Deductibles</b> <ul style="list-style-type: none"> <li>• Employee Only</li> <li>• Employee + One/Family</li> </ul>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 50%;"><u>Network</u></td> <td style="text-align: center; width: 50%;"><u>Non-Network</u></td> </tr> <tr> <td style="text-align: center;">\$300</td> <td style="text-align: center;">\$ 600</td> </tr> <tr> <td style="text-align: center;">\$600</td> <td style="text-align: center;">\$1,200</td> </tr> </table> Individual deductible also applies.	<u>Network</u>	<u>Non-Network</u>	\$300	\$ 600	\$600	\$1,200	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>Network/Non-Network</u></td> </tr> <tr> <td style="text-align: center;">\$1,600</td> </tr> <tr> <td style="text-align: center;">\$3,200</td> </tr> </table> For Employee + One and Family coverage, the entire corresponding deductible must be met before the plan begins to pay benefits.	<u>Network/Non-Network</u>	\$1,600	\$3,200	Not Applicable
<u>Network</u>	<u>Non-Network</u>											
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<b>Out-of-Pocket (OOP) Maximum</b> <ul style="list-style-type: none"> <li>• Employee Only</li> <li>• Employee + One/Family</li> </ul> When your share of covered expenses (including the deductible) reaches the OOP limit, covered expenses for the remainder of the calendar year are paid at 100%.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 50%;"><u>Network</u></td> <td style="text-align: center; width: 50%;"><u>Non-Network</u></td> </tr> <tr> <td style="text-align: center;">\$1,500</td> <td style="text-align: center;">\$2,500</td> </tr> <tr> <td style="text-align: center;">\$3,000</td> <td style="text-align: center;">\$5,000</td> </tr> </table> Individual OOP also applies.	<u>Network</u>	<u>Non-Network</u>	\$1,500	\$2,500	\$3,000	\$5,000	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>Network/Non-Network</u></td> </tr> <tr> <td style="text-align: center;">\$3,000</td> </tr> <tr> <td style="text-align: center;">\$6,000</td> </tr> </table> The entire OOP must be met before the plan begins to pay 100%.	<u>Network/Non-Network</u>	\$3,000	\$6,000	\$1,500 \$3,000
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\$1,500	\$2,500											
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<u>Network/Non-Network</u>												
\$3,000												
\$6,000												
<b>Lifetime Maximum Benefit</b>	Unlimited (per person)	Unlimited (per person)	Unlimited (per person)									

Plan Feature <sup>1</sup>	Core Medical	High Deductible Medical	Kaiser HMO
<b>Office Visits</b> <ul style="list-style-type: none"> <li>• Primary Care Physician</li> <li>• Specialist</li> </ul>	\$20 copay \$40 copay	80% 80%	\$30 copay \$30 copay
<b>Other Medical Expenses</b> <ul style="list-style-type: none"> <li>• Surgery</li> <li>• Diagnostic X-rays Not Billed by Physician; Lab; Ambulance (for emergencies)</li> </ul>	90% 90%	80% 90%	\$30/outpatient procedure Covered in full
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>• Routine Physicals/Well Child Care</li> <li>• Flu Shots</li> <li>• Mammography</li> <li>• PSA Test</li> <li>• Cervical Cancer Screening (and exam)</li> <li>• Colorectal Cancer Screening</li> </ul> All preventive services are subject to age and frequency guidelines.	\$0 copay	100%, no deductible	\$0 copay
<b>Vision Care</b> <ul style="list-style-type: none"> <li>• Routine Exam</li> <li>• Materials</li> </ul>	\$0 copay Discounts available	100%, no deductible Discounts available	\$0 copay
<b>Chiropractic Care</b>	90%	80%	Not covered
<b>Mental Health and Substance Abuse Treatment</b> <ul style="list-style-type: none"> <li>• Inpatient/Outpatient Facility</li> <li>• Outpatient Office Visit</li> </ul>	90% \$20 copay	90% 80%	\$250 copay \$ 30 copay
<b>Hospital/Surgical Center</b> (Inpatient/Outpatient)	90%	90%	\$250/Inpatient admission

<sup>1</sup>Coverage levels shown apply only to covered in-network expenses. Coinsurance (amounts indicated as percentages in the table) applies after the deductible unless otherwise noted. Non-coinsurance services are covered at 100% after your payment of the designated fixed-dollar copay. Most non-network services are subject to deductible, coinsurance, and usual and customary (U&C) or local plan allowance limits. For more detailed information, see each plan's Summary Plan Description (SPD), Summary of Benefits and Coverage, and/or subsequent issues of benefits newsletters (Summaries of Material Modification).

Plan Feature <sup>1</sup>	Core Medical	High Deductible Medical	Kaiser HMO
Emergency Room	<p style="text-align: center;">90%</p> <p style="text-align: center;">(Emergency admissions must be certified within 48 hours of admission)</p>		\$100 copay (\$0 if admitted)
Precertification Requirements	<p>All inpatient care must be precertified.</p> <ul style="list-style-type: none"> <li>• In most cases, network providers will handle precertification.</li> <li>• If you use non-network providers, it is your responsibility to obtain precertification to avoid a noncompliance penalty of up to \$500.</li> </ul>		All inpatient care must be precertified

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Plan Feature <sup>1</sup>	Core Medical	High Deductible Medical	Kaiser HMO																										
<b>Prescription Drugs</b> • Deductible	No Deductible	You pay the full cost of drugs until the annual deductible is met.	No Deductible																										
• Retail; up to 30-day supply	Using lowest cost approach (i.e., generics and mail order for maintenance drugs), you pay <sup>2</sup> <table border="0"> <tr> <td>Generic</td> <td>\$10</td> <td>Generic</td> <td>\$10</td> </tr> <tr> <td>Preferred Brand</td> <td>\$30</td> <td>Preferred Brand</td> <td>25% (Min \$10/Max \$50)</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>\$50</td> <td>Non-Preferred Brand</td> <td>25% (Min \$25/Max \$100)</td> </tr> <tr> <td>Specialty<sup>3</sup></td> <td>30%</td> <td>Specialty<sup>3</sup></td> <td>30%</td> </tr> <tr> <td>Specialty<sup>3</sup> – PrudentRx</td> <td>\$0</td> <td>Specialty<sup>3</sup> – PrudentRx</td> <td>\$0</td> </tr> </table> You pay full cost after 2nd refill at retail for maintenance drugs.	Generic	\$10	Generic	\$10	Preferred Brand	\$30	Preferred Brand	25% (Min \$10/Max \$50)	Non-Preferred Brand	\$50	Non-Preferred Brand	25% (Min \$25/Max \$100)	Specialty <sup>3</sup>	30%	Specialty <sup>3</sup>	30%	Specialty <sup>3</sup> – PrudentRx	\$0	Specialty <sup>3</sup> – PrudentRx	\$0	<table border="0"> <tr> <td>Generic</td> <td>\$15</td> </tr> <tr> <td>Preferred Brand</td> <td>\$35</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>\$35</td> </tr> </table>	Generic	\$15	Preferred Brand	\$35	Non-Preferred Brand	\$35	
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<sup>2</sup>Certain preventive drugs are covered at 100% (\$0 copay).

<sup>3</sup>If you participate in The PrudentRx Copay Program, your cost for specialty medication is \$0.