

|                              | KAISER                              |                   |            |                   |                               |                   |
|------------------------------|-------------------------------------|-------------------|------------|-------------------|-------------------------------|-------------------|
| PLAN NAMES:                  | MED PLAN 1                          |                   | MED PLAN 2 |                   | MED PLAN 3                    |                   |
|                              |                                     |                   |            |                   | Health Savings Account Option |                   |
|                              | InNetwork                           | OutOfNetwork      | InNetwork  | OutOfNetwork      | InNetwork                     | OutOfNetwork      |
| Deductible Per Person        | None                                | N/A               | \$800      | N/A               | \$1,600                       | N/A               |
| Max Deduct Per Family        | None                                | N/A               | \$2,400    | N/A               | \$3,200                       | N/A               |
| Max Out of Pocket Per Person | \$1,500                             | N/A               | \$4,000    | N/A               | \$6,550                       | N/A               |
| Max Out of Pocket Per Family | \$3,000                             | N/A               | \$12,000   | N/A               | \$13,100                      | N/A               |
| Routine Exam                 | \$0                                 | Not Covered       | \$0        | Not Covered       | \$0                           | Not Covered       |
| Primary Care Office Visit    | \$20                                | Not Covered       | \$25       | Not Covered       | 20%                           | Not Covered       |
| Virtual Care                 | \$0                                 | Not Covered       | \$0        | Not Covered       | 20%                           | Not Covered       |
| Specialist Office Visit      | \$30                                | Not Covered       | \$35       | Not Covered       | 20%                           | Not Covered       |
| Urgent Care Visit            | \$35                                | See Plan Handbook | \$40       | See Plan Handbook | 20%                           | See Plan Handbook |
| Emergency Room               | \$100 per visit, waived if admitted |                   | 20%        |                   | 20%                           |                   |

|                              | MODA                                                |         |                |                                                     |          |                |                                                     |          |                |                               |          |                   |
|------------------------------|-----------------------------------------------------|---------|----------------|-----------------------------------------------------|----------|----------------|-----------------------------------------------------|----------|----------------|-------------------------------|----------|-------------------|
| PLAN NAMES:                  | PLAN 1                                              |         |                | PLAN 2                                              |          |                | PLAN 3                                              |          |                | PLAN 6                        |          |                   |
|                              |                                                     |         |                |                                                     |          |                |                                                     |          |                | Health Savings Account Option |          |                   |
| Network Available Per Plan   | In -Network                                         |         | Out of Network | In -Network                                         |          | Out of Network | In -Network                                         |          | Out of Network | In -Network                   |          | Out of Network    |
|                              | CC                                                  | Non-CC  | Out of Network | CC                                                  | Non-CC   | Out of Network | CC                                                  | Non-CC   | Out of Network | CC                            | Non-CC   | Out of Network    |
| Deductible Per Person        | \$400                                               | \$500   | \$800          | \$800                                               | \$900    | \$1,600        | \$1,200                                             | \$1,300  | \$2,400        | \$1,600                       | \$1,700  | \$3,200           |
| Max Deduct Per Family        | \$1,500                                             | \$1,500 | \$2,400        | \$2,700                                             | \$2,700  | \$4,800        | \$3,900                                             | \$3,900  | \$7,200        | \$3,400                       | \$3,400  | \$6,400           |
| Max Out of Pocket Per Person | \$2,850                                             | \$3,250 | \$6,000        | \$3,850                                             | \$4,250  | \$8,000        | \$4,850                                             | \$5,250  | \$10,000       | \$6,400                       | \$6,750  | \$13,100          |
| Max Out of Pocket Per Family | \$9,750                                             | \$9,750 | \$18,000       | \$12,750                                            | \$12,750 | \$24,000       | \$15,750                                            | \$15,750 | \$27,400       | \$13,500                      | \$13,500 | \$26,200          |
| Routine Exam                 | \$0                                                 | \$0     | 50%            | \$0                                                 | \$0      | 50%            | \$0                                                 | \$0      | 50%            | \$0                           | \$0      | 50%               |
| Primary Care Office Visit    | \$20                                                | 20%     | 50%            | \$20                                                | 20%      | 50%            | \$25                                                | 25%      | 50%            | 15%                           | 20%      | 50%               |
| Virtual Care                 | \$10                                                | \$10    | 50%            | \$10                                                | \$10     | 50%            | \$10                                                | \$10     | 50%            | \$10                          | \$10     | 50%               |
| Specialist Office Visit      | \$40                                                | 20%     | 50%            | \$40                                                | 20%      | 50%            | \$50                                                | 25%      | 50%            | 15%                           | 20%      | 50%               |
| Urgent Care Visit            | \$40                                                | 20%     | 20%            | \$40                                                | 20%      | 20%            | \$50                                                | 25%      | 25%            | 15%                           | 20%      | 20%               |
| Emergency Room               | \$100 copay, plus 20%<br>(copay waived if admitted) |         |                | \$100 copay, plus 20%<br>(copay waived if admitted) |          |                | \$100 copay, plus 25%<br>(copay waived if admitted) |          |                | 20%                           | 25%      | See Plan Handbook |

All Moda Plans: If you select the CC (Coordinated Care) = PCP 360 network, each person on the plan must select a PCP 360 Provider (each person can have a different provider) to receive enhanced benefits and savings. For more information on the CC (Coordinated Care) = PCP 360 plans, please call OEBB at 1-888-469-6322.