MEDICAL PLANS COMPARISON CHART

The information below is a summary of medical coverage only. Please go to **join.collectivehealth.com/spacex** for plan summaries with more detailed information. Any deductibles, copays, and coinsurance shown in the chart are the amounts for which you will be responsible.

PLAN TYPE	MEDICAL EPO	MEDICAL PPO		GUIDE PPO		HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)		HMO
PLAN ADMINISTRATOR NETWORK	**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**	**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**		**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**		**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**		**KAISER PERMANENTE**
	IN-NETWORK ONLY*	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Calendar Year Deductible								
Individual	$500	$500		$0	$1,000	$1,600	$4,500	$500
Family	$1,000	$1,000		$0	$2,000	$3,200	$9,000	$1,000
SpaceX HSA Account Funding	N/A	N/A	N/A	N/A	N/A			N/A
Individual						$500		
Family						$1,000		
Annual Out-of-Pocket Limit								
Individual	$3,400	$3,400	$10,500	$3,000	$6,000	$4,500	$13,500	$3,000
Family	$6,800	$6,800	$21,000	$6,000	$12,000	$9,000	$27,000	$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Physician Services								
Preventive Care Services**	Covered in full	Covered in full	40% Coinsurance	See **pages 12-13**	50% Coinsurance	Covered in full	40% Coinsurance	Covered in full
Doctor's Office Visit	$25 Copay (deductible waived)	$25 Copay (deductible waived)	40% Coinsurance	$10 Copay	50% Coinsurance	20% Coinsurance	40% Coinsurance	$25 Copay (deductible waived)
Specialist	$40 Copay (deductible waived)	$40 Copay (deductible waived)	40% Coinsurance	$50 Copay	50% Coinsurance	20% Coinsurance	40% Coinsurance	$40 Copay (deductible waived)
Lab and X-ray Services	15% Coinsurance	20% Coinsurance	40% Coinsurance	See **pages 12 & 14**	50% Coinsurance	20% Coinsurance	40% Coinsurance	$10 Copay
Inpatient Hospital Services	15% Coinsurance	20% Coinsurance	40% Coinsurance	$200 Copay***	50% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance
Emergency Treatment								
ER (true emergency)	15% Coinsurance	20% Coinsurance	20% Coinsurance	See **pages 12 & 14**	See **pages 12 & 14**	20% Coinsurance	20% Coinsurance	20% Coinsurance
Ambulance	15% Coinsurance	20% Coinsurance	20% Coinsurance	$200 Copay	$200 Copay (deductible waived)	20% Coinsurance	20% Coinsurance	$150 Copay
Urgent Care	$25 Copay (deductible waived)	$25 Copay (deductible waived)	40% Coinsurance	$10 Copay	$10 Copay (deductible waived)	20% Coinsurance	40% Coinsurance	$25 Copay (deductible waived)

This information is provided for summary purposes only. Please refer to the Summary Plan Description for specific plan information. In the event of a discrepancy, the official plan document prevails.

Note: *Reasonable and Customary (R&C) charges apply to out-of-network coverage.*

PLAN TYPE	MEDICAL EPO	MEDICAL PPO		GUIDE PPO		HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)		HMO
PLAN ADMINISTRATOR NETWORK	**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**	**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**		**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**		**COLLECTIVE HEALTH Blue Shield of California (BlueCard Nationwide)**		**KAISER PERMANENTE**
	IN-NETWORK ONLY*	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Mental Health/Substance Abuse								
Inpatient	15% Coinsurance (in-network) Not Covered (out-of-network)	20% Coinsurance	40% Coinsurance	$200 Copay	50% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance
Office Visits	$25 Copay (in-network; deductible waived) 40% Coinsurance (out-of-network)	$25 Copay (deductible waived)	40% Coinsurance	$10 Copay	50% Coinsurance	20% Coinsurance	40% Coinsurance	$25 Copay (deductible waived)
Lyra Health (mental health therapy or medication consultations)	$25 Copay (deductible waived)	$25 Copay (deductible waived)	N/A	$10 Copay	N/A	20% Coinsurance	N/A	N/A
Outpatient Facility or Inpatient/ Residential Stay	15% Coinsurance (in-network) Not Covered (out-of-network)	20% Coinsurance	40% Coinsurance	$200 Copay	50% Coinsurance	20% Coinsurance	40% Coinsurance	$25 Copay (deductible waived) Outpatient 20% Coinsurance Inpatient
Other Services								
Chiropractic/ Acupuncture	$40 Copay (deductible waived) (limited to 30 visits per calendar year)	$40 Copay (deductible waived) (limited to 30 visits per calendar year)	40% Coinsurance	$50 Copay (limited to 20 visits per calendar year)	50% Coinsurance (limited to 20 visits per calendar year)	20% Coinsurance (limited to 30 visits per calendar year)	40% Coinsurance (limited to 30 visits per calendar year)	$15 Copay (deductible waived) (limited to 30 visits per calendar year combined chiropractic and acupuncture session limit)

**Out-of-network mental health office visits as well as care received at out-of-network emergency departments are covered under the Medical EPO.*
***Includes well woman exams, mammograms, adult periodic exams with preventive tests.*
****Inpatient maternity delivery services are covered at a $0 copay.*