

MEDICARE¹

MA PPO Medicare Advantage PPO

TCN Traditional Care Network

HMO Health Maintenance Organization

| | | | |
|--|--------------------------|---|--|
| Monthly Contribution | \$0 Single \$0 Family | \$17 Single ² \$34 Family ² | \$0 Single \$0 Family |
| Deductible (Amount you pay annually before the plan begins to pay a portion of the costs) | \$245 / Person | \$400 Single \$675 Family | \$400 Single ³ \$675 Family ³ |
| Coinsurance (Amount you pay after your deductible is met) | 10% | 10% | N/A |
| Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs) | \$630 / Person | \$800 Single \$1,475 Family | N/A |
| Primary Care Physician (PCP) Office Visit | \$20 Copay | Covered by Medicare at 80%, after Part B deductible is met; Member pays remaining 20% | \$25 Copay |
| Specialist Office Visit | \$25 Copay | Covered by Medicare at 80%, after Part B deductible is met; Member pays remaining 20% | \$35 Copay ³ |
| Urgent Care (Including Retail Health Clinics) | \$25 Copay | \$50 Copay | \$25 Copay |
| Emergency Room (Waived if admitted) | \$50 Copay | \$125 Copay | \$50 Copay |

1. Reflects in-network costs 2. Protected population: single or family \$17 3. Does not apply to protected population (Refer to plan materials for actual costs)

NON-MEDICARE¹

TCN Traditional Care Network

HMO Health Maintenance Organization

| | | |
|--|--|--|
| Monthly Contribution | \$17 Single ² \$34 Family ² | \$17 Single ² \$34 Family ² |
| Deductible (Amount you pay annually before the plan begins to pay a portion of the costs) | \$400 Single \$675 Family | \$400 Single ³ \$675 Family ³ |
| Coinsurance (Amount you pay after your deductible is met) | 10% | N/A |
| Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs) | \$800 Single \$1,475 Family | N/A |
| Primary Care Physician (PCP) Office Visit | \$25 Copay per visit for 6 routine PCP office visits | \$25 Copay |
| Specialist Office Visit | Not Covered | \$35 Copay ³ |
| Urgent Care (Including Retail Health Clinics) | \$50 Copay | \$50 Copay |
| Emergency Room (Waived if admitted) | \$125 Copay | \$125 Copay ³ |

1. Reflects in-network costs 2. Protected population: single or family \$17 3. Does not apply to protected population (Refer to plan materials for actual costs)