

2015 Standard Platinum Plan - 90%

Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>	\$0 \$0	\$2,000 \$4,000
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>	\$2,000 \$4,000	\$4,000 \$8,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	20% coinsurance
Primary Care (injury or illness)	\$10 copayment	20% coinsurance after OON deductible is met
Specialist	\$30 copayment	20% coinsurance after OON deductible is met
Emergency/Urgent Care		
Urgent Care Center or Facility	\$50 copayment	20% coinsurance after OON deductible is met
Emergency Room	\$100 copayment	\$100 copayment
Ambulance	\$0	\$0
Hospital Services		
Inpatient	\$250 copayment per day to a maximum of \$500 per admission	20% coinsurance after OON deductible is met
Outpatient (performed at hospital or ambulatory facility)	\$250 copayment	20% coinsurance after OON deductible is met
Skilled Nursing Facility <i>90 day calendar year maximum</i>	\$250 copayment per day to a maximum of \$500 per admission	20% coinsurance after OON deductible is met
Mental Health, Substance Abuse & Behavioral Health Care		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0	20% coinsurance after OON deductible is met
Outpatient Services		
Home Health Care <i>100 visit calendar year maximum</i>	\$0	20% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$75 copayment per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	20% coinsurance after OON deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	\$30 copayment	20% coinsurance after OON deductible is met

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Outpatient Services		
Laboratory Services	\$10 copayment	20% coinsurance after OON deductible is met
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$10 copayment	20% coinsurance after OON deductible is met
Chiropractic Care <i>20 visit calendar maximum</i>	\$30 copayment	20% coinsurance after OON deductible is met
Other Services		
Durable Medical Equipment	20% coinsurance	20% coinsurance after OON deductible is met
Prosthetics	20% coinsurance	20% coinsurance after OON deductible is met
Diabetic Supplies & Equipment	20% coinsurance	20% coinsurance after OON deductible is met
Prescription Drugs		
Tier 1	\$5 copayment	20% coinsurance after OON deductible is met
Tier 2	\$15 copayment	20% coinsurance after OON deductible is met
Tier 3	\$30 copayment	20% coinsurance after OON deductible is met
Tier 4	20% coinsurance	20% coinsurance after OON deductible is met

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance after OON deductible is met
Basic Restorative (Filling, Simple Extraction)	20% coinsurance	50% coinsurance after OON deductible is met
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance after OON deductible is met
Orthodontia Services <i>medically necessary only</i>	50% coinsurance	50% coinsurance after OON deductible is met
Pediatric Vision Care		
Routine Eye Exam	\$10 copayment	20% coinsurance
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>	lenses: \$0; collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance