

## Standard Platinum Plan - 90%

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

\*After out-of-network deductible is met

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<b>Outpatient Services</b>		
<b>Laboratory Services</b>	\$10 copay	20% coinsurance*
<b>Rehabilitative &amp; Habilitative Therapy</b> (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$10 copay	20% coinsurance*
<b>Chiropractic Care</b> <i>20 visit calendar maximum</i>	\$30 copay	20% coinsurance*
<b>Other Services</b>		
<b>Durable Medical Equipment</b>	20% coinsurance	20% coinsurance*
<b>Prosthetics</b>	20% coinsurance	20% coinsurance*
<b>Diabetic Supplies &amp; Equipment</b>	20% coinsurance	20% coinsurance*
<b>Prescription Drugs</b>		
<b>Generic Drugs</b>	\$5 copay	20% coinsurance*
<b>Preferred Brand Drugs</b>	\$15 copay	20% coinsurance*
<b>Non-Preferred Brand Drugs</b>	\$30 copay	20% coinsurance*
<b>Specialty Drugs</b>	20% coinsurance	20% coinsurance*
<b>Pediatric-Only Services (for children under age 19)</b>		
<b>Pediatric Dental Care</b>		
<b>Diagnostic &amp; Preventive</b> (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance*
<b>Basic Restorative</b> (Filling, Simple Extraction)	20% coinsurance	50% coinsurance*
<b>Major Restorative</b> (Endodontic, Crown)	40% coinsurance	50% coinsurance*
<b>Orthodontia Services</b> <i>medically necessary only</i>	50% coinsurance	50% coinsurance*
<b>Pediatric Vision Care</b>		
<b>Routine Eye Exam</b>	\$10 copay	20% coinsurance
<b>Prescription Eye Glasses</b> <i>one pair of frames &amp; lenses per calendar year</i>	lenses: \$0 collection frames: \$0 non-collection frames: \$0 up to a \$150 allowance; any amount over the \$150 allowance is payable by the member minus a 20% discount	lenses: \$0 frames: \$0 up to a \$30 allowance; any amount over the allowance is payable by the member

\*After out-of-network deductible is met