

PLATINUM 90 HMO 0/15 W/ CHILD DENTAL + INFERTILITY**Copay HMO Plan**

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	\$0
OUT-OF-POCKET MAXIMUM Individual/Family	\$2,500/\$5,000 ^{1,2} (embedded)
IN THE MEDICAL OFFICE Primary care visits Urgent care visits Specialty office visits Preventive exams, vaccines (immunizations) Prenatal care Postpartum care Well-child preventive care visits Allergy injections Infertility services Physical, occupational, and speech therapy Most laboratory tests Most X-rays and diagnostic testing Most MRI/CT/PET scans Outpatient surgery (per procedure)	\$15 \$15 \$15 \$0 ³ \$0 ⁴ \$0 ⁴ \$0 ⁵ \$5 50% (IVF not covered) \$15 \$20 \$40 \$100 \$250
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$150 \$150
PRESCRIPTIONS Generic drugs (up to a 30-day supply) Brand-name drugs (up to a 30-day supply) Specialty drugs (up to a 30-day supply)	\$5 ⁶ \$15 ⁶ 10% per prescription up to \$250 maximum ⁶
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services Skilled nursing facility care (up to 100 days per benefit period)	\$250 per admission \$250 per admission
MENTAL HEALTH SERVICES In the medical office In the hospital	\$15 \$250 per admission
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	\$15 \$250 per admission
OTHER Certain durable medical equipment (DME) (supplemental and base) Certain prosthetic and orthotic devices Pediatric optical (eyewear) Pediatric vision exam Adult optical (eyewear) Adult vision exam (for eye refraction) Home health care (up to 100 visits per year) Hospice care	10% ⁷ \$0 1 pair of eyeglasses or contact lenses per year ⁸ \$0 \$175 allowance ⁹ \$0 \$0 \$0

¹This plan has an embedded out-of-pocket maximum. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.

²Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.

³Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

⁴Scheduled prenatal visits and the first postpartum visit

⁵Well-child visits through age 23 months

⁶Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

⁷Supplemental coverage: \$2,000 benefit limit per year

⁸Under age 19

⁹Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months