

Platinum 90 PPO 0/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance (COI)* should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK ^{1,2}	OUT-OF-NETWORK ^{1,3}
Unlimited lifetime maximum.	✓	✓
Plan maximums		
Calendar year deductible ⁴	N/A	\$1,000 / \$2,000
Out-of-pocket maximum (single / family) ⁶	\$4,500 / \$9,000	\$9,000 / \$18,000
Professional services		
Office visit ⁷	\$15	50%
Specialist visit	\$30	50%
Telehealth services through Teladoc ⁸	\$0	Not covered
Rehabilitation and habilitation therapy	\$15	50%
X-ray/Laboratory procedures	\$30 / \$15	50% / 50%
Complex radiology services (MRI, CT, PET)	10%	50%
Outpatient services		
Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%	50% / 50%
Hospital services		
Inpatient hospital	10%	50%
Skilled nursing facility	10%	50%
Emergency services		
Emergency room (copay waived if admitted)	\$150	\$150 (ded. waived)
Urgent care	\$15	50%
Mental/Behavioral health / Substance use disorder services⁹		
Mental/Behavioral health / Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$15	50%
Other services		
Durable medical equipment	10%	50%
Acupuncture (medically necessary) ¹¹	\$15	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage^{13,14}		
Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 ¹² (up to a 30-day supply obtained through a participating pharmacy)	\$5 / \$15 / \$25	Not covered
Tier 4 Specialty drugs ¹⁵	10%	Not covered
Pediatric dental¹⁶		
Diagnostic and preventive services	\$0	10%
Pediatric vision¹⁷		
Routine eye exam	\$0	Not covered
Glasses (limitations apply)	\$0	Not covered