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 Babylon[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)	$200	$200 (ded. waived)
Urgent care	$15	50%
Mental/Behavioral health / Substance use disorder services[9] 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)	$10 / $25 / $40	Not covered
Tier 4 Specialty drugs[15]	10%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

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