

	<i>PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA</i>
Plan Name	Platinum⁹⁰
SERVICES AND FEATURES	
Annual Deductible	\$0
Out-of-Pocket Limit On Expenses	Individual \$4,000 / Family \$8,000
LIFETIME MAXIMUMS	No Limit
PROFESSIONAL SERVICES	Member Cost Share
Preventive Care/Screening/Immunization	\$0 Copay
Primary Care Visit to Treat an Injury or Illness	\$15 Copay
Specialist Visit	\$40 Copay
Maternity Care - Preconception/Prenatal/Postnatal Care	\$0 Copay
Delivery and all Inpatient Services (Hospital Services)	\$250 Copay Per Day (Up to First 5 days)
Delivery and all Inpatient Services (Professional Services)	\$40 Copay
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	\$20 Copay (Laboratory) / \$40 Copay (X-Ray)
Imaging (CT/PET Scans, MRIs)	\$150 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$250 Copay
Physician/Surgery Fees	\$40 Copay
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	\$250 Copay Per Day (Up To First 5 Days)
Physician/Surgeon Fees	\$40 Copay
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	\$150 Copay
Professional Services	\$0 Copay
Urgent Care Center	\$15 Copay
PRESCRIPTION DRUG COVERAGE	
Annual Tier 2/Tier 3/Tier 4 Rx Deductible	\$0
Tier 1 Drugs (30-Day Supply)	\$5 Copay
Tier 2 Drugs (30-Day Supply)	\$15 Copay
Tier 3 Drugs (30-Day Supply)	\$25 Copay
Tier 4 Drugs (30-Day Supply)	10% Coinsurance Up to \$250 Per Prescription
PEDIATRIC VISION AND DENTAL (Included in Plan)	
Child Needs Eye Care (Ages 0-18)	
Eye Exam (1 Per Calendar Year)	\$0 Copay
Eyewear (Frames) (1 Pair Per Calendar Year)	\$0 Copay
Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses)	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share
Eyewear (Contact Lenses)	\$0 Copay
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.

Footnotes: Preventive care services are not subject to the deductible.