

Plan Name	<i>PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA</i>
	Platinum 90 HMO
SERVICES AND FEATURES	
Annual Deductible	\$0
Out-of-Pocket Limit On Expenses	Individual \$3,350 / Family \$6,700
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	\$30 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)	\$0 Copay
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	\$15 Copay (Laboratory) / \$30 Copay (X-Ray)
Imaging (CT/PET Scans, MRIs)	\$75 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$100 Copay
Physician/Surgeon Fees	\$25 Copay
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	\$250 Copay Per Day Up To First 5 Days
Physician/Surgeon Fees	\$0 Copay
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	\$150 Copay
Professional Services	\$0 Copay
Urgent Care Center	\$15 Copay
PRESCRIPTION DRUG COVERAGE	
Annual 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 \$0 Copay
Eyewear (Contact Lenses)	\$0 Copay
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.