

# Summary of Platinum Radius Plus Benefits

Benefit	In-Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b>	Plan Year	
<b>Provider Network</b>	NENY HMO/POS 200 Network	
<b>Deductible</b>		
Individual	N/A	\$5,000
Family	N/A	\$10,000
<b>Coinsurance</b>	N/A	50% after deductible
<b>Out-of-Pocket Maximum</b>		
Individual	\$7,000	\$10,000
Family	\$14,000	\$20,000
<b>Domestic Partner and Children</b>	Includes coverage for Domestic Partner and Children	
<b>Office Visits</b>		
<b>Primary Care Provider Office &amp; Telehealth Visits</b>	\$15 copay	50% after deductible
<b>Specialist Office &amp; Telehealth Visits</b>	\$30 copay	50% after deductible
<b>Telemedicine (Doctor on Demand)</b>	Covered in full	Not Covered
<b>Allergy Testing &amp; Injections</b>	\$15 copay / \$30 copay	50% after deductible
<b>Prenatal and Postnatal Care</b> Cost-share applies to initial visit only	\$15 copay	50% after deductible
<b>Preventive Care</b>		
<b>Immunizations</b>	Covered in full	50% after deductible
<b>Colorectal cancer screening</b>	Covered in full	50% after deductible
<b>Mammograms</b>	Covered in full	50% after deductible
<b>Routine Physical exams</b>	Covered in full	Not Covered
<b>Routine Gynecological exams</b>	Covered in full	50% after deductible
<b>Routine Diagnostic services</b>	Covered in full	50% after deductible
<b>Well Child Visits</b>	Covered in full	Not Covered
<b>Hospital Services</b>		
<b>Inpatient Hospital</b>	\$500 copay	50% after deductible
<b>Inpatient Maternity</b>	\$500 copay	50% after deductible
<b>Outpatient Surgery Facility</b>	\$100 copay	50% after deductible
<b>Skilled Nursing Facility</b>	\$500 copay Limit: None	50% after deductible
<b>Emergency &amp; Urgent Care Services</b>		
<b>Emergency Room</b> Waived if admitted	\$100 copay	Covered as In-Network
<b>Ambulance</b>	\$100 copay	Covered as In-Network
<b>Urgent Care Center</b>	\$50 copay	Covered as In-Network
<b>Therapy, Rehabilitative and Habilitative Services</b>		
<b>Chiropractic Care</b>	\$15 copay	50% after deductible
<b>Physical, Occupational, &amp; Speech Therapies</b> (Rehabilitative and Habilitative)	\$15 copay	50% after deductible
<b>Therapy Benefit Maximum</b>	60 combined PT/OT/ST Visits per condition per plan year	
<b>Respiratory Therapy</b>	\$30 copay	50% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient Mental Health</b>	\$500 copay	50% after deductible
<b>Inpatient Substance Abuse</b> Detoxification & Rehabilitation	\$500 copay	50% after deductible
<b>Outpatient Mental Health</b>	\$15 copay	50% after deductible
<b>Outpatient Substance Abuse</b> Detoxification & Rehabilitation	\$15 copay	50% after deductible
<b>Diagnostic Services</b>		
<b>Advanced Imaging</b> (MRI, CAT, PET scan, etc.)	\$30 copay	50% after deductible
<b>Radiology</b> (X-ray, Diagnostic testing)	\$30 copay	50% after deductible
<b>Laboratory Testing &amp; Pathology</b>	\$30 copay	50% after deductible
<b>Other Services</b>		
<b>Diabetic Insulin, Equipment, &amp; Supplies</b> Includes Test strips, Syringes, etc	\$15 copay	50% after deductible
<b>Diabetes Care Management Program</b>	100%	Not Covered
	Continuous glucose monitor sprints are limited to three (3) per benefit period	
<b>Dialysis</b>	\$15 copay / \$30 copay	50% after deductible
<b>Outpatient Chemotherapy</b>	\$15 copay / \$30 copay	50% after deductible
<b>Durable Medical Equipment</b>	50%	50% after deductible
<b>Orthotics &amp; Prosthetics</b>	50%	50% after deductible
	\$15 copay / \$30 copay	50% after deductible

<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Home Health Care</b>	Limit: 40 aggregate visits per year; Home Infusion counts toward home health care visit limit.	
<b>Hospice</b>	\$100 copay	50% after deductible
	Limit: None	
	\$250 per contract	
<b>Wellness Card</b>	Benefit allowance accessible through the use of a debit card, at participating providers for exercise centers, fitness clubs, & gyms	
<b>Prescription Drugs</b>		
<b>Prescription Drug</b>	<b>Retail Drugs (30-day Supply)</b>	
	\$10.00	
	\$35.00	
	\$100.00	
	<b>Mail Order Drugs (90-day Supply)</b>	
	\$25.00	
\$87.50		
\$250.00		
<b>Pediatric Vision Services - Davis Vision National Network</b>		
<b>Exam</b>	Covered in full	Not Covered
<b>Pediatric frame selection</b>	Covered in full	Not Covered
<b>Standard eyeglass lenses (per pair)</b>	Covered in full	Not Covered
<b>Pediatric Dental Services - United Concordia Elite Prime Network</b>		
<b>Preventive Services</b>	\$25 copay	\$25 copay
<b>Basic Services</b>	50%	50%
<b>Major Services</b>	50%	50%
<b>Medically Necessary Orthodontics</b>	50%	50%

### Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
 200 Independence Avenue, SW  
 Room 509F, HHH Building  
 Washington, D.C. 20201  
 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHỦ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY：711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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