

Daily Plan

PLAN BENEFITS

	In-Network	Out-of-Network
Lifetime Maximum	\$5 million in- and out-of-network combined	
Calendar Year Maximum	\$1 million in- and out-of-network combined	
Daily Deductible Per insured person for covered medical expenses	Individual: \$250 or \$500 Family: 2x individual	Individual: \$500 or \$1,000 Family: 2x individual
Coinsurance	100% after daily deductible	100% after daily deductible
Calendar Year Maximum Out-of-Pocket	Individual: \$4,000 Family: \$8,000	2x in-network
Physician Charge at Office Visit or Urgent Care Center Other covered services performed are subject to deductible and coinsurance	\$25 copay per visit, then 100%	100% after daily deductible
Routine Mammography	100% coverage, no deductible or copay	100% coverage, no deductible or copay
OUTPATIENT		
Diagnostic Lab Save money on lab services by using your LabOne Select card at LabOne providers	100% after daily deductible	100% after daily deductible
Diagnostic Imaging	100% after daily deductible	100% after daily deductible
Surgery	100% after daily deductible	100% after daily deductible
Non-Surgical Back Treatment	100% after daily deductible	100% after daily deductible
Mental, Nervous or Chemical Dependency Care	100% after daily deductible	100% after daily deductible
INPATIENT		
Hospital Services Includes physician, facility and surgery charges	100% after daily deductible	100% after daily deductible
Mental and Nervous Care	100% after daily deductible	100% after daily deductible
Emergency Room	100% after daily deductible	100% after daily deductible
Ambulance (Ground, air, water)	100% after daily deductible	100% after daily deductible

OUTPATIENT PRESCRIPTION DRUGS

Choice of Two Options

All options include oral contraceptives and mail-order program for maintenance prescriptions.

OPTION 1 Discount Drug Program - automatically included at no additional premium!
(not an insurance benefit)

or

OPTION 2 Separate \$500 Rx deductible then:

- **Generic:** \$10 copay or 20%, whichever is greater
- **Formulary:** \$40 copay or 30%, whichever is greater
- **Non-Formulary:** \$60 copay or 30%, whichever is greater
- **Specialty:** \$40 copay or 30%, whichever is greater
(self-injectable medications and select inhalants)