2009 Preferred Care USdirect and Basix for Employer Groups and Sole Proprietors

Services	Preferred Care USdirect 6 In Network	Preferred Care USdirect 6 Out of Network	Preferred Care USdirect 4 In Network	Preferred Care USdirect 4 Out of Network	Basix 220-4	Basix 220-3
Annual Deductible	**N/A**	**Single $1,500** **Family 2 $2,500** **Family 3+ $2,500**	**Single $300** **Family 2 $600** **Family 3+ $900**	**Single $1,500** **Family 2 $2,500** **Family 3+ $2,500**	**N/A**	**N/A**
Out of Pocket Maximum	**N/A**	**Single $4,000** **Family 2 $6,000** **Family 3+ $6,000**	**Single $2,000** **Family 2 $3,000** **Family 3+ $3,000**	**Single $4,000** **Family 2 $6,000** **Family 3+ $6,000**	**N/A**	**N/A**
Coinsurance	**N/A**	**40%**	**20%**	**40%**	**N/A**	
Referrals	**Not Required**	Not Required	Not Required	Not Required	Required	Required
PCP Visits **Specialist Visits**	$15 Copay $15 Copay	PCP: You Pay 40% Specialist: You Pay 40%	$20 PCP Copay $20 Specialist Copay	PCP: You Pay 40% Specialist: You Pay 40%	$25 PCP $40 Specialist	$25 PCP $40 Specialist
GYN Routine Exams	$15 Copay	You Pay 40%	$20 Copay	You Pay 40%	$25 Copay	$25 Copay
Adult Physicals	$15 Copay	You Pay 40%	$20 Copay	You Pay 40%	$25 Copay	$25 Copay
Well Child Visits	Covered in Full	You Pay 40%	Covered in Full	You Pay 40%	Covered in Full	Covered in Full
Sick Child Visits	$15 Copay	You Pay 40%	$20 Copay	You Pay 40%	$25 Copay	$25 Copay
X-rays	$15 Copay	You Pay 40%	20% Coinsurance	You Pay 40%	$40 Copay	$40 Copay
Mammograms	$15 Copay	You Pay 40%	$20 Copay	You Pay 40%	$25 Copay	$25 Copay
Laboratory	$15 Copay	You Pay 40%	20% Coinsurance	You Pay 40%	$15 copay	$15 copay
Inpatient Hospital	Covered in Full	You Pay 40%	20% Coinsurance	You Pay 40%	$250 Copay $40 Surgical Copay	$500 Copay $40 Surgical Copay
Maternity	Covered in Full	You Pay 40% You Pay 40%	Prenatal: No Copay Radiology & Tests: 20% Delivery/Nursery: $200 Copay	You Pay 40% You Pay 40%	Prenatal: $50 Copay Delivery: $50 Copay Hospital: $250 Copay	Prenatal: $50 Copay Delivery: $50 Copay Hospital: $500 Copay
Mental Health **Inpatient: 30 days** **Outpatient: 20 visits**	Covered in Full $15 Copay	You Pay 40%	20% Coinsurance $20 Copay	You Pay 40%	$250 Copay $40 Copay	$500 Copay $40 Copay
Outpatient Surgery	Covered in Full	You Pay 40%	20% Coinsurance	You Pay 40%	$75 Facility Copay $40 Physician Copay	$75 Facility Copay $40 Physician Copay
Emergency Room	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$75 Copay	$75 Copay
Routine Eye Exams	$15 Copay	You Pay 40%	$20 Copay	You Pay 40%	$40 Copay	For disease or injury ONLY
Eyewear	$60 Allowance	$60 Allowance	$60 Allowance	$60 Allowance	$60 Allowance	20% Discount
Chiropractic	$15 Copay	You Pay 40%	$20 Copay	You Pay 40%	$40 Copay	$40 Copay
Durable Medical Equipment	20% Copay 15000 annual max.	You Pay 40% $15,000 Annual Max	20% Coinsurance $15,000 Annual Max	You Pay 40% $15,000 Annual Max	50% Copay $5,000 Annual Max.	50% Copay $5,000 Annual Max.
External Prosthetics	20% Copay 15,000 annual max.	You Pay 40% $15,000 Annual Max	20% Coinsurance $15,000 Annual Max	You Pay 40% $15,000 Annual Max	50% Copay $15,000 yr. Max.	50% Copay $15,000 yr. Max.
Diabetic Supplies/ Insulin/Oral Agents	$15 Copay	N/A	1 Month Supply (Retail): $20 3 Month (Mail Order): $50	N/A	30 day (retail): $25 90 day (Mail Order): $62.50	30 day (retail): $25 90 day (Mail Order): $62.50
Prescription Coverage	Copay per 30 day Tier 1: $10 Copay Tier 2: $25 Copay Tier 3: $40 Copay	N/A	Copay Per 30 Day Supply Tier 1/$10 Tier 2/$30 Tier 3/$50 **$1000 Annual Max**	N/A	Copay per 30 day Tier 1/$10 Tier 2/$25 Tier 3/$40	Copay per 30 day supply $10 Copay on Generic Drugs ONLY
Out of Network	Emergency/Urgent Care	Emergency/Urgent Care	Emergency/Urgent Care	Emergency/Urgent Care	Emergency/Urgent Care	Emergency/Urgent Care
Dependent Coverage	Age 26	Age 26	Age 26	Age 26	Age 19 / FTS 23	Age 19 / FTS 23
Extra Benefits	Earn up to $300 per calendar year by engaging in healthy activities. $50 Health Dollars		Earn up to $300 per calendar year by engaging in healthy activities. $50 Health Dollars		$50 Health Dollars	$50 Health Dollars
Single **Family of 2** **Family 3+**	**$475.78** **$1,094.26** **$1,294.86**		**$304.56** **$700.46** **$828.85**		**$313.73** **$705.94** **$815.75**	**$245.32** **$552.00** **$637.84**

This comparison is intended to be only a brief summary of plan benefits. This is not a contact.