

2009 Preferred Care MyCare HSA Options

Services	Preferred Care MyCare 680-2		Preferred Care MyCare 680-3	
	In Network	Out of Network	In Network	Out of Network
Annual Deductible	Single \$1,800 Family \$3,600	Single \$1,800 Family \$3,600	Single \$2,500 Family \$5,000	Single \$2,500 Family \$5,000
Out of Pocket Maximum	Single \$3,000 Family \$6,000	Single \$3,000 Family \$6,000	Single \$5,000 Family \$10,000	Single \$5,000 Family \$10,000
Coinsurance	20%	40%	20%	40%
Referrals	Not Required	Not Required	Not Required	Not Required
PCP Visits	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
Specialist Visits	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
GYN Routine Exams	Covered in Full	You Pay 40%	Covered in Full	You Pay 40%
Adult Physicals	Covered in Full	You Pay 40%	Covered in Full	You Pay 40%
Well Child Visits	Covered in Full	You Pay 40%	Covered in Full	You Pay 40%
Sick Child Visits	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
X-rays	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
Mammograms	Covered in Full	You Pay 40%	Covered in Full	You Pay 40%
Laboratory	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
Inpatient Hospital	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
Maternity	Pre/Post Natal: \$50 Copay Radiology & Tests: 20% Copay Delivery/Nursery: \$500 Copay	Pre/Post Natal: 40% Copay Radiology & Tests: 40% Copay Delivery/Nursery: 40% Copay	Pre/Post Natal: \$50 Copay Radiology & Tests: 20% Copay Delivery/Nursery: \$500 Copay	Pre/Post Natal: 40% Copay Radiology & Tests: 40% Copay Delivery/Nursery: 40% Copay
Mental Health				
Inpatient: 30 days	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
Outpatient: 20 visits	You Pay 20%		You Pay 20%	
Outpatient Surgery	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
Emergency Room	You Pay 20%	You Pay 20%	You Pay 20%	You Pay 20%
Routine Eye Exams	Covered in Full	You Pay 40%	Covered in Full	You Pay 40%
Eyewear	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Chiropractic	You Pay 20%	You Pay 40%	You Pay 20%	You Pay 40%
Durable Medical Equipment	You Pay 20% \$5,000 annual max.	You Pay 40% \$5,000 Annual Max	You Pay 20% \$5,000 annual max.	You Pay 40% \$5,000 Annual Max
External Prosthetics	You Pay 20% \$15,000 annual max.	You Pay 40% \$15,000 Annual Max	You Pay 20% \$15,000 annual max.	You Pay 40% \$15,000 Annual Max
Diabetic Supplies/ Insulin/Oral Agents	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay
Prescription Coverage	<u>Copay per 30 day</u> Tier 1: 10% Copay Tier 2: 30% Copay Tier 3: 50% Copay	N/A	<u>Copay per 30 day</u> Tier 1: 10% Copay Tier 2: 30% Copay Tier 3: 50% Copay	N/A
Out of Network	Emergency/Urgent Care	Emergency/Urgent Care	Emergency/Urgent Care	Emergency/Urgent Care
Dependent Coverage	Age 26	Age 26	Age 26	Age 26
Single	\$179.32		\$157.35	
Family of 2	\$412.41		\$361.90	
Family 3+	\$488.02		\$428.25	