

BlueCare & Century Preferred Benefits Comparison

See Outline of Coverage for a more detailed description of benefits.

PLAN NAME	BlueCare Direct	Century Preferred Direct 80/20	Century Preferred Direct 100
Plan Type	HMO	PPO	PPO
Deductible Choices <i>(Individual/Family)</i>	\$1,500/\$3,000	\$250/\$500	\$1,500/\$3,000, \$5,000/\$10,000 or \$10,000/\$20,000
Out-of-State Benefits	No - <i>except for urgent or emergency care</i>	Yes	Yes
Out-of-Network Benefits	No - <i>except for urgent or emergency care</i>	Yes - <i>subject to higher coinsurance</i>	Yes - <i>subject to higher coinsurance</i>
Lifetime Maximum	\$5 million	\$5 million	\$5 million
Member Cost Shares	In-Network You Pay	In-Network You Pay	In-Network You Pay
Individual Deductible <i>(per person, per calendar year)</i>	\$1,500 <i>applies only to Hospital Care, including outpatient surgery performed in a hospital or surgical center</i>	\$250 <i>applies to services in-and-out-of-network combined</i>	\$1,500, \$5,000 or \$10,000 <i>applies to services in-and-out-of-network combined</i>
Family Deductible	\$3,000	\$500	\$3,000, \$10,000 or \$20,000
Preventive Care <i>(including routine physicals)</i>	\$20 copay per visit <i>no copay for Child Preventive Care exams up to the age of 13</i>	20% coinsurance after deductible	No charge after deductible
Prescription Drugs <i>(per person, per calendar year)</i>	Yes <i>(\$10GE/\$25LB/\$40NLB* copay with \$500 or \$2,000 calendar year max.) Not subject to deductible</i>	Optional <i>(\$10GE/\$25LB/\$40NLB* copay with \$2,000 calendar year max.) Not subject to deductible</i>	Optional <i>(\$10GE/\$25LB/\$40NLB* copay with \$2,000 calendar year max.) Not subject to deductible</i>
Vision <i>(Not subject to deductible)</i> <i>Routine Eye Exam</i> <i>(per person, per 12 months)</i>	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
<i>Choice of:</i> <i>Frames and Lenses every 24 months- (\$120 allowance on frames) or Contact Lenses every 24 months- (\$105 allowance)</i>	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
Maternity Care	Physician: \$30 copay for initial visit Hospital: No charge after deductible	Not covered	Not covered
Office Visits	\$20 copay per visit	20% coinsurance after deductible	No charge after deductible
Specialist Visits	\$30 copay per visit	20% coinsurance after deductible	No charge after deductible
Diagnostic Services <i>(MRI, MRA, CAT, CTA, PET and SPECT)</i>	\$75 copay per visit <i>(max. of \$375 per member per calendar year)</i>	20% coinsurance after deductible	No charge after deductible
Lab / X-Ray	No charge	20% coinsurance after deductible	No charge after deductible
Outpatient Surgery <i>(In a hospital or surgi-center)</i>	No charge after deductible	20% coinsurance after deductible	No charge after deductible
Emergency Room	\$75 copay per visit <i>(waived if admitted)</i>	20% coinsurance after deductible	No charge after deductible
Hospitalization	No charge after deductible	20% coinsurance after deductible	No charge after deductible
Infertility Services			
<i>Office Visit</i>	Office visit copay	20% coinsurance after deductible	No charge after deductible
<i>Outpatient Hospital</i>	No charge after deductible	20% coinsurance after deductible	No charge after deductible
<i>Inpatient Hospital</i>	No charge after deductible	20% coinsurance after deductible	No charge after deductible
<i>Infertility Drugs</i> <i>(with infertility diagnosis)</i>	No charge	40% coinsurance after deductible	20% coinsurance after deductible

*GE = Generic Drugs; LB = Listed Brand Drugs; NLB = Non-Listed Brand Drugs

Lumenos® Benefits Comparison

See Outline of Coverage for a more detailed description of benefits.

PLAN NAME	Lumenos HSA	Lumenos HIA	Lumenos HIA Plus
Plan Type	PPO	PPO	PPO
Deductible Choices <i>(Individual/Family)</i>	\$1,250/\$2,500; \$2,500/\$5,000*; or \$5,000/\$10,000	\$1,500/\$3,000; \$2,500/\$5,000	\$2,500/\$5,000 <i>HIA Plus also offers an amount of \$200 (\$400 Family) placed in your account to use first for covered services</i>
Out-of-State Benefits	Yes	Yes	Yes
Out-of-Network Benefits	Yes - subject to higher coinsurance	Yes - subject to higher coinsurance	Yes - subject to higher coinsurance
Lifetime Maximum	Unlimited In-Network; \$1,000,000 Out-of-Network	Unlimited In-Network; \$1,000,000 Out-of-Network	Unlimited In-Network; \$1,000,000 Out-of-Network
Member Cost Shares	In-Network You Pay	In-Network You Pay	In-Network You Pay
Individual Deductible <i>(per person, per calendar year)</i>	\$1,250; \$2,500; \$5,000 <i>applies to services in-and-out-of-network combined</i>	\$1,500; \$2,500 <i>applies to services in-and-out-of-network combined</i>	\$2,500 <i>applies to services in-and-out-of-network combined</i>
Family Deductible	\$2,500; \$5,000; \$10,000	\$3,000; \$5,000	\$5,000
Preventive Care <i>(including routine physicals)</i>	No cost share	No cost share	No cost share
Prescription Drugs	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
Maternity Care	Not covered	Not covered	Not covered
Office Visits	No charge after deductible*	Deductible and coinsurance	Deductible and coinsurance
Specialist Visits	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services <i>(MRI, MRA, CAT, CTA, PET and SPECT)</i>	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
Lab / X-Ray	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery <i>(In a hospital or surgi-center)</i>	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
Hospitalization	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
Infertility Services			
<i>Office Visit</i>	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
<i>Outpatient Hospital</i>	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
<i>Inpatient Hospital</i>	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible
<i>Infertility Drugs</i> <i>(with infertility diagnosis)</i>	No charge after deductible*	20% coinsurance after deductible	20% coinsurance after deductible

* Lumenos HSA \$2,500 has two coinsurance options for in-network services; 80% or 100% coverage after deductible. You'll pay 20% after deductible if you select the 80% option.