

Blue Direct benefits comparison

Traditional PPO Plans

		Blue Direct \$1,000 PPO	Blue Direct \$2,000 PPO	Blue Direct \$5,000 PPO
Deductible	In-Network	\$1,000/member \$3,000/family	\$2,000/member \$6,000/family	\$5,000/member \$15,000/family
	Out-of-Network	\$2,000/member \$6,000/family	\$3,000/member \$9,000/family	\$7,500/member \$22,500/family
Coinsurance	In-Network	20% to a max of \$3,000/member \$9,000/family	30% to a max of \$3,000/member or \$9,000/family	20% to a max of \$1,000/member or \$3,000/family
	Out-of-Network	40% to a max of \$4,000/member \$12,000/family	50% to a max of \$4,000/member or \$12,000/family	50% to a max of \$1,000/member or \$3,000/family
Lifetime Maximum Benefit¹		\$2 million/member	\$2 million/member	\$2 million/member
Covered Services		In-Network	In-Network	In-Network
Preventive Care	Immunizations, Screenings, Pap Smear, Mammogram, PSA Testing	No cost to member	No cost to member	No cost to member
	Routine Physical, Hearing & Vision Exams	\$20 per visit	\$40 per visit	Deductible & Coinsurance for all these services
Other Outpatient Care	Medical Exams, Injections, Physical, Occupational & Speech Therapy	\$20 per visit	\$40 per visit	Deductible & Coinsurance for all these services
	Lab, X-ray, Ultrasound, CT & MRI scans, Outpatient & Ambulatory Surgery	Deductible & Coinsurance for all these services	Deductible & Coinsurance for all these services	Deductible & Coinsurance for all these services
Inpatient Care <ul style="list-style-type: none"> · Semi-private Room & Board · Physician Services, Surgery, Anesthesia, Lab · X-ray, CT & MRI scans, supplies & medications · Physical, Occupational & Speech Therapy² · Skilled Nursing & Physical Rehab Facility (limited to 100 inpatient days per member per year for each facility) 		Deductible & Coinsurance for all these services	Deductible & Coinsurance for all these services	Deductible & Coinsurance for all these services
Emergency Room Services	ER Charge	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	Deductible & Coinsurance
	ER Physician, CT & MRI scans & medical supplies	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mental Health & Substance Abuse³	Outpatient	\$20 per visit	\$40 per visit	Deductible & Coinsurance
	Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Durable Medical Equipment (DME) (limited to \$3,000 per member/year)		\$100 DME Deductible 30% Coinsurance	\$100 DME Deductible 30% Coinsurance	\$100 DME Deductible 30% Coinsurance
Prescription Drugs (<i>\$100 deductible per member per calendar year; deductible does not apply to generic drugs; max out-of-pocket is \$2,000 per member</i>)		\$10/\$25/\$40 copay	\$10/\$25/\$40 copay	\$10/\$25/\$40 copay

¹ Stated maximums are applicable to in-network and out-of-network combined

² Physical, occupational and speech therapy limited to \$3,000 per member per year

³ Inpatient and outpatient services subject to combined \$3,000 per member per year and \$10,000 per member per lifetime maximums

Lumenos benefits comparison

Consumer-Driven Health (CDH) PPO Plans

	Lumenos HSA Plan		Lumenos HIA Plan		Lumenos HIA Plus Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Choices <i>(Individual/Family)</i>	\$ 1,250 / \$ 2,500 \$ 2,500 / \$ 5,000 \$ 5,000 / \$10,000		\$ 1,500 / \$ 3,000 \$ 2,500 / \$ 5,000		\$ 2,500 / \$ 5,000 Places \$200 (\$400 Family) in your account to use first for covered services	
Coinsurance	No cost to member after deductible*	30% coinsurance**	80% coinsurance	40% coinsurance	80% coinsurance	30% coinsurance
Lifetime Maximum Benefit	Unlimited	\$1,000,000	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Covered Services	In-Network		In-Network		In-Network	
Preventive Care · Immunizations and Screenings · Pap Smear, Mammogram, PSA Testing · Routine Physical Exams	No cost to member		No cost to member		No cost to member	
Other Outpatient Care · Medical Exams and Injections · Lab, X-ray, Ultrasound, CT & MRI Scans · Physical, Occupational & Speech Therapy · Outpatient & Ambulatory Surgery	No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services	
Inpatient Care · Semi-private Room & Board · Physician Services, Surgery, Anesthesia · Lab, X-ray, CT & MRI scans · Supplies & Medications · Physical, Occupational & Speech Therapy ² · Skilled Nursing & Physical Rehab Facility <i>(limited to 100 inpatient days per member per year for each facility)</i>	No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services	
Emergency Room Services · ER Physician, CT & MRI scans · Supplies & Medications · ER Charge	No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services	
Mental Health & Substance Abuse³ <i>(inpatient services & outpatient visit)</i>	No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services	
Durable Medical Equipment <i>(limited to \$3,000 per member per year)</i>	No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services		No member charge after Deductible & Coinsurance for all these services	
Prescription Drugs <i>(per member, per calendar year; any combination of in- and out-of-network benefits counts toward this maximum)</i>	\$2,000 maximum		\$2,000 maximum		\$2,000 maximum	

² Physical, occupational and speech therapy limited to \$3,000 per member per year

³ Inpatient and outpatient services subject to combined \$3,000 per member per year and \$10,000 per member per lifetime maximums

*There is an 80% in-network coinsurance option for the \$2,500 deductible plan. With this option, you pay 20% coinsurance for covered services after the deductible.

**The 80% in-network coinsurance option for the \$2,500 deductible plan has an out-of-network coinsurance of 60%. With this option, you pay 40% coinsurance for covered services after the deductible.