Product Comparison

Plan Name	BlueCare Direct	Century Preferred Direct 80/20	Century Preferred Direct 100	Century Preferred Direct HSA
Plan Type	HMO	PPO	PPO	PPO
Deductible Choices (Individual/Family)	$1,500/$3,000	$250/$500	$1,500/$3,000, $5,000/$10,000 or $10,000/$20,000	$1,250/$2,500, $2,500/$5,000 or $4,000/$8,000
Out-of-State Benefits	No - except for urgent or emergency care	Yes	Yes	Yes
Out-of-Network Benefits	No - except for urgent or emergency care	Yes - subject to higher coinsurance	Yes - subject to higher coinsurance	Yes - subject to higher coinsurance
Lifetime Maximum	$5 million	$5 million	$5 million	$5 million
Member Cost Shares	**In-Network You Pay**	**In-Network You Pay**	**In-Network You Pay**	**In-Network You Pay**
Individual Deductible *(per person, per calendar year)*	$1,500 applies only to Hospital Care, including outpatient surgery performed in a hospital or surgical center	$250 applies to services in-and-out-of-network combined	$1,500, $5,000 or $10,000 applies to services in-and-out-of-network combined	$1,250, $2,500 or $4,000 applies to services in-and-out-of-network combined
Family Deductible	$3,000	$500	$3,000, $10,000 or $20,000	$2,500, $5,000 or $8,000
Preventive Care *(Including routine physicals)*	$20 copay per visit	20% coinsurance after deductible	No charge after deductible	No charge
Prescription Drugs *(per person, per calendar year)*	Yes ($10GE/$25LB/$40NLB* copay with $500 or $2,000 calendar year max.) Not subject to deductible	Optional ($10GE/$25LB/$40NLB* copay with $2,000 calendar year max.) Not subject to deductible	Optional ($10GE/$25LB/$40NLB* copay with $2,000 calendar year max.) Not subject to deductible	Optional (No charge after deductible)
Vision Rider *(Not subject to deductible)*				
Routine Eye Exam *(per person, per 12 months)*	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit**
Choice of: Frames and Lenses every 24 months– (*$120 allowance on frames)*	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
or Contact Lenses every 24 months– (*$105 allowance)*	$20 copay per visit	$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	Not covered
Office Visits	$20 copay per visit	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Specialist Visits	$30 copay per visit	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Diagnostic Services *(MRI, MRA, CAT, CTA, PET and SPECT)*	$200 copay per visit	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Lab /X-Ray	No charge	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery *(In a hospital or surgi-center)*	No charge after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Emergency Room	$75 copay per visit (waived if admitted)	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Hospitalization	No charge after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Infertility Services				
Office Visit	Office visit copay	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Outpatient Hospital	No charge after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Inpatient Hospital	No charge after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Infertility Drugs *(with infertility diagnosis)*	No charge	40% coinsurance after deductible	20% coinsurance after deductible	No charge after deductible

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

** No charge using the Century Preferred Direct Health Savings Account (HSA) 100% Preventive Benefit.

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