

Comparison of Plan Differences BlueDirect® Basic, Enhanced & Premier vs. BlueDirect Plans A, B, & C



Not all benefits are listed
For Producers Only

Benefit	BlueDirect BASIC		BlueDirect ENHANCED		BlueDirect PREMIER		BlueDirect Plan A		BlueDirect Plan B		BlueDirect Plan C
	PPO	NonPPO	PPO	NonPPO	PPO	NonPPO	PPO	NonPPO	PPO	NonPPO	EPO/PPO.
Deductible Individual shown; Family deductible = 3 x individual amount	\$1,000 \$2,000 \$3,500 \$5,000 \$7,500 \$10,000	\$2,000 \$4,000 \$7,000 \$10,000 \$15,000 \$20,000	\$500 \$1,000 \$2,000 \$3,500 \$5,000 \$7,500	\$1,000 \$2,000 \$4,000 \$7,000 \$10,000 \$15,000	\$500 \$1,000 \$2,000 \$3,500 \$5,000	\$1,000 \$2,000 \$4,000 \$7,000 \$10,000	\$100 \$250 \$500 \$1,000	\$200 \$500 \$1,000 \$2,000	\$250 \$500 \$1,000 \$2,000 \$5,000	\$500 \$1,000 \$2,000 \$4,000 \$10,000	\$500 \$1,000 \$2,000 \$5,000
Out-of-Pocket Maximum Coinsurance only, except for Plan C. For ABC Plans, family limit = 3 x individual limit. For BEP Plans, family limit = 2x individ limit.	\$7,000 (Ind) \$14,000 (Fam)	\$14,000 (Ind) \$28,000 (Fam)	\$4,000 (Ind) \$8,000 (Fam)	\$8,000 (Ind) \$16,000 (Fam)	\$3,000 (Ind) \$6,000 (Fam)	\$6,000 (Ind) \$12,000 (Fam)	\$1,000 (Ind) \$3,000(Fam)	\$2,000 (Ind) \$6,000 (Fam)	\$2,000 (Ind) \$6,000 (Fam)	\$4,000 (Ind) \$12,000 (Fam)	\$5,000 (Ind) \$15,000 (Fam) <i>Coinsurance & Copays apply</i>
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member		\$5 million per member		\$5 million per member		\$5 million per member
Coinsurance	30%	50%	20%	40%	15%	30%	10%	30%	20%	40%	30%; ded waived for Lab/X-Ray only
PCP & Specialist Office Visits (OV) & Related Services	\$40 OV copay/visit; related services subject to ded & coins; also see next row	50% after deductible	\$25 OV copay/visit; related services subject to ded & coins; also see next row	40% after deductible	\$20 OV copay/visit; related services subject to ded & coins; also see next row	30% after deductible	PCP & Specialist \$20 copay/visit; related services subject to ded & coins	30% after deductible	PCP & Specialist \$20 copay/visit; related services subject to ded & coins	40% after deductible	PPP-\$40 copay/visit Specialist-\$55 copay/visit; most related svcs paid at 100% except Lab/X-Ray
Routine/ Preventive Services	\$40 OV copay, then Plan pays 100% up to \$400 (no deductible), thereafter all services subject to ded & 30% coins	50% after deductible	\$25 OV copay, then Plan pays 100% up to \$400 (no deductible), thereafter all services subject to ded & 20% coins	40% after deductible	\$20 OV copay, then Plan pays 100% up to \$400 (no deductible), thereafter all services subject to ded & 15% coins	30% after deductible	Plan pays 100% up to \$400, thereafter OV copay or ded & coinsurance apply.	30% after deductible	Plan pays 100% up to \$400, thereafter OV copay or ded & coinsurance apply.	40% after deductible	OV copay covers most services; Lab/X-Ray subject to 30% coins, but no ded
Lab, X-Ray, Diagnostic Services	30% after deductible	50% after deductible	20% after deductible	40% after deductible	15% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible	30% coinsurance; not subject to deductible
Emergency Room Treatment	\$250 copay/visit – all inclusive		\$200 copay/visit – all inclusive		\$150 copay/visit – all inclusive		\$100 copay per visit – all inclusive		\$150 copay per visit – all inclusive		\$300 copay per visit – all inclusive

Benefit	BlueDirect BASIC		BlueDirect ENHANCED		BlueDirect PREMIER		BlueDirect Plan A		BlueDirect Plan B		BlueDirect Plan C
	PPO	NonPPO	PPO	NonPPO	PPO	NonPPO	PPO	NonPPO	PPO	NonPPO	EPO/PPO.
Urgent Care	\$60 facility copay/visit. Other services subject to ded & coins	50% after deductible	\$40 facility copay/visit. Other services subject to ded & coins	40% after deductible	\$30 facility copay/visit. Other services subject to ded & coins	30% after deductible	\$30 facility copay/visit. Other svcs subject to ded & coins	30% after deductible	\$30 facility copay/visit. Other svcs subject to ded & coins	40% after deductible	\$100 facility copay/visit. Other svcs subject to ded & coins
Acupuncture Treatment Max \$1,500/yr	30% after deductible	50% after deductible	20% after deductible	40% after deductible	15% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible	\$55 copay per visit
Spinal Manipulation Max \$1,500/yr	30% after deductible	50% after deductible	20% after deductible	40% after deductible	15% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible	\$55 copay per visit
Cardiac/ Pulmonary Rehab	30% after deductible	50% after deductible	20% after deductible	40% after deductible	15% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible	30% after deductible
Short-Term Rehab: Occupational, Physical & Speech Therapy; includes Physical Rehab & Skilled Nursing Facility. Limits apply.	30% after deductible	50% after deductible	20% after deductible	40% after deductible	15% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible	30% after deductible
Home Health Care and Hospice	30% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	50% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	20% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	40% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	15% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	30% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	10% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	30% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	20% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	40% after deductible. Limit of 100 visits/year combined for svcs & in- or out-of-network	HOME HEALTH: Subject to ded & coins; 100 visit limit HOSPICE: Inpatient-ded/coins Home-no charge No limit
Transplants	No deductible; subject to coinsurance	Not covered	No deductible; subject to coinsurance	Not covered	No deductible; subject to coinsurance	Not covered	No deductible; subject to coinsurance	Not covered	No deductible; subject to coinsurance	Not covered	Based on type of service and place of treatment
Prescription Drug Plan	4-tier plan \$15/45/75/15%		4-tier plan \$10/40/70/15%		4-tier plan \$7/35/65/15%		4-tier plan \$7/30/60/15%		4-tier plan \$10/35/75/15%		25/50% w/ Min & Max Copays \$5000 ded option: only covers state mandated drugs

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