

2010-2011 Spartanburg County BLUECHOICE HEALTHPLAN

	Standard Plan		Enhanced Plan	
	What You Pay In Network	What You Pay Out of Network	What You Pay In Network	What You Pay Out of Network
Deductible:				
Individual	\$1,500	\$3,000	\$1,000	\$2,000
Family	\$4,500	per individual	\$3,000	per individual
Coinsurance	80% plan coverage; You pay 20%	60% plan coverage; You pay 40%	80% plan coverage; You pay 20%	60% plan coverage; You pay 40%
Coinsurance Maximum:				
Individual	\$2,500	\$5,000	\$2,000	\$4,000
Family	\$5,000	\$10,000	\$4,000	\$8,000
Physician Services:				
Primary Care Physicians	\$35 Copay	Deductible + 40%	\$35 Copay	Deductible + 40%
Specialists	\$50 Copay	Deductible + 40%	\$50 Copay	Deductible + 40%
Urgent Care????	\$35 Copay	Deductible + 40%	\$35 Copay	Deductible + 40%
Routine Mammograms	100%	Deductible + 40%	100%	Deductible + 40%
Routine Colonoscopies	100%	Deductible + 40%	100%	Deductible + 40%
Routine GYN Exam	\$35 Copay	Deductible + 40%	\$35 Copay	Deductible + 40%
Chiropractic Care (\$1,000 max annually)	\$50 Copay	Not Covered	\$50 Copay	Not Covered
Hospital (inpatient, outpatient, ambulatory and ER care)	Deductible + 20%	Deductible + 40%	Deductible + 20%	Deductible + 40%
Hospital Benefits:				
Inpatient Hospital Copay	\$500 copay	Deductible + 40%	\$500 copay	Deductible + 40%
Inpatient Hospital Services	Copay + 20%	Deductible + 40%	Copay + 20%	Deductible + 40%
Outpatient Hospital Copay	Deductible + 20%	Deductible + 40%	Deductible + 20%	Deductible + 40%
Outpatient Hospital Services	Deductible + 20%	Deductible + 40%	Deductible + 20%	Deductible + 40%
Emergency Services:				
Emergency Services Copay	\$200 copay	\$200 copay	\$200 copay	\$200 copay
Emergency Services Charges	Copay + 20%	Copay + 20%	Copay + 20%	Copay + 20%
Retail Drugs (31-day supply)				
Value Generic Copay	\$8	Not Covered	\$8	Not Covered
Generic Copay	\$15	Not Covered	\$15	Not Covered
Preferred Brand Name Copay	\$35	Not Covered	\$35	Not Covered
Non-Preferred Brand Name Copay	\$55	Not Covered	\$55	Not Covered
Specialty Pharmaceuticals	\$125	Not Covered	\$125	Not Covered
Mail Order Drugs (90-day supply)				
Value Generic Copay	\$20.00	Not Covered	\$20.00	Not Covered
Generic Copay	\$37.50	Not Covered	\$37.50	Not Covered
Preferred Brand Name Copay	\$87.50	Not Covered	\$87.50	Not Covered
Non-Preferred Brand Name Copay	\$137.50	Not Covered	\$137.50	Not Covered
Vision:				
Exam for corrective lenses	One per year at no cost	Not Covered	One per year at no cost	Not Covered
Exam for contact lenses	\$45 copay once per year	Not Covered	\$45 copay once per year	Not Covered
Eyewear	Once every two years	Not Covered	Once every two years	Not Covered
Plan Lifetime Maximum (combines in and out of network)	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000

This is intended to only be a brief overview of your benefits. Please review the contract for specific information.