

**2009-2010 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 | \$1,000 | \$2,000 | \$500 | \$1,000 |
| Family | \$3,000 | per individual | \$1,500 | 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 | \$2,000 | \$4,000 | \$1,500 | \$3,000 |
| Family | \$4,000 | \$8,000 | \$3,000 | \$6,000 |
| Physician Services: | | | | |
| Primary Care Physicians | \$25 Copay | Deductible + 40% | \$25 Copay | Deductible + 40% |
| Specialists | \$40 Copay | Deductible + 40% | \$40 Copay | Deductible + 40% |
| Urgent Care | \$25 Copay | Deductible + 40% | \$25 Copay | Deductible + 40% |
| Routine Mammograms | 100% | Deductible + 40% | 100% | Deductible + 40% |
| Routine Colonoscopies | 100% | Deductible + 40% | 100% | Deductible + 40% |
| Routine GYN Exam | \$25 Copay | Deductible + 40% | \$25 Copay | Deductible + 40% |
| Chiropractic Care | \$40 Copay | Not Covered | \$40 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 | \$250 (first 3 visits) | Deductible + 40% | \$250 (first 3 visits) | Deductible + 40% |
| Outpatient Hospital Services | Copay + 20% | Deductible + 40% | Copay + 20% | Deductible + 40% |
| Emergency Services: | | | | |
| Emergency Services Copay | \$125 copay | \$125 copay | \$125 copay | \$125 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 |
| Mail Order Drugs (90-day supply) | | | | |
| Value Generic Copay | \$16 | Not Covered | \$16 | Not Covered |
| Generic Copay | \$30 | Not Covered | \$30 | Not Covered |
| Preferred Brand Name Copay | \$70 | Not Covered | \$70 | Not Covered |
| Non-Preferred Brand Name Copay | \$110 | Not Covered | \$110 | 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.