

SUMMARY OF STATE HEALTH PLAN OPTIONS

HEALTH COVERAGE	<u>STANDARD PLAN</u>	<u>BlueChoice Health Plan of SC</u>	<u>CIGNA HMO</u>	<u>SHP SAVINGS PLAN</u>
PLAN TYPE:	Coverage Worldwide	Available in all SC counties Coverage Worldwide	Available in <i>most</i> SC counties All care directed/approved by the HMO.	Coverage Worldwide
PREMIUMS	Semi-Monthly Regular Tobacco	Semi-Monthly Regular Tobacco	Semi-Monthly Regular Tobacco	Semi-Monthly Regular Tobacco
Enrollee:	\$46.73 \$59.23	\$92.78 \$105.28	\$125.97 \$138.47	\$4.64 \$17.14
Enrollee/Spouse:	\$118.75 \$131.25	\$254.39 \$266.89	\$304.21 \$316.71	\$36.28 \$48.78
Enrollee/Child(ren):	\$71.23 \$83.73	\$191.33 \$203.83	\$259.04 \$271.54	\$10.14 \$22.64
Full Family:	\$147.29 \$159.79	\$370.61 \$383.11	\$465.42 \$477.92	\$54.28 \$66.78
ANNUAL DEDUCTIBLE:	\$350 Single/\$700 Family Annual	\$250 Single/\$500 Family	NONE	\$3,000 Single/\$6,000 Family Must be met in full before co-insurance
CO-INSURANCE:	<u>In-Network</u> <u>Out-of-Network</u> Plan – 80% Plan – 60% Insured – 20% Insured – 40%	HMO – 85% after co-pays You Pay - 15%	HMO – 80% after co-pays You pay - 20%	<u>In-Network</u> <u>Out-of-Network</u> Plan – 80% Plan – 60% Insured – 20% Insured – 40%
CO-INSURANCE; MAX (Out of Pocket Limit)	\$2,000(Single) \$4,000 \$4,000(Family) \$8,000 excludes deductibles & co-pay	\$2,000 (Single) \$4,000 (Family) Excludes deductibles	\$2,000 (Single) \$4,000 (Family) Includes inpatient/outpatient, co-pays and coinsurance)	<u>In-Network</u> <u>Out-of-Network</u> Single \$2,000 Single \$4,000 Family \$4,000 Family \$8,000 Excludes deductibles
Hospitalization/Emergency Care	Outpatient hospital: \$75 per-occurrence deductible Emergency Care: \$125 per-occurrence deductible	Inpatient: \$200 co-pay Outpatient: \$100 co-pay/first 3 visits Emergency Care: \$125 co-pay, HMO pays 85 % after co-pays \$35 urgent care co-pay, then HMO pays 100%	Inpatient: \$500 co-pay per admission then HMO pays 80% Outpatient: \$250 co-pay per admission then HMO pays 80%. Emergency Care: \$100 co-pay then HMO pays 100%	No per-occurrence deductibles or co-payments.
Physicians Office Visits:	\$10 per-occurrence deductible then: <u>In-Network</u> <u>Out-of-Network</u> Plan – 80% Plan – 60% Insured – 20% Insured – 40% Chiropractic payments limited to \$2,000 a year, per person	\$15 PCP co-payment \$15 OB/GYN well woman exam \$40 Specialist co-pay \$35 Urgent care co-pay	\$15 PCP co-payment \$15 OB/GYN exam \$30 Specialist co-pay	Chiropractic limited to \$500 a year, per person. <u>In-Network</u> <u>Out-of-Network</u> Plan – 80% Plan – 60% Insured – 20% Insured – 40%
Prescription Drugs:	Participating pharmacies only: (up to 31-day supply): \$9 tier 1 (generic — lowest cost), \$30 tier 2 (brand — higher cost), \$50 tier 3 (brand — highest cost) Mail order (up to 90-day supply): \$22 tier 1, \$75 tier 2, \$125 tier 3 Co-pay max: \$2,500 Additional Information	Participating pharmacies only: (31-day supply): \$8/\$15 generic, \$35 preferred brand, \$55 non-preferred brand, \$80/\$125 specialty pharmaceuticals Mail order (Up to 90-day supply): \$20/\$37.50 generic, \$87.50 preferred brand, \$137.50 non-preferred brand	Participating pharmacies only: (up to 30-day supply): \$7 generic, \$25 preferred brand, \$50 non-preferred brand Mail order (up to 90-day supply): \$14 generic, \$50 preferred brand, \$100 non-preferred brand	Participating pharmacies and mail order only: You pay the State Health Plan's allowable charge until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable charge; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable charge. Additional Information
MENTAL HEALTH PARITY:	In-Network & Out-of-Network Providers. Call 1-800-221-8699. Subject to above deductibles and co-insurance.	Participating providers only. Call 1-800-868-1032. Inpatient: \$200 co-pay, then 90% Outpatient: \$25 specialist co-pay	Participating providers only. Inpatient: \$500 co-pay, then 80% Outpatient: \$40 specialist co-pay	In-Network & Out-of-Network Providers. Call 1-800-221-8699. Subject to above deductibles and co-insurance.
LIFETIME MAX:	\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$2,000,000.00