Individual Coverage Benefits and Rates Guide

Effective April 1, 2025, for policies issued before March 23, 2010. The benefit period (BP) is 12 consecutive months from the effective date of coverage.

BENEFIT	PLAN 1	PLAN 2	PLAN 3	PLAN 4
Deductible[1]	$250 per member per BP	$500 per member per BP	$750 per member per BP	$1,500 per member per BP
Coinsurance Maximum[1]	$1,500 per member per BP	$2,000 per member per BP	$2,500 per member per BP	$5,000 per member per BP
Primary Care Physician Services	$10 copayment per visit	$15 copayment per visit	$15 copayment per visit	$25 copayment per visit
Routine Preventive Office Services	$10 copayment per visit	$15 copayment per visit	$15 copayment per visit	$25 copayment per visit
Specialty Care Office Services[2]	80% — Subject to deductible	80% — Subject to deductible	80% — Subject to deductible	70% — Subject to deductible
Inpatient Services (Including Behavioral Health)[3]	80% — Subject to deductible	80% — Subject to deductible	80% — Subject to deductible	70% — Subject to deductible
Outpatient Services (Including Behavioral Health)[4]	80% — Subject to deductible	80% — Subject to deductible	80% — Subject to deductible	70% — Subject to deductible
Urgent Care Services[5]	$35 per visit, then 100% coverage	$35 per visit, then 100% coverage	$35 per visit, then 100% coverage	$50 per visit, then 100% coverage
Mental Health (Office Services Only)	$10 copayment per visit	$15 copayment per visit	$15 copayment per visit	$25 copayment per visit
Prescription Drugs	$7/$15/$30 copayment, then 100%	$7/$30/$50 copayment, then 100%	$7/$30/$50 copayment, then 100%	$8/$30/$60 copayment, then 100%
Specialty Pharmaceuticals	100% after $100 copayment	100% after $100 copayment	100% after $100 copayment	100% after $100 copayment
Vision Care	Free annual eye exam	Free annual eye exam	Free annual eye exam	Free annual eye exam
Dental Care	Up to $20 for one exam and $30 for one cleaning per BP	Up to $20 for one exam and $30 for one cleaning per BP	Up to $20 for one exam and $30 for one cleaning per BP	Up to $20 for one exam and $30 for one cleaning per BP
Durable Medical Equipment	80% — Subject to deductible	80% — Subject to deductible	80% — Subject to deductible	80% — Subject to deductible
Physical Therapy, Speech Therapy and Occupational Therapy	80% — Subject to deductible	80% — Subject to deductible	80% — Subject to deductible	70% — Subject to deductible

MONTHLY PREMIUMS	PLAN 1		PLAN 2		PLAN 3		PLAN 4	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	769.17	769.17	724.13	724.13	657.70	657.70	530.43	530.43
Ages 5 – 18	603.65	603.65	568.74	568.74	516.94	516.94	416.67	416.67
Ages 19 – 24	694.86	757.91	655.49	714.02	595.75	648.73	478.63	522.49
Ages 25 – 29	762.38	928.04	719.62	873.87	654.34	793.99	524.79	639.71

MONTHLY PREMIUMS WITH BANK DRAFT**	PLAN 1		PLAN 2		PLAN 3		PLAN 4	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	749.94	749.94	705.99	705.99	641.25	641.25	517.19	517.19
Ages 5 – 18	588.57	588.57	554.50	554.50	503.99	503.99	406.27	406.27
Ages 19 – 24	677.49	738.99	639.06	696.16	580.87	632.49	466.65	509.44
Ages 25 – 29	743.34	904.82	701.64	852.02	637.97	774.13	511.66	623.69

BENEFIT	PLAN 5	PLAN 6 — HDHP*	PLAN 7 — HDHP
Deductible[1]	$2,500 per member per BP	$3,000 per member per BP	$5,000 per member per BP
Coinsurance Maximum[1]	$5,000 per member per BP	N/A	N/A
Primary Care Physician Services	$35 copayment per visit	100% — Subject to deductible	100% — Subject to deductible
Routine Preventive Office Services	$35 copayment per visit	$35 copayment per visit	$35 copayment per visit
Specialty Care Office Services[2]	70% — Subject to deductible	100% — Subject to deductible	100% — Subject to deductible
Inpatient Services (Including Behavioral Health)[3]	70% — Subject to deductible	100% — Subject to deductible	100% — Subject to deductible
Outpatient Services (Including Behavioral Health)[4]	70% — Subject to deductible	100% — Subject to deductible	100% — Subject to deductible
Urgent Care Services[5]	$50 per visit, then 100% coverage	100% — Subject to deductible	100% — Subject to deductible
Mental Health (Office Services Only)	$35 copayment per visit	100% — Subject to deductible	100% — Subject to deductible
Prescription Drugs	$8/$30/$60 copayment, then 100%	100% — Subject to deductible	100% — Subject to deductible
Specialty Pharmaceuticals	100% after $100 copayment	100% — Subject to deductible	100% — Subject to deductible
Vision Care	Free annual eye exam	Free annual eye exam	Free annual eye exam
Dental Care	Up to $20 for one exam and $30 for one cleaning per BP	Up to $20 for one exam and $30 for one cleaning per BP	Up to $20 for one exam and $30 for one cleaning per BP
Durable Medical Equipment	70% — Subject to deductible	100% — Subject to deductible	100% — Subject to deductible
Physical Therapy, Speech Therapy and Occupational Therapy	70% — Subject to deductible	100% — Subject to deductible	100% — Subject to deductible

MONTHLY PREMIUMS	PLAN 5		PLAN 6 — HDHP		PLAN 7 — HDHP	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	462.85	462.85	471.88	471.88	362.65	362.65
Ages 5 – 18	363.79	363.79	370.51	370.51	284.88	284.88
Ages 19 – 24	417.81	454.96	425.73	464.00	327.73	357.05
Ages 25 – 29	458.36	557.46	467.39	567.62	359.23	436.95

MONTHLY PREMIUMS WITH BANK DRAFT**	PLAN 5		PLAN 6 — HDHP		PLAN 7 — HDHP	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	451.26	451.26	460.12	460.12	353.57	353.57
Ages 5 – 18	354.69	354.69	361.22	361.22	277.79	277.79
Ages 19 – 24	407.35	443.64	415.07	452.40	319.54	348.11
Ages 25 – 29	446.90	543.51	455.71	553.40	350.28	426.03

*High deductible health plan (HDHP)

**Rates reflect a 2.5 percent discount when the payer takes advantage of the bank draft option.

[1]Includes out-of-network air ambulance services, emergency services and, subject to limited provider advance notice and consent requirements, other (nonemergency) provider services furnished at certain in-network facilities.

[2]Except behavioral health care.

[3]Includes inpatient services provided by an out-of-network provider at certain in-network facilities, out-of-network inpatient emergency services and, unless provider advance notice and consent requirements are met, inpatient post-stabilization services resulting from an emergency.

[4]Includes outpatient services provided by an out-of-network provider at certain in-network facilities, unless provider advance notice and consent requirements are met.

[5]For services provided by a participating urgent care center.

Focus on life. Focus on health. ***Stay focused.***

BlueChoice® HealthPlan
South Carolina