

MyChoice Individual Health Coverage Benefits and Rates Guide



MyChoice Individual Health Coverage from BlueChoice HealthPlan

Benefits

Effective 1-1-2011

(The benefit period is 12 consecutive months from the effective date of coverage.)

Benefit	\$500 80% HMO Plan	\$750 80% HMO Plan	\$1,000 80% HMO Plan	\$3,250 80% HMO Plan
Deductible	\$500	\$750	\$1,000	\$3,250
Coinsurance Maximum	\$2,000	\$2,500	\$3,000	\$3,250
Primary Care Physician Services	\$15 copayment per visit	\$15 copayment per visit	\$20 copayment per visit	\$35 copayment per visit
Mandated Preventive Services	\$0 copayment per visit	\$0 copayment per visit	\$0 copayment per visit	\$0 copayment per visit
Specialist Visit	80% - Subject to deductible	80% - Subject to deductible	80% - Subject to deductible	80% - Subject to deductible
Inpatient Hospital Services	80% - Subject to deductible	80% - Subject to deductible	80% - Subject to deductible	80% - Subject to deductible
Outpatient Hospital Services	80% - Subject to deductible	80% - Subject to deductible	80% - Subject to deductible	80% - Subject to deductible
Urgent Care	\$35 per visit, then 100%	\$35 per visit, then 100%	\$35 per visit, then 100%	80% - Subject to deductible
Mental Health and Substance Abuse (office services only)	80% - Subject to deductible, up to 20 visits per benefit period	80% - Subject to deductible, up to 20 visits per benefit period	80% - Subject to deductible up to 20 visits per benefit period	80% - Subject to deductible up to 20 visits per benefit period
Prescription Deductible	None	\$500 - Brand only	None	None
Prescription Drugs	\$8/\$15/\$35/\$55 copayment, then 100%	\$8/\$15/\$35/\$55 copayment, then 100%	\$8/\$15/\$35/\$55 copayment, then 100%	80% - Subject to deductible
Specialty Pharmaceuticals	100% after \$125 copayment	100% after \$125 copayment	100% after \$125 copayment	\$350 copayment per 31-day supply or per episode
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 benefit period	Up to \$20 for one exam and \$30 for one cleaning per benefit period	Up to \$20 for one exam and \$30 for one cleaning per benefit period	Up to \$20 for one exam and \$30 for one cleaning per benefit period
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 Up to 20 visits per therapy per benefit period	80% - Subject to deductible Up to 20 visits per therapy per benefit period	80% - Subject to deductible Up to 20 visits per therapy per benefit period	80% - Subject to deductible Up to 20 visits per therapy per benefit period
Transplants	Blue Distinction® Centers of Excellence network only	Blue Distinction Centers of Excellence network only	Blue Distinction Centers of Excellence network only	Blue Distinction Centers of Excellence network only
Annual Benefit Maximum	\$750,000	\$750,000	\$750,000	\$750,000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited

MyChoice Individual Health Coverage from BlueChoice HealthPlan

Benefits

Effective 1-1-2011

(The benefit period is 12 consecutive months from the effective date of coverage.)

Benefit	\$1,500 70% HMO Plan	\$2,500 70% HMO Plan	\$3,000 100% HDHP	\$5,000 100% HDHP
Deductible	\$1,500	\$2,500	\$3,000	\$5,000
Coinsurance Maximum	\$5,000	\$5,000	N/A	N/A
Primary Care Physician Services	\$25 copayment per visit	\$35 copayment per visit	100% - Subject to deductible	100% - Subject to deductible
Mandated Preventive Services	\$0 copayment per visit	\$0 copayment per visit	\$0 copayment per visit	\$0 copayment per visit
Specialist Visit	70% - Subject to deductible	70% - Subject to deductible	100% - Subject to deductible	100% - Subject to deductible
Inpatient Hospital Services	70% - Subject to deductible	70% - Subject to deductible	100% - Subject to deductible	100% - Subject to deductible
Outpatient Hospital Services	70% - Subject to deductible	70% - Subject to deductible	100% - Subject to deductible	100% - Subject to deductible
Urgent Care	\$50 per visit, then 100%	\$50 per visit, then 100%	100% - Subject to deductible	100% - Subject to deductible
Mental Health and Substance Abuse (office services only)	70% - Subject to deductible, up to 20 visits per benefit period	70% - Subject to deductible, up to 20 visits per benefit period	100% - Subject to deductible	100% - Subject to deductible
Prescription Deductible	\$500 - Brand only	\$500 - Brand only	None	None
Prescription Drugs	\$8/\$15/\$35/\$55 copayment, then 100%	\$8/\$15/\$35/\$55 copayment, then 100%	100% - Subject to deductible	100% - Subject to deductible
Specialty Pharmaceuticals	100% after \$125 copayment	100% after \$125 copayment	100% - Subject to deductible	100% - Subject to deductible
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 benefit period	Up to \$20 for one exam and \$30 for one cleaning per benefit period	Up to \$20 for one exam and \$30 for one cleaning per benefit period	Up to \$20 for one exam and \$30 for one cleaning per benefit period
Durable Medical Equipment	70% - Subject to deductible	70% - Subject to deductible	100% - Subject to deductible	100% - Subject to deductible
Physical Therapy, Speech Therapy and Occupational Therapy	70% - Subject to deductible Up to 20 visits per therapy per benefit period	70% - Subject to deductible Up to 20 visits per therapy per benefit period	100% - Subject to deductible Up to 20 visits per therapy per benefit period	100% - Subject to deductible Up to 20 visits per therapy per benefit period
Transplants	Blue Distinction Centers of Excellence network only	Blue Distinction Centers of Excellence network only	Blue Distinction Centers of Excellence network only	Blue Distinction Centers of Excellence network only
Annual Benefit Maximum	\$750,000	\$750,000	\$750,000	\$750,000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited

MyChoice Individual Health Coverage

Rates

Effective 4-1-2011

Base Rates* Age	\$500 80% HMO Plan		\$750 80% HMO Plan		\$1,000 80% HMO Plan		\$3,250 80% HMO Plan	
	Male	Female	Male	Female	Male	Female	Male	Female
19-24	\$150.38	\$202.07	\$137.53	\$184.81	\$140.28	\$188.50	\$87.99	\$118.24
25-29	\$165.03	\$247.37	\$150.93	\$226.24	\$153.95	\$230.76	\$96.57	\$144.75
30-34	\$200.08	\$311.03	\$182.99	\$284.46	\$186.65	\$290.14	\$117.08	\$181.99
35-39	\$234.10	\$357.78	\$214.10	\$327.22	\$218.38	\$333.76	\$136.98	\$209.35
40-44	\$289.62	\$419.15	\$264.87	\$383.34	\$270.17	\$391.00	\$169.46	\$245.26
45-49	\$368.83	\$519.99	\$337.32	\$475.57	\$344.06	\$485.07	\$215.81	\$304.26
50-54	\$478.14	\$555.46	\$437.29	\$508.01	\$446.03	\$518.16	\$279.78	\$325.02
55-59	\$616.39	\$606.23	\$563.72	\$554.43	\$574.99	\$565.52	\$360.67	\$354.72
60-64	\$806.72	\$688.35	\$737.79	\$629.54	\$752.54	\$642.12	\$472.04	\$402.77

Base Rates* Age	\$1,500 70% HMO Plan		\$2,500 70% HMO Plan		\$3,000 100% HDHP Plan		\$5,000 100% HDHP Plan	
	Male	Female	Male	Female	Male	Female	Male	Female
19-24	\$113.31	\$152.26	\$99.12	\$133.20	\$99.76	\$134.05	\$76.72	\$103.09
25-29	\$124.35	\$186.39	\$108.79	\$163.06	\$109.48	\$164.10	\$84.20	\$126.20
30-34	\$150.76	\$234.36	\$131.89	\$205.02	\$132.73	\$206.33	\$102.08	\$158.68
35-39	\$176.39	\$269.58	\$154.31	\$235.84	\$155.30	\$237.35	\$119.43	\$182.53
40-44	\$218.22	\$315.82	\$190.91	\$276.29	\$192.12	\$278.06	\$147.75	\$213.84
45-49	\$277.91	\$391.80	\$243.12	\$342.76	\$244.67	\$344.95	\$188.17	\$265.29
50-54	\$360.27	\$418.53	\$315.18	\$366.14	\$317.19	\$368.48	\$243.94	\$283.38
55-59	\$464.44	\$456.78	\$406.30	\$399.61	\$408.90	\$402.16	\$314.46	\$309.28
60-64	\$607.85	\$518.66	\$531.77	\$453.74	\$535.16	\$456.63	\$411.57	\$351.18

*The above base rates are subject to health underwriting.
Rates can be reduced 2.5 percent with recurring bank draft or credit card payment.