

## Limitations and Exclusions

Benefits Per Member	BlueAdvantage		BlueBasic		Regence HSA Healthplan
	Copay Plan	Coinsurance	Copay Plan	Coinsurance	Health Savings Account Qualified
Alternative Care	Excluded		Excluded		Excluded
Birth Control	Included (except for non-prescription contraceptives)		Included (except for non-prescription contraceptives)		Included (except for non-prescription contraceptives)
Cosmetic / Reconstructive Services and Supplies	Excluded		Excluded		Excluded
Counseling	Excluded		Excluded		Excluded
Custodial, Domiciliary and Convalescent Care	Excluded		Excluded		Excluded
Dental Services	Excluded (accidental injury to sound natural teeth is covered)		Excluded (accidental injury to sound natural teeth is covered)		Excluded (accidental injury to sound natural teeth is covered)
Durable Medical Equipment	Not limited		Not limited		\$2,500 per calendar year
Erectile Dysfunction	Excluded		Excluded		Excluded
Foot Care	Excluded		Excluded		Excluded
Gastric Procedures such as gastric bypass	Excluded		Excluded		Excluded
Genetic Services	Excluded		Excluded		Excluded
Growth Hormone	Excluded		Excluded		\$20,000 per calendar year
Hearing Treatment	Excluded		Excluded		Excluded
Home Health Care	Not limited		Not limited		130 visits per calendar year
Infertility, except diagnosis	Excluded		Excluded		Excluded
Maternity Care	Included after \$5,000 copayment		Included after \$5,000 copayment		Excluded
Mental Health Treatment	\$1,500 per calendar year		\$1,500 per calendar year		\$1,500 per calendar year
Obesity or Weight Control	Excluded		Excluded		Excluded
Orthognathic Surgery	Excluded		Excluded		Excluded
Preventive - 0 - 24 mo.	10 exams included		10 exams included		Not limited
Preventive - age 2 - 5	4 exams per calendar year		4 exams per calendar year		Not limited
Preventive - age 6 to adult	\$300 per calendar year		\$300 per calendar year		Not limited
Rehabilitative Care (inpatient)	Not limited		Not limited		\$4,000 per calendar year
Rehabilitative Care (outpatient) including chiropractic care	\$1,500 per calendar year		\$1,500 per calendar year		\$2,000 per calendar year
Temporomandibular Joint Dysfunction (TMJ) Treatment	Excluded		Excluded		Excluded
Tobacco Addiction Treatment	Excluded		Excluded		Excluded
Transplants	Not limited		Not limited		\$250,000 lifetime maximum
Vision Care	Excluded		Excluded		Excluded
<b>You must be covered for at least 12 months before we pay for any of the following</b>					
Pre-existing Conditions	12-month waiting period		12-month waiting period		12-month waiting period
Sterilization (e.g. vasectomy, tubal ligation)	12-month waiting period		12-month waiting period		12-month waiting period

All benefits are listed per member. This comparison does not include all benefits, limitations, exclusions and other terms of coverage (such as eligibility and cancellation provisions) applicable to these available plans. See the Outline of Coverage for more details.

**Regence BlueCross BlueShield of Utah**  
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Comp Bro 4.1.09 rev. 4.2.09



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah

**Compare Individual and Family Plans**



Benefits	BlueAdvantage				BlueBasic				Regence HSA Healthplan	
	Copay Plan		Coinsurance Plan		Copay Plan		Coinsurance Plan		Health Savings Account Qualified	
	Per Member	Family	Per Member	Family	Per Member	Family	Per Member	Family	Single	Family
<b>Annual Deductibles</b> Deductible may not apply to certain benefits	\$500 \$1,000	\$1,000 \$2,000	\$2,500 \$5,000 \$7,500	\$5,000 \$10,000 \$15,000	\$500 \$1,000	\$1,000 \$2,000	\$2,500 \$5,000 \$7,500	\$5,000 \$10,000 \$15,000	\$1,500 \$2,500 \$3,500	\$3,000 \$5,000 \$7,000
<b>Annual Out-of-Pocket Maximum</b> The out-of-pocket maximum includes the deductible	\$3,000 \$3,500	\$6,000 \$7,000	\$4,000 \$6,500 \$9,000	\$8,000 \$12,000 \$17,000	\$4,000 \$5,000	\$8,000 \$10,000	\$6,000 \$7,000 \$10,000	\$11,000 \$13,000 \$18,000	\$5,000	\$10,000
<b>Lifetime Maximum</b>	\$2 million per member		\$2 million per member		\$2 million per member		\$2 million per member		\$2 million per member	
<b>Provider Networks *</b> Choose from two networks	ValueCare PPO or Traditional (BCBS)	Providers Not in the Networks	ValueCare PPO or Traditional (BCBS)	Providers Not in the Networks	ValueCare PPO or Traditional (BCBS)	Providers Not in the Networks	ValueCare PPO or Traditional (BCBS)	Providers Not in the Networks	ValueCare PPO or Traditional (BCBS)	Providers Not in the Networks
<b>Coinsurance</b> Percentage you pay after the deductible for most services	You pay 20%	You pay 40%	You pay 20%	You pay 40%	You pay 30%	You pay 45%	You pay 30%	You pay 45%	You pay 20%	You pay 40%
<b>Office and Urgent Care</b> Physician office visits Minor procedures	You pay \$20 copay no deductible	After deductible, you pay \$20 copay and coinsurance	Deductible and coinsurance		You pay \$30 copay no deductible	After deductible, you pay \$30 copay and coinsurance	Deductible and coinsurance		Deductible and coinsurance	
<b>Prescription Medications</b>	<b>Generic:</b> You pay \$5 copay <b>Formulary:</b> You pay 25% <b>Non-Formulary:</b> You pay 50% no deductible no annual limit		You must go to the pharmacy first, pay for your prescription and submit a claim to us for credit or reimbursement. <b>After the medical deductible,</b> you pay 20%, no annual limit		<b>Separate Rx Deductible:</b> \$200 <b>Generic:</b> You pay \$10 copay <b>Formulary:</b> You pay 25% <b>Non-Formulary:</b> You pay 50% no annual limit		You must go to the pharmacy first, pay for your prescription and submit a claim to us for credit or reimbursement. <b>After the medical deductible,</b> you pay 30%, no annual limit		You must go to the pharmacy first, pay for your prescription and submit a claim to us for credit or reimbursement. <b>After the medical deductible,</b> you pay 50%, no annual limit	
<b>Preventive Care Over Six</b> Adults (both male and female) Children over age six	You pay \$20 copay no deductible	After deductible, you pay \$20 copay and coinsurance	Deductible and coinsurance		You pay \$30 copay no deductible	After deductible, you pay \$30 copay and coinsurance	Deductible and coinsurance		Coinsurance only no deductible no age or frequency limits	
	<b>Limited to \$300 per member per calendar year</b>		<b>Limited to \$300 per member per calendar year</b>		<b>Limited to \$300 per member per calendar year</b>		<b>Limited to \$300 per member per calendar year</b>			
<b>Preventive Care Under Six</b> 10 visits in first 24 months 4 visits for ages 2-5 years per calendar year	You pay \$20 copay no deductible	After deductible, you pay \$20 copay and coinsurance	Deductible and coinsurance		You pay \$30 copay no deductible	After deductible, you pay \$30 copay and coinsurance	Deductible and coinsurance		Coinsurance only no deductible no age or frequency limits	
<b>Other Services</b>										
<b>Diagnostic Laboratory &amp; Radiology Services</b>	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
<b>Durable Medical Equipment</b>	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
<b>Emergency Room</b> Copay waived if admitted	After deductible, you pay \$75 copay and coinsurance		After deductible, you pay \$75 copay and coinsurance		After deductible, you pay \$100 copay and coinsurance		After deductible, you pay \$100 copay and coinsurance		Deductible and coinsurance	
<b>Hospitalizations</b> Inpatient & outpatient	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
<b>Maternity Care</b> Diagnosis, Pre-natal, Labor and Delivery	After separate \$5,000 copayment, you pay 0% coinsurance does not apply to out-of-pocket max		After separate \$5,000 copayment, you pay 0% coinsurance does not apply to out-of-pocket max		After separate \$5,000 copayment, you pay 0% coinsurance does not apply to out-of-pocket max		After separate \$5,000 copayment, you pay 0% coinsurance does not apply to out-of-pocket max		Not covered	
<b>Mental Health</b> Inpatient Outpatient	After deductible, you pay 50% coinsurance <b>Limited to \$1,500 per calendar year</b> does not apply to out-of-pocket max		After deductible, you pay 50% coinsurance <b>Limited to \$1,500 per calendar year</b> does not apply to out-of-pocket max		After deductible, you pay 50% coinsurance <b>Limited to \$1,500 per calendar year</b> does not apply to out-of-pocket max		After deductible, you pay 50% coinsurance <b>Limited to \$1,500 per calendar year</b> does not apply to out-of-pocket max		After deductible, you pay 50% coinsurance <b>Limited to \$1,500 per calendar year</b> applies to out-of-pocket max	
<b>Accidental Death</b>	We pay \$25,000 per subscriber/spouse and \$5,000 for other dependents (up to age 26)		We pay \$25,000 per subscriber/spouse and \$5,000 for other dependents (up to age 26)		We pay \$25,000 per subscriber/spouse and \$5,000 for other dependents (up to age 26)		We pay \$25,000 per subscriber/spouse and \$5,000 for other dependents (up to age 26)		Not covered	
<b>Additional Accident</b>	\$1,000 per member per calendar year		\$1,000 per member per calendar year		Not covered		Not covered		Not covered	

\* Note: You are covered no matter which doctor or facility you use. However, if you go to the ValueCare PPO network or the Traditional (BCBS) network, you will pay less for services rendered.

The Regence HSA Healthplan is the only plan federally qualified to be paired with a Health Savings Account. BlueAdvantage and BlueBasic plans, even those with high deductibles, are not federally qualified.