

Regence BlueCross BlueShield of Utah

Compare Individual and Family Plans



Regence

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

Which health plan fits you?

Every individual is different. Which is why we offer different individual health plans. Whether you want the works, or just the basics, Regence BlueCross BlueShield of Utah offers an individual health plan that delivers. Here's how they all stack up—pick the one that's right for you.

	BLUE ADVANTAGE*				BLUE BASIC*				REGENCE HSA HEALTHPLAN	
	Copay		Coinsurance		Copay		Coinsurance		Health Savings Account Qualified	
Network Choices	Regence Traditional or ValueCare				Regence Traditional or ValueCare				Regence Traditional or ValueCare	
Annual Deductible	You pay \$250 per person or \$750 per family You pay \$500 per person or \$1,000 per family You pay \$1,000 per person or \$2,000 per family		You pay \$2,500 per person or \$5,000 per family You pay \$5,000 per person or \$10,000 per family You pay \$7,500 per person or \$15,000 per family		You pay \$250 per person or \$750 per family You pay \$500 per person or \$1,000 per family You pay \$1,000 per person or \$2,000 per family		You pay \$2,500 per person or \$5,000 per family You pay \$5,000 per person or \$10,000 per family You pay \$7,500 per person or \$15,000 per family		You pay \$1,500 for self only coverage or \$3,000 for family coverage You pay \$2,500 for self only coverage or \$5,000 for family coverage You pay \$3,500 for self only coverage or \$7,000 for family coverage	
Annual out-of-pocket maximum includes deductibles listed above	You pay \$2,500 per person or \$5,000 per family You pay \$3,000 per person or \$6,000 per family You pay \$3,500 per person or \$7,000 per family		You pay \$4,000 per person or \$8,000 per family You pay \$6,500 per person or \$12,000 per family You pay \$9,000 per person or \$17,000 per family		You pay \$3,000 per person or \$6,000 per family You pay \$4,000 per person or \$8,000 per family You pay \$5,000 per person or \$10,000 per family		You pay \$6,000 per person or \$11,000 per family You pay \$7,000 per person or \$13,000 per family You pay \$10,000 per person or \$18,000 per family		\$5,000 for self only coverage \$10,000 for family coverage	
Preventive Care (Adults and Children over 6)**	IN-NETWORK We pay 100% after you pay \$20 copayment, not subject to deductible	OUT-OF-NETWORK After deductible, we pay 80% after you pay \$20 copayment	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK We pay 100% after you pay \$30 copayment, not subject to deductible	OUT-OF-NETWORK After deductible, we pay 80% after you pay \$30 copayment	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK Deductible waived We pay 80%	OUT-OF-NETWORK Deductible waived We pay 60%
	Limited to \$300 per person per calendar year		Limited to \$300 per person per calendar year		Limited to \$300 per person per calendar year		Limited to \$300 per person per calendar year		No annual limitations	
Preventive Care Under Age 6 (10 visits in first 24 months, 4 visits each year from ages 2-5 years) **	IN-NETWORK We pay 100% after you pay \$20 copayment, not subject to deductible	OUT-OF-NETWORK After deductible, we pay 80% after you pay \$20 copayment	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK We pay 100% after you pay \$30 copayment, not subject to deductible	OUT-OF-NETWORK After deductible, we pay 80% after you pay \$30 copayment	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK Deductible waived We pay 80% <i>No annual limits</i>	OUT-OF-NETWORK Deductible waived We pay 60% <i>No annual limits</i>
Professional Visits	IN-NETWORK We pay 100% after you pay \$20 copayment, not subject to deductible	OUT-OF-NETWORK After deductible, we pay 80% after you pay \$20 copayment	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK We pay 100% after you pay \$30 copayment, not subject to deductible	OUT-OF-NETWORK After deductible, we pay 80% after you pay \$30 copayment	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%
Hospitalizations Inpatient & Outpatient	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%
Emergency Room	After deductible, we pay 80% after you pay \$75 copayment	After deductible, we pay 60% after you pay \$75 copayment	After deductible, we pay 80% after you pay \$75 copayment	After deductible, we pay 60% after you pay \$75 copayment	After deductible, we pay 70% after you pay \$100 copayment	After deductible, we pay 55% after you pay \$100 copayment	After deductible, we pay 70% after you pay \$100 copayment	After deductible, we pay 55% after you pay \$100 copayment		
Laboratory and Radiology Services	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%
Outpatient Rehabilitative Care (including Chiropractic)	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%
Durable Medical Equipment	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 70%	OUT-OF-NETWORK After deductible, we pay 55%	IN-NETWORK After deductible, we pay 80%	OUT-OF-NETWORK After deductible, we pay 60%
Maternity Care	We pay 100% after you pay \$5,000 copayment, does not apply to out-of-pocket maximum								Not covered	
Prescription Drugs	You pay \$5 copayment for generics. We pay 75% for formulary prescriptions. or 50% for non-formulary.		After deductible, we pay 80%. Member must go to the pharmacy and pay for prescription first, then submit a claim to us for reimbursement.		You pay \$200 separate Rx deductible for prescriptions. You pay \$10 copayment for generics. We pay 75% for formulary prescriptions or 50% for non-formulary.		After deductible, we pay 70%. Member must go to the pharmacy and pay for prescription first, then submit a claim to us for reimbursement.		After deductible, we pay 50%	
Mental Health	After deductible, we pay 50% to maximum benefit of \$1,500, does not apply to out-of-pocket maximum								After deductible, we pay 50% which does apply to the out-of-pocket maximum	
Lifetime Maximum	We pay \$2 million per person								We pay \$2 million per person	
Accidental Death	We pay \$25,000 per subscriber/spouse and \$5,000 for other dependents (up to age 26)								Not covered	
Additional Accident	\$1,000 per person per calendar year		\$1,000 per person per calendar year		Not covered		Not covered		Not covered	

* Note: This plan is not federally qualified to be paired with a Health Savings Account (HSA). For a federally qualified HSA plan, see the Regence HSA Healthplan.

** Age limitations and visit maximums do not apply to Regence HSA Healthplan

Limitations and Exclusions

	Individual BlueChoices				Regence HSA Healthplan (Health Savings Account Qualified)
	BlueAdvantage		BlueBasic		
	Copay	Coinsurance	Copay	Coinsurance	
Alternative Care	Excluded			Excluded	
Birth Control	Included (except for non-prescription contraceptives)			Included (except for non-prescription contraceptives)	
Cosmetic / Reconstructive Services and Supplies	Excluded			Excluded	
Counseling	Excluded			Excluded	
Custodial, Domiciliary and Convalescent Care	Excluded			Excluded	
Dental Services	Excluded (accidental injury to sound natural teeth is covered)			Excluded (accidental injury to sound natural teeth is covered)	
Durable Medical Equipment	Not Limited			\$2,500 limit per Enrollee per Calendar Year	
Erectile Dysfunction	Excluded			Excluded	
Foot Care (routine)	Excluded			Excluded	
Gastric Procedures such as gastric bypass	Excluded			Excluded	
Genetic Studies	Excluded			Excluded	
Growth Hormone	See Contract for Limitations			\$20,000 limit per Enrollee per Calendar Year See Contract for Limitations	
Hearing Treatment	Excluded			Excluded	
Home Health Care	Not Limited			130 visits per Enrollee per Calendar Year	
Infertility	Excluded			Excluded	
Maternity Care	Included After \$5,000 Copayment			Excluded	
Mental Health Treatment	\$1,500 limit per Enrollee per Calendar Year			\$1,500 limit per Enrollee per Calendar Year	
Obesity or Weight Control	Excluded			Excluded	
Orthognathic Surgery	Excluded			Excluded	
Rehabilitative Care (inpatient)	Not Limited			\$4,000 limit per Enrollee per Calendar Year	
Rehabilitative Care (outpatient) including chiropractic care	\$1,500 limit per Enrollee per Calendar Year			\$2,000 limit per Enrollee per Calendar Year	
Temporomandibular Joint Dysfunction (TMJ) Treatment	Excluded			Excluded	
Tobacco Addiction Treatment	Excluded			Excluded	
Transplants	See Contract for Limitations			Limited to \$250,000 per person per lifetime	
Vision Care	Excluded			Excluded	

You must be continuously covered for at least 12 months before we pay for any of the following

Pre-existing Conditions	12 month waiting period	12 month waiting period
Sterilization (e.g. vasectomy, tubal ligation)	12 month waiting period	12 month waiting period

Preventive Care

Children - first 24 months	10 exams included	No annual limitations
Children - age 2 - 5	Four exams per Enrollee per Calendar Year	
Children - ages 6 and older	Limited to \$300 per Enrollee per Calendar Year	
Adult men and women	Limited to \$300 per Enrollee per Calendar Year	

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 Outline of Coverage for more details.