

COMPARE INDIVIDUAL HEALTH PLANS
that offer more of
what you need,
less of what you don't.

Regence Individual and Family Health Benefit Plans

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



| Regence BlueCross BlueShield of Utah | Regence Evolve Core 2.0 SM | | Regence RealValue SM | | Regence Evolve HSA Plan 2.0 SM (80%/60% or 60%/50% coinsurance options) | | Regence Evolve HSA 100 Plan 2.0 SM | | What you should know |
|--|---|---|---|---|--|---|--|---|--|
| <p>Calendar Year Deductible Applies to all covered expenses except where noted.</p> <p>Separate deductibles for In-Network and Out-of-Network services.</p> | <p>Individual deductible options per calendar year:</p> <p>In-Network: \$2,500 / Out-of-Network: \$5,000 In-Network: \$5,000 / Out-of-Network: \$10,000 In-Network: \$7,500 / Out-of-Network: \$15,000 In-Network: \$10,000 / Out-of-Network: \$20,000</p> <p>Family deductible is two times the In-Network / Out-of-Network Individual deductible amount</p> | | <p>Individual deductible options per calendar year:</p> <p>In-Network: \$2,500 / Out-of-Network: \$5,000 In-Network: \$5,000 / Out-of-Network: \$10,000 In-Network: \$7,500 / Out-of-Network: \$15,000 In-Network: \$10,000 / Out-of-Network: \$20,000</p> <p>Family deductible is three times the In-Network / Out-of-Network Individual deductible amount</p> | | <p>Deductible per calendar year \$1,200, \$2,000 or \$3,500 for single coverage \$2,400, \$4,000 or \$7,000 for family coverage</p> <p>Family coverage: no one family member is eligible for benefits until the entire family deductible is met.</p> | | <p>Deductible per calendar year \$3,000 or \$5,000 for single coverage \$6,000 or \$10,000 for family coverage</p> <p>Family coverage: no one family member is eligible for benefits until the entire family deductible is met.</p> | | <p>Your deductible is the dollar amount you pay in a calendar year before the plan pays covered benefits. Not all benefits apply toward the deductible. Some benefits require a copay or other costsharing amount.</p> |
| <p>Calendar Year Coinsurance or Out-of-Pocket Maximums Applies to all covered expenses except where noted. When the coinsurance maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year. (Applies only to services received in the applicable network for which the coinsurance maximum was reached).</p> <p>Separate coinsurance maximums for In-Network and Out-of-Network services.</p> | <p>Individual coinsurance maximum per calendar year:</p> <p>In-Network: \$5,000 / Out-of-Network: \$10,000</p> <p>Family coinsurance maximum is two times the In-Network / Out-of-Network Individual coinsurance maximum amount</p> | | <p>Individual coinsurance maximum per calendar year:</p> <p>In-Network: \$5,000 / Out-of-Network: \$10,000</p> <p>Family coinsurance maximum is three times the In-Network / Out-of-Network Individual coinsurance maximum amount</p> | | <p>Out-of-Pocket Maximum per calendar year \$3,600 for single coverage on \$1,200 deductible plan \$5,000 for single coverage on \$2,000 and \$3,500 deductible plans \$7,200 for family coverage on \$2,400 deductible plan \$10,000 for family coverage on \$4,000 and \$7,000 deductible plans</p> <p>Family coverage: no one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.</p> | | <p>Out-of-Pocket Maximum per calendar year \$5,000 for single coverage on \$3,000 deductible plan \$5,950 for single coverage on \$5,000 deductible plan \$10,000 for family coverage on \$6,000 deductible plan \$11,900 for family coverage on \$10,000 deductible plan</p> <p>Family coverage: no one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.</p> | | <p>On Regence Evolve Core 2.0 and RealValue, this is the total amount you pay for coinsurance, in addition to the deductible and copays, in a calendar year before the plan covers the full cost (100%) of eligible expenses. For the Regence Evolve HSA 2.0 Plans, the out-of-pocket maximum includes the deductible.</p> |
| Annual Maximum | \$2,000,000 annual maximum | | \$2,000,000 annual maximum | | \$2,000,000 annual maximum | | \$2,000,000 annual maximum | | |
| Network Options | Preferred BlueOption Network, Preferred ValueCare Network or Preferred FocalPoint Network | | Preferred ValueCare Network or Preferred FocalPoint Network | | Preferred BlueOption Network, Preferred ValueCare Network or Preferred FocalPoint Network | | Preferred BlueOption Network, Preferred ValueCare Network or Preferred FocalPoint Network | | Choose a network for In-Network benefits |
| Cost Sharing | <p>Member Responsibility Coinsurance applies after In-Network / Out-of-Network deductible is met and until In-Network / Out-of-Network coinsurance maximum is reached.</p> | | <p>Member Responsibility Coinsurance applies after In-Network / Out-of-Network deductible is met and until In-Network / Out-of-Network coinsurance maximum is reached.</p> | | <p>Member Responsibility Coinsurance applies after deductible is met and until out-of-pocket maximum is reached.</p> | | <p>Member Responsibility Coinsurance applies after deductible is met and until out-of-pocket maximum is reached.</p> | | |
| | In-Network | Out-of-Network (Member may be responsible for any provider costs above the allowed amount) | In-Network | Out-of-Network (Member may be responsible for any provider costs above the allowed amount) | In-Network | Out-of-Network (Member may be responsible for any provider costs above the allowed amount) | In-Network | Out-of-Network (Member may be responsible for any provider costs above the allowed amount) | |
| Office Visits (Injury and Illness) | \$35 copay (In-Network deductible waived) | 25% (Out-of-Network deductible applies) | 35% (In-Network deductible applies) | 50% (Out-of-Network deductible applies) | 20% / 40% | 40% / 50% | 0% | 20% | Copay applies only to the office exam. All other services provided during the visit are subject to the applicable deductible and coinsurance. |
| | First four visits per person per calendar year. After four, then subject to deductible and coinsurance. | | | | | | | | |
| Professional Services Office and inpatient services and supplies. | 30% (In-Network deductible applies) Deductible applies after upfront benefit limits are met. | 45% (Out-of-Network deductible applies) | 35% (In-Network deductible applies) | 50% (Out-of-Network deductible applies) | 20% / 40% | 40% / 50% | 0% | 20% | |
| Preventive Care and Immunizations | 0% (In-Network deductible waived) | 25% (Out-of-Network deductible applies) | 0% (In-Network deductible waived) | 25% (Out-of-Network deductible applies) | 0% (Deductible waived) | 25% (Deductible applies) | 0% (Deductible waived) | 20% (Deductible applies) | Covered according to federal preventive guidelines. |
| Outpatient Radiology and Laboratory | 0% (In-Network deductible waived) | 0% (Out-of-Network deductible waived) | 35% (In-Network deductible applies) | 50% (Out-of-Network deductible applies) | 20% / 40% | 40% / 50% | 0% | 20% | |
| | Deductible is waived and 0% coinsurance for first \$200 per year; then subject to deductible and coinsurance. | | | | | | | | |
| Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies | 30% (In-Network deductible applies) | 45% (Out-of-Network deductible applies) | 35% (In-Network deductible applies) | 50% (Out-of-Network deductible applies) | 20% / 40% | 40% / 50% | 0% | 20% | |
| Maternity Separate routine maternity deductible \$7,500 per pregnancy | 30% (Separate routine maternity deductible applies) | 45% (Separate routine maternity deductible applies) | Excluded, except complications | Excluded, except complications | Excluded, except complications | Excluded, except complications | Excluded, except complications | Excluded, except complications | The maternity deductible for Regence Evolve Core 2.0 is separate from the medical deductible. |
| Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density) | 50% (In-Network deductible applies) | 50% (Out-of-Network deductible applies) | 50% (In-Network deductible applies) | 50% (Out-of-Network deductible applies) | 50% | 50% | 0% | 20% | |
| Emergency Room Services | 30% (In-Network deductible and coinsurance maximum applies) | 30% (In-Network deductible and coinsurance maximum applies) | 35% (In-Network deductible and coinsurance maximum applies) | 35% (In-Network deductible and coinsurance maximum applies) | 20% / 40% | 20% / 40% | 0% | 0% | |
| | \$150 copay per ER visit (waived if directly admitted). | | \$200 copay per ER visit (waived if directly admitted). | | | | | | |
| Prescription Medications | <p>\$10 copay for generics \$3,750 deductible, 50% coinsurance for brand formulary only. Brand formulary tobacco cessation medications not covered.</p> <p>Retail: 30-day supply per copay Mail order: 90-day supply (one copay per 30-day supply) Up to 30-day supply for covered self-administrable injectable medications at retail and mail order</p> | | <p>No deductible \$10 copay for generics 35% coinsurance for brand diabetic drugs and supplies only. No other coverage for brand medications.</p> <p>Retail: 30-day supply per copay Mail order: 90-day supply (one copay per 30-day supply) Up to 30-day supply for covered self-administrable injectable medications at retail and mail order.</p> | | <p>20% coinsurance for generics. 50% coinsurance for brand formulary only. Brand formulary tobacco cessation medications not covered.</p> <p>Subject to medical deductible. Retail or Mail Order: Up to 90 day supply for covered prescription medications.</p> | | <p>0% coinsurance for generics. 50% coinsurance for brand formulary only. Brand formulary tobacco cessation medications not covered.</p> <p>Subject to medical deductible. Retail or Mail Order: Up to 90 day supply for covered prescription medications.</p> | | <p>We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription</p> |

Other Considerations

Waiting Periods There is a 12-month waiting period that must be met before benefits are available for pre-existing conditions. (The pre-existing conditions waiting period does not apply to members up to age 19.) By pre-existing condition, we mean a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the enrollment date of coverage. The exclusion period will end 12 months following your enrollment date of coverage.

If your enrollment date is within 63 days after similar coverage with another insurance carrier ends, we'll credit the time you were covered by the other company to the 12-month pre-existing condition waiting period. We need to receive a copy of your Certificate of Creditable Coverage from your previous insurance carrier in order to apply credits.

Outside the Service Area

Members have the security of knowing they can access Blue Cross and/or Blue Shield (Blue Plan) providers across the country and worldwide through the BlueCard® Program. Policy benefits apply as described above, and members may receive discounts on their services.

This material reflects information available at the time of its preparation. The contents are subject to change in response to further state or federal guidance regarding health care reform requirements.

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. Please refer to the policy for a complete list of benefits, limitations and exclusions.

Optional Benefits: You may add one of these dental plan options to any medical plan for an additional cost. (Optional benefits that are not elected are excluded from coverage.)

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|---|--|
| <p>Dental Option I: Incentive Dental Plan When you incur services less than \$750, you may be rewarded with an additional benefit of \$250 the following year, not to exceed a total benefit of \$1,500 Waiting Periods: Six months for Basic and 12 months for Major Services.</p> | <p>No deductible and 0% for Preventive Services \$50 deductible per calendar year for Basic and Major Services 20% for Basic Services 50% for Major Services</p> |
| <p>Dental Option II: Dollar-Based Dental Plan Coverage is limited to \$750 per calendar-year maximum benefit (Preventive, Basic and Major Services combined). No age limits or frequency limits. Waiting Period: Six months for all covered services.</p> | <p>No deductible 0% for the first \$200 of covered services, then 50% up to the annual maximum</p> |

Limitations and Exclusions

| | Evolve Core 2.0 | RealValue | Evolve HSA 2.0 Plans |
|--|--|--|--|
| Home Health Care | 130 visits per calendar year | 130 visits per calendar year | 130 visits per calendar year |
| Rehabilitative Services | Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year | Inpatient: 5 days per calendar year Outpatient: 15 visits per calendar year | Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year |
| Respite Care | 14 days inpatient/outpatient per lifetime | 14 days inpatient/outpatient per lifetime | 14 days inpatient/outpatient per lifetime |
| Skilled Nursing Facility Care | 30 inpatient days per calendar year | 30 inpatient days per calendar year | 30 inpatient days per calendar year |
| Mental Health and Chemical Dependency Treatment (combined) | Excluded | Excluded | Inpatient: 6 days per calendar year Outpatient: 12 visits per calendar year |

This chart does not contain all limitations and exclusions. Please refer to your policy for a complete list of benefits, limitations and exclusions that apply.

To learn more, please visit regence.com or call 1 (888) REGENCE.