Regence BlueShield of Idaho

Compare Individual and Family Plans

Regence

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

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Which Health Plan Fits You?

Cost Sharing:	Regence Summit℠ *A Comprehensive Health Plan* — Per Member	Regence Summit℠ — Family	Regence NowSelect℠ *A Limited Health Plan* — Per Member	Regence NowSelect℠ — Family	Regence HSA Healthplan *A Health Plan with a Financial Advantage* — Single	Regence HSA Healthplan — Family	What You Should Know
Deductibles	$1,000 per member $2,500 per member $5,000 per member $7,500 per member	No greater than two deductibles to meet the family maximum	$1,000 per member $2,500 per member $5,000 per member $7,500 per member	No greater than two deductibles to meet the family maximum	$1,500 single $2,500 single $3,500 single	$3,000 family $5,000 family $7,000 family	Deductibles are the dollar amount the member pays in a calendar year before the plan pays benefits. Not all benefits apply toward the deductible. Some benefits require a copay or other cost-sharing amount.
Coinsurance	**PPO network:** You pay 20% **Non-PPO network:** You pay 40%		**PPO network:** You pay 20% **Non-PPO network:** You pay 50%		**PPO network:** You pay 20% **Non-PPO network:** You pay 40%		This is the percentage you pay after the deductible on services, unless otherwise stated.
Coinsurance Maximum (Maximum includes PPO and Non-PPO Combined)	You pay $2,000 per member	No greater than three maximums to meet the family maximum	You pay $2,500 per member	No greater than three maximums to meet the family maximum	You pay $5,000 Includes deductible	You pay $10,000	On Regence Summit and NowSelect, this is the total amount you pay for coinsurance, in addition to the deductible, in a calendar year before the plan covers the full cost (100%) of eligible expenses. For the Regence HSA Healthplan, the maximum includes the deductible.
Lifetime Maximum	$2 million per member		$2 million per member		$2 million per member		This is the largest dollar amount we will pay toward all health care services during your lifetime under this plan.
Everyday Needs:							
Physician Office Visits*	$20 copay, no limits per calendar year		$25 copay, six visits per calendar year		Deductible and coinsurance, no limits per calendar year		Copay applies only to the office exam. All other services provided during the visit are subject to the applicable deductible and coinsurance.
Prescription Medications	$10 copay for generics (unlimited), 50% for brand medications, up to $2,000 per calendar year		$10 copay for generics (unlimited), 50% for brand medications, up to $1,200 per calendar year		Deductible and 50% coinsurance, up to $1,200 per calendar year		After you reach the annual limit, you can receive discounts off the full retail price of medications through the Regence Rx discount program. Just show your member ID card at your pharmacy.
Preventive Care*	$20 copay for office visits, all other services coinsurance only, no limits per calendar year		$25 copay for office visits, We pay 100% for routine lab and x-ray, up to $300 per calendar year		Deductible waived, coinsurance only, no limits per calendar year		Includes routine physical exams, lab and X-ray, and well-baby care. **Annual mammogram and gynecological exams do not apply to the calendar-year limits.**
Vision Care	We pay 100% for one exam per year, and up to $100 for hardware		Not Covered		Not Covered		Hardware not subject to deductible. Includes eyeglasses (lenses and frames) and contact lenses.
Special Needs:							
Alternative Care	Deductible and coinsurance, up to $500 per calendar year		Not Covered		Chiropractic services covered, subject to deductible and coinsurance, up to $500 per year		Alternative care includes chiropractic care, acupuncture, naturopathic care, and massage therapy. Benefits are paid after you reach the deductible.
Ambulance	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		No annual limit.
Hospital Services	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		A $100 copay for emergency room visits ($50 on the HSA) is waived if you are admitted to the hospital.
Laboratory and X-ray	Deductible and coinsurance, no annual limits		Deductible and coinsurance outpatient limited to $2,500 per year		Deductible and coinsurance, no annual limits		Limits do not apply to preventive care services.
Maternity Care	Separate $5,000 deductible, coinsurance applies after deductible		Separate $5,000 deductible, coinsurance applies after deductible		Not Covered		The maternity deductible is separate from the medical deductible.
Mental Health and Chemical Dependency	Deductible and 50% coinsurance Mental Health: Limited to $1,500 per year Chemical Dependency: Limited to $1,500 per year		Not Covered		Deductible and 50% coinsurance, Inpatient: 8 days calendar year max, Outpatient: 20 visits calendar year max		Regence Summit includes inpatient and outpatient services combined. For the Regence HSA Healthplan, Mental Health and Chemical Dependency are combined.
Rehabilitation Services	Deductible and coinsurance, Inpatient: No annual limit, Outpatient: $800 per year for each therapy		Not Covered		Deductible and coinsurance, Inpatient: $15,000 per year, Outpatient: $800 per year for each therapy		Outpatient rehabilitation services include occupational, physical, respiratory and speech therapies.
Other Considerations:							
Accidental Death	$25,000 per subscriber/spouse and $5,000 for dependents		Not Covered		Not Covered		Death benefit paid upon the accidental death of a covered family member.
Individual Assistance Program	Four visits per calendar year		Not Covered		Not Covered		Outpatient counseling services available separate from medical benefits.
Provider Networks	Regence PPO Network		Regence PPO Network		Regence PPO Network		What's a network? An organized group of physicians, hospitals, health care professionals and health care facilities. Our provider networks span the entire state of Idaho. Travel outside of Idaho, and you are covered with BlueCard in more than 200 countries around the globe.

*Copays apply to PPO, Non-PPO network services for Summit and NowSelect.
Please note: This is a partial listing of benefits. You can download complete benefit summaries at **www.id.regence.com**. Or, call 1-888-REGENCE.

Regence Now Select-$1000 DED-1-2006
Regence Now Select-$2500 DED-1-2006
Regence Now Select-$5000 DED-1-2006
Regence Now Select-$7500 DED-1-2006

Regence Summit-$1000 DED-7-2007
Regence Summit-$2500 DED-7-2007
Regence Summit-$5000 DED-7-2007
Regence Summit-$7500 DED-7-2007

Reg HSA Healthplan-IND-variable Fam Ded-1-2008
Reg HSA Healthplan-IND-variable Ind Ded-1-2008

Please note: If you are declined coverage or are HIPAA eligible with 18 months of creditable coverage, you may be eligible for your choice of the following High Risk Pool Plans: Basic, Standard, Catastrophic A, Catastrophic B, or the Regence HSA Healthplan. You may also be eligible for any High Risk plan if your insurance carrier refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool Plan. Please contact us for more information.

Limitations and Exclusions

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

	Regence Summit℠	Regence NowSelect℠	Regence HSA Healthplan
Alcoholism and Chemical Dependency Treatment	$1,500 calendar year max. for inpatient and outpatient combined	Excluded	See Mental Health
Alternative Care—including acupuncture, chiropractic, naturopathic, and massage therapy	$500 calendar year max. for all combined	Excluded	Only covers chiropractic $500 calendar year max.
Cosmetic/Reconstructive Surgery	Excluded	Excluded	Excluded
Custodial Care and Rest Cures	Excluded	Excluded	Excluded
Diabetic Education	$400 calendar year max.	$400 calendar year max.	Excluded
Durable Medical Equipment	Not limited	Excluded	Not limited
Eye Exams and Hardware (including frames, lenses, and contacts)	One exam and $100 for hardware each calendar year	Excluded	Excluded
Experimental or Investigational Services and Procedures	Excluded	Excluded	Excluded
Family Planning Services/Supplies—such as infertility treatment, surrogate pregnancy, etc. (except sterilization)	Excluded	Excluded	Excluded
Foot Care (routine)	Excluded	Excluded	Excluded
Hearing Aids	Excluded	Excluded	Excluded
Home Health Care	$5,000 calendar year max.	Excluded	$5,000 calendar year max.
Hospice Care	$5,000 lifetime max.	Excluded	$5,000 lifetime max.
Human Growth Hormone Therapy	$25,000 calendar year max.	Excluded	$25,000 calendar year max.
Lab & X-ray (no limits on inpatient)	Not limited	$2,500 calendar year max.	Not limited
Maternity Care including prenatal, delivery, and routine newborn care (not included for dependent children)	Separate $5,000 deductible	Separate $5,000 deductible	Excluded
Mental Health Treatment (Alcoholism, Chemical Dependency, and Mental Health Combined on the HSA)	$1,500 calendar year max. for inpatient and outpatient combined	Excluded	**Inpatient:** 8 days calendar year max. / **Outpatient:** 20 visits calendar year max.
Medically Unnecessary Services	Excluded	Excluded	Excluded
Obesity or Weight Control	Excluded	Excluded	Excluded
Physician Office Visits	Not limited	6 visits calendar year max.	Not limited
Prescription Medications	**Generic:** Unlimited **Brand:** $2,000 calendar year max.	**Generic:** Unlimited **Brand:** $1,200 calendar year max.	$1,200 calendar year max.
Rehabilitative Care (inpatient)	Not limited	Excluded	$15,000 calendar year max.
Rehabilitative Care (outpatient) Occupational Therapy Physical Therapy Respiratory Therapy Speech Therapy	$800 per calendar year max. per therapy	Excluded	$800 calendar year max. per therapy
Skilled Nursing Facility	30 days calendar year max.	30 days calendar year max.	30 days calendar year max.
TMJ Disorder and Orthognathic Surgery	$2,000 lifetime max.	Excluded	$2,000 lifetime max.
Transplants	$250,000 lifetime max.	$250,000 lifetime max.	$250,000 lifetime max.
Preventive Care			
Routine Immunizations (not for travel)	Not limited	Non-PPO: subject to deductible	Not limited, no deductible
Routine Physical Exams	Not limited	Combined $300 calendar year max.	Not limited, no deductible
Routine Baby and Child Care			
Labs and X-rays (with routine exams)			

A **pre-existing condition** is a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or a pregnancy existing on the effective date of coverage.

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