Comparison of Regence Qualifier Plans and BlueAdvantage $20 Copayment Plans

	CURRENT PLAN	NEW PLAN
	Qualifier Plans	**BlueAdvantage $20 Copay Plans**
Calendar Year Deductible *(Individual/Family)*	No calendar year deductible $250 individual / $750 family $500 individual / $1,500 family $500 individual / $1,000 family $1,000 individual / $2,000 family	$250 individual / $750 family $500 individual / $1,000 family $1,000 individual / $2,000 family
Pharmacy Deductible(s)	Subject to medical deductible $50 individual $100 individual $2,000 individual	No separate pharmacy deductible and not subject to medical deductible
Calendar Year Coinsurance Maximum	$500 individual / $1,000 family $1,000 individual / $2,000 family $1,000 individual / $3,000 family $1,500 individual / $3,000 family $1,750 individual / $3,500 family $2,500 individual / $5,000 family (two individuals must each meet the $2,500) including coinsurance	$2,500 individual / $5,000 family $3,000 individual / $6,000 family $3,500 individual / $7,000 family including medical deductible and coinsurance
Lifetime Maximum Benefit	$1,000,000	$2,000,000
Provider Network	Traditional	ValueCare or Traditional

	Qualifier Plans Your Responsibility (Network Providers)	BlueAdvantage $20 Copay Plans Your Responsibility (Network Providers)
Durable Medical Equipment	20% coinsurance	Same
Emergency Room Services	20% coinsurance; or 20% coinsurance plus $75 copay per visit	20% coinsurance after $75 copay per visit
Hospital Care	20% coinsurance	Same
Maternity Care	$5,000 copay per pregnancy; or All charges that exceed $300, $350, or $400, $450; or You are responsible for all charges	$5,000 copay per pregnancy
Mental Health	50% coinsurance; limited to $1,500 per calendar year	Same
Office Visits	20% coinsurance; or $10 copay per visit	$20 copay per visit; deductible waived

This comparison provides a brief description of health care plan benefits and is not a guarantee of benefit payment. Benefit payments will be made based upon policy provisions and eligibility criteria.

Benefit Summary Code: F

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Prescription Drugs	20% coinsurance; or 20% coinsurance for generic prescription drugs 30% coinsurance for formulary prescription drugs 50% for non-formulary prescription drugs; or $5 copay for generic prescription drugs 25% coinsurance for formulary prescription drugs 50% for non-formulary prescription drugs; or 20% coinsurance, once the plan pays a maximum of $3,000 per calendar, you are responsible for 50% coinsurance	$5 copay for generic prescription drugs 25% coinsurance for formulary prescription drugs 50% coinsurance for non-formulary prescription drugs
Preventive Care	20% coinsurance; limited to $150 or $300 per calendar year; or you are responsible for all charges	$20 copay per visit; limited to $300 per calendar year for adults and children over 6 years of age; deductible waived
Radiology and Lab	20% coinsurance	20% coinsurance
Rehabilitation	20% outpatient coinsurance; no benefit limit; or 50% coinsurance; limited to $1,500 per calendar year, including chiropractic care	20% outpatient coinsurance; limited to $1,500 per calendar year, including chiropractic care

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Benefit Summary Code: F