

**Comparison of Regence ValueCare Plans and
BlueChoices BlueBasic \$30 Copay Plans**

	CURRENT PLAN	NEW PLAN
	ValueCare Plans	BlueBasic \$30 Copay Plans
Calendar Year Deductible <i>(Individual/Family)</i>	\$500 individual / \$1,500 family	\$250 individual / \$750 family \$500 individual / \$1,000 family \$1,000 individual / \$2,000 family
Pharmacy Deductible(s)	\$2,000 separate pharmacy deductible	\$200 separate pharmacy deductible
Calendar Year Coinsurance Maximum	\$1,500 individual / \$3,000 family including coinsurance	\$3,000 individual / \$6,000 family \$4,000 individual / \$8,000 family \$5,000 individual / \$10,000 family including medical deductible and coinsurance
Lifetime Maximum Benefit	\$1,000,000	\$2,000,000
Provider Network	ValueCare	ValueCare or Traditional

	ValueCare Plans Your Responsibility (Network Providers)	BlueBasic \$30 Copay Plans Your Responsibility (Network Providers)
Durable Medical Equipment	20% coinsurance	30% coinsurance
Emergency Room Services	20% coinsurance after \$50 copay per visit	30% coinsurance after \$100 copay per visit
Hospital Care	20% coinsurance	30% coinsurance
Maternity Care	\$5,000 copay per pregnancy	\$5,000 copay per pregnancy
Mental Health	20% coinsurance; limited to \$1,500 per calendar year	50% coinsurance; limited to \$1,500 per calendar year
Office Visits	\$20 copay per visit; or 20% coinsurance	\$30 copay per visit; deductible waived
Prescription Drugs	20% coinsurance for generic prescription drugs; 30% coinsurance for formulary prescription drugs; 50% coinsurance for non-formulary prescription drugs	\$10 copay for generic prescription drugs; 25% coinsurance for formulary prescription drugs; 50% coinsurance for non-formulary prescription drugs
Preventive Care	\$20 copay per visit; or 20% coinsurance; limited to \$150 per calendar year, except for well- child care through age 5	\$30 copay per visit; limited to \$300 per calendar year for adults and children over 6 years of age; deductible waived
Radiology and Lab	No member responsibility; or 20% coinsurance	30% coinsurance
Rehabilitation	20% outpatient coinsurance; limited to \$1,500 per calendar year, including chiropractic care	30% outpatient coinsurance; limited to \$1,500 per calendar year, including chiropractic care

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: P



Regence BlueCross BlueShield of Utah is an independent
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