Regence

	Blue Selections Premier plan	Regence Evolve Plus℠ plan
Calendar Year Deductible	$2500 Individual $7500 Family	$2500 Individual $7500 family
Calendar Year Coinsurance Maximum	$4000 Individual $12000 Family	$5500 Individual $16500 family
Lifetime Maximum Benefit	$2,000,000	$2,000,000
	Your Responsibility (Network Providers)	**Your Responsibility (Network Providers)**
Alcoholism Treatment (inpatient and outpatient combined)	20% coinsurance; $4,500 every 24-consecutive months maximum benefit	20% coinsurance; $4,500 every two calendar years maximum benefit
Emergency Room Services	20% coinsurance; $100 copay (waived if admitted)	20% coinsurance; $100 copay (waived if admitted)
Mental Health	Inpatient: 20% coinsurance; 30 days per calendar year maximum benefit; Outpatient: not covered	20% coinsurance; Inpatient: 6 days per calendar year maximum benefit; Outpatient: 12 visits per calendar year maximum benefit
Medical Office Visits	$20 copay; no deductible; 0% coinsurance	First four medical visits per calendar year no deductible; $25 copay per visit; 0% coinsurance; subsequent visits: deductible and coinsurance
Hospital Services (coverage limitations may apply)	20% coinsurance	20% coinsurance
Prescription Drugs	Generic: $10 copay; no deductible; no limit. Brand: 50% coinsurance; no deductible	Generic: $10 copay. Brand: $500 deductible; 50% coinsurance. $4,500 per calendar year maximum benefit
Preventive Care	$20 copay; no deductible; 0% coinsurance	20% coinsurance; no deductible
Radiology and Lab - Outpatient	20% coinsurance	First $400 per calendar year no deductible (does not apply to preventive care); 0% coinsurance; subsequent services: deductible and coinsurance Complex imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density) 50% coinsurance

Rehabilitation	20% coinsurance; Inpatient: 30 days per calendar year maximum benefit (60 days for head and spinal cord injuries or strokes); Outpatient: 30 sessions per calendar year maximum benefit (60 sessions for head and spinal cord injuries or stroke) (physical, occupational, speech, and audiology therapy services)	20% coinsurance; Inpatient: $8,000 per calendar year maximum benefit; Outpatient: $1,500 per calendar year maximum benefit (physical, occupational and speech therapy)
Skilled Nursing Facility	20% coinsurance; 100 days per stay maximum benefit	20% coinsurance; 30 days per calendar year maximum benefit

BCOR5

This comparison provides a brief description of your current health plan benefits compared to those of the new plan closely matching your current coverage.

*Instructions for the Plan Change Request Form:

1. You do not need to complete this form if you are not making any changes.
2. Please make sure your full name is printed on the top line next to "Policy Holder Name."
3. Please leave "Type of Request" section blank.
4. If you are only adding dental to your new medical plan, check the dental option you wish to include (it is not necessary to reselect your medical plan).
5. Only select a "base plan" choice if you are choosing a Medical plan different than the one you are matched to within this letter.

Please include your Member Identification Number for accurate processing.