

## Comparison of Regence Utah Medical Association Plans and BlueAdvantage \$20 Copay Plans

	<b>CURRENT PLAN</b>	<b>NEW PLAN</b>
	<b>Utah Medical Association Plans</b>	<b>Regence BlueAdvantage \$20 Copay Plans</b>
<b>Calendar Year Deductible</b> <i>(Individual/Family)</i>	No calendar year deductible \$100 individual / \$300 family \$250 individual / \$500 family \$250 individual / \$750 family \$300 individual / \$900 family \$500 individual / \$1,000 family \$500 individual / \$1,500 family \$1,000 individual / \$2,000 family	\$250 individual / \$750 family \$500 individual / \$1,000 family \$1,000 individual / \$2,000 family
<b>Pharmacy Deductible(s)</b>	No separate pharmacy deductible	No separate pharmacy deductible and not subject to medical deductible
<b>Calendar Year Coinsurance Maximum</b>	\$1,000 per member, \$1,500 per member, \$2,000 per member including coinsurance with exceptions	\$4,000 individual / \$8,000 family \$6,500 individual / \$12,000 family \$9,000 individual / \$17,000 family including medical deductible and coinsurance
<b>Lifetime Maximum Benefit</b>	\$1,000,000	\$2,000,000
<b>Provider Network</b>	ValueCare or Traditional	Same

	<b>Utah Medical Association Plans Your Responsibility (Network Providers)</b>	<b>Regence BlueAdvantage \$20 Copay Plans Your Responsibility (Network Providers)</b>
<b>Durable Medical Equipment</b>	20% coinsurance	Same
<b>Emergency Room Services</b>	20% coinsurance; or 20% coinsurance after \$50 or \$75 copay per visit; or no member responsibility after \$50 copay per visit	20% coinsurance after \$75 copay per visit
<b>Hospital Care</b>	No member responsibility after \$200 copay per hospital admit; or 20% coinsurance; or 10% coinsurance, limited to \$1,000 coinsurance maximum	20% coinsurance
<b>Maternity Care</b>	All charges that exceed \$350 or \$500; or 20% coinsurance; or \$5,000 copay per pregnancy; or 10% coinsurance for facility services; limited to \$1,000 coinsurance maximum; or you are responsible for all charges	\$5,000 copay per pregnancy

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: H



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<b>Mental Health</b> including alcohol / drug use / abuse	50% coinsurance; limited to \$1,500 for per calendar year; or 50% coinsurance after \$25 copay per visit; limited to \$1,500 per calendar year; or 20% coinsurance; inpatient limited to \$5,000 and outpatient limited to \$1,500 per calendar year; or 20% coinsurance after \$200 copay per inpatient hospital admit; \$15 copay per visit up to \$1,500 maximum	50% coinsurance; limited to \$1,500 per calendar year
<b>Office Visits</b>	20% coinsurance; or no member responsibility; or \$15 or \$20 copay per visit	\$20 copay per visit; deductible waived
<b>Prescription Drugs</b>	20% coinsurance; or you are responsible for all charges; or 20% coinsurance up to \$3,000 coinsurance maximum, then 50% coinsurance; or \$5 generic copay for prescription drugs \$10 copay or 25% coinsurance for formulary prescription drugs 50% coinsurance for non-formulary prescription drugs	\$5 copay for generic prescription drugs; 25% coinsurance for formulary prescription drugs; 50% coinsurance for non-formulary prescription drugs
<b>Preventive Care</b>	You are responsible for all charges; or 20% coinsurance; or \$15 copay per visit; limited to \$150 or \$300 per calendar year, except for well-child care through age 5	\$20 copay per visit; limited to \$300 per calendar year for adults and children over 6 years of age; deductible waived
<b>Radiology and Lab</b>	20% coinsurance; or \$15 copay per visit	20% coinsurance
<b>Rehabilitation</b>	20% coinsurance; or 50% outpatient coinsurance or \$15 copay per office visit; or outpatient limited to \$1,500 per calendar year, including chiropractic care	20% outpatient coinsurance; limited to \$1,500 per calendar, including chiropractic care

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