

**Regence Utah Medical Association Plans and
BlueBasic 70% / 55% Coinsurance Plans with Major Medical Pharmacy**

	CURRENT PLAN	NEW PLAN
	Utah Medical Association Plans	BlueBasic 70% / 55% Coinsurance Plans
Calendar Year Deductible <i>(Individual/Family)</i>	\$1,000 individual / \$2,000 family \$2,000 individual / \$4,000 family \$2,500 individual / \$5,000 family \$5,000 individual / \$10,000 family	\$2,500 individual / \$5,000 family \$5,000 individual / \$10,000 family \$7,500 individual / \$15,000 family
Pharmacy Deductible(s)	Subject to medical deductible	Same
Calendar Year Coinsurance Maximum	\$1,000 individual / \$2,000 family \$1,000 individual / \$3,000 family \$1,000 individual / \$4,000 family \$2,000 individual / \$4,000 family including coinsurance with exceptions	\$6,000 individual / \$11,000 family \$7,000 individual / \$13,000 family \$10,000 individual / \$18,000 family including medical deductible and coinsurance
Lifetime Maximum Benefit	\$1,000,000	\$2,000,000
Provider Network	Traditional or ValueCare	Same

	Utah Medical Association Plans Your Responsibility (Network Providers)	BlueBasic 70% / 55% Coinsurance 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	20% coinsurance; or \$5,000 copay per pregnancy	\$5,000 copay per pregnancy
Mental Health	Outpatient: 20% coinsurance after \$25 copay per visit; Inpatient: 20% coinsurance for first 7 days then 50% coinsurance; limited to 30 days per calendar year; or 50% coinsurance; limited to \$1,500 per calendar year	50% coinsurance; limited to \$1,500 per calendar year
Office Visits	20% coinsurance	30% coinsurance
Prescription Drugs	20% coinsurance	30% coinsurance
Preventive Care	You are responsible for all charges; or 20% coinsurance; limited to \$150 per calendar year	30% coinsurance; limited to \$300 per calendar year for adults and children over 6 years of age
Radiology and Lab	20% coinsurance	30% coinsurance
Rehabilitation	20% coinsurance; or 50% 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: I



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