

**Comparison of Regence Utah Farm Bureau Plans and
BlueChoices BlueAdvantage \$20 Copay Plans**

	CURRENT PLAN	NEW PLAN
	Utah Farm Bureau Plans	BlueAdvantage \$20 Copay Plans
Calendar Year Deductible <i>(Individual/Family)</i>	\$200 individual / \$600 family \$250 individual / \$500 family \$500 individual / \$1,000 family \$750 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
Pharmacy Deductible(s)	\$100 Individual/\$200 Family \$200 Individual/\$400 Family \$300 Individual/\$600 Family	No separate pharmacy deductible and not subject to medical deductible
Calendar Year Coinsurance Maximum	\$1,000 individual / \$2,000 family \$3,000 individual / \$6,000 family 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	\$1,250,000; or \$2,000,000	\$2,000,000
Provider Network	ValueCare or Traditional	Same

	Utah Farm Bureau 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 \$50 copay per visit	20% coinsurance after \$75 copay per visit
Hospital Care	10% or 20% coinsurance	Same
Maternity Care	\$1,000 or \$1,100 copay per pregnancy; or 20% coinsurance	\$5,000 copay per pregnancy
Mental Health	20% or 25% coinsurance; inpatient limited to \$5,000 per calendar year; outpatient limited to \$1,500 per calendar year	Same
Office Visits	20% coinsurance; or \$15 copay per visit	\$20 copay per visit; deductible waived
Prescription Drugs	20% copay; or 20% for formulary, 50% for non-formulary	\$5 copay for generic prescription drugs; 25% coinsurance for formulary prescription drugs; 50% coinsurance for non-formulary prescription drugs

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: J



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Preventive Care	20% coinsurance; limited to \$150 per calendar year	\$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 copay per visit for minor diagnostic tests; and 20% coinsurance per major diagnostic test
Rehabilitation	No member responsibility; or 50% outpatient 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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