

Comparison of Regence Utah State Bar Plans and BlueAdvantage \$20 Copay Plans

	CURRENT PLAN	NEW PLAN
	Utah State Bar Plans	BlueAdvantage \$20 Copay Plans
Calendar Year Deductible <i>(Individual/Family)</i>	\$300 individual / \$900 family \$500 individual / \$1,000 family \$1,000 individual / \$2,000 family	\$250 individual / \$750 family \$500 individual / \$1,000 family \$1,000 individual / \$2,000 family
Pharmacy Deductible	Subject to medical deductible	No separate pharmacy deductible and not subject to medical deductible
Calendar Year Coinsurance Maximum	\$1,000 individual / \$2,000 family \$1,000 individual / \$3,000 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	\$1,000,000	\$2,000,000
Provider Network	Traditional	ValueCare or Traditional

	Utah State Bar Plans Your Responsibility (Network Providers)	BlueAdvantage \$20 Copay Plans Your Responsibility (Network Providers)
Durable Medical Equipment	20% coinsurance	20% coinsurance
Emergency Room Services	20% coinsurance	20% coinsurance after \$75 copay per visit
Hospital Care	20% coinsurance	20% coinsurance
Maternity Care	All charges that exceed \$250 or \$875; C-section delivery all charges that exceed \$3,000; or You are responsible for all charges, except for C-section delivery, you are responsible for all charges that exceed \$3,000	\$5,000 copay per pregnancy
Mental Health	50% inpatient coinsurance (\$150 maximum per visit or per day); limited to \$5,000 per calendar year; 50% outpatient coinsurance (\$25 maximum per visit or per day); limited to \$1,000 per calendar year	50% coinsurance; limited to \$1,500 per calendar year

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: M



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Office Visits	20% coinsurance	\$20 copay per visit; deductible waived
Prescription Drugs	20% coinsurance	\$5 copay for generic prescription drugs 25% coinsurance for formulary prescription drugs 50% coinsurance for non-formulary prescription drugs
Preventive Care	You are responsible for all charges	\$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	Same
Rehabilitation	20% outpatient coinsurance	20% outpatient coinsurance; limited to \$1,500 per calendar year, including chiropractic care

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