SUMMARY COMPARISON OF UNIVERSITY OF UTAH MEDICARE ADVANTAGE PLAN OPTIONS
January 1, 2021 - December 31, 2021

*This brief summary is meant as an informal comparison of available **Medicare Advantage options** and is not meant to be a complete description of benefits, exclusions and limitations. Please refer to the detailed coverage information provided by each company for specific information on covered services, limitations, and any other contractual conditions. If a discrepancy arises between this information and the actual Plan Document or Evidence of Coverage, the Plan Document or Evidence of Coverage will prevail in all instances.*

Sponsor	**Humana**		**Regence BlueCross BlueShield**				**UnitedHealthcare**		**University of Utah Health Insurance Plans**	
Name of Plan	**Group Medicare Employer Local Preferred Provider Organization (LPPO) 079-082 Rx 413**		**Regence Group Medicare Retiree MedAdvantage + Rx Primary PPO Plan**		**Regence Group Medicare Retiree MedAdvantage + Rx Classic Custom PPO Plan**		**Group Medicare Advantage (PPO)**		**Advantage U - Signature (PPO) provided through University of Utah Health Insurance Plans**	
Contact Number	**(866) 396-8810 / 6 am - 7 pm Monday - Friday**		**Tina Davis (801) 499-9695 or tina@retireehealthsolutions.org**		**Tina Davis (801) 499-9695 or tina@retireehealthsolutions.org**		**(877) 714-0178 / 8 am - 8 pm 7 days a week https://uhcvirtualretiree.com/ra/**		**(855-275-0374) / 8 am - 8 pm daily**	
Monthly Premium	**$0**		**$0**		**$99**		**$0**		**$0**	
Utah Counties in which coverage is available	Counties Available: Davis, Iron, Salt Lake, Utah, Washington and Weber *Please confirm the availability of the plan in your county with customer service; coverage may be available in other states with a monthly premium*		Counties Available: All Medicare-eligible individuals residing anywhere within the United States		Counties Available: All Medicare-eligible individuals residing anywhere within the United States		Counties Available: Davis, Morgan, Salt Lake, Utah, Wasatch, and Weber *Please confirm the availability of the plan in your county with customer service; coverage may be available in other states with a monthly premium*		Counties Available: Davis, Salt Lake, Tooele, Utah, and Weber	
Provider Network	Includes Davis, Jordan Valley, Tanner Clinic, Ogden Clinic and Granger Medical. **Does not include University of Utah Health or MountainStar**		Includes University of Utah Health, IHC, MountainStar, and Steward providers and facilities, and nationwide through Blue Medicare Advantage PPO		Includes University of Utah Health, IHC, MountainStar, and Steward providers and facilities, and nationwide through Blue Medicare Advantage PPO		Includes University of Utah Health, IHC, MountainStar, and Steward providers and facilities, and in select counties throughout the United States		Broad provider network, including all University Health Care, Mountain Star, Steward providers & facilities. Granger, Revere, and many others.	
	In Network	**Out-of-Network**	**In Network**	**Out-of-Network**	**In Network**	**Out-of-Network**	**In Network**	**Out-of-Network**	**In Network**	**Out-of-Network**
Medical Deductible	None	None	$0	$0	$0	$0	None	None	None	None
Plan Year Out-of-Pocket Maximum	$4,900	$10,000	$5,900	$10,000 (in and out of network combined)	$5,500	$10,000 (in and out of network combined)	$4,500	$10,000 (annual combined in and out of network max)	$6,900	$11,300
Covered Services										
	In Network	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network**
Physician – Primary Care	$5	$65	$5	50%	$0	50%	$10 Copay	$35 Copay	$0 Copay	45% Coinsurance
Physician – Specialist	$40	$65	$45	50%	$40	50%	$40 Copay	$60 Copay	$30 Copay	45% Coinsurance
Virtual/Telephone Doctor Visits	$0 for PCP $40 for Specialist	N/A	$5	50%	$0	50%	$0 copay when members use Doctors on Demand and AmWell for virtual doctor visits		$0 Copay PCP $30 Copay Specialist	Not Covered
Annual Routine Physical Exam	$0	50%	$0	50%	$0	50%	$0	40% Coinsurance	$0	45% Coinsurance
Urgent Care Clinic	$15	$65	$45		$40		$35 Copay worldwide		$45 Copay Clinic Visit $0 Copay Virtual Visit	$45 Copay
Emergency Room	$90	$90	$90		$90		$90 Copay worldwide (waived if admitted within 24 hours)		$90 Copay (In and Out-of-Network), waived if admitted.	
Ambulance	$240	$240	$275 (air or ground)		$275 (air or ground)		$150 Copay		$300 Copay	
Inpatient Hospital Services	100% after $343 per day (days 1-4)	100% after $495 per day (days 1-27)	$400 per day 1-4	50%	$350 per day 1-4	50%	$275 Copay per day (days 1 - 6 only); $0 Copay per day after	40% Coinsurance	Days 1-4: $325 / per day Days 5-90: $0	45% Coinsurance
Outpatient Hospital Services	Between $30-$250 or 80%-100% depending on service	50%-80%	$300 ambulatory surgical center $350 hospital	50%	$225 ambulatory surgical center $300 hospital	50%	20% Coinsurance	40% Coinsurance	$325 Copay (Surgery)	45% Coinsurance
Skilled Nursing Facility Care (3-day hospital stay not required)	100% per day (days 1-20); 100% after $160 per day (days 21-100); Plan pays $0 after 100 days	100% after $250 day (days 1-58); 100% per day (days 59-100); Plan pays $0 after 100 days	Days 1-20: $0/day Days 21-100: $167/day (no benefit after 100 days)	Days 1-100: 50% (no benefit after 100 days)	Days 1-20: $0/day Days 21-100: $160/day (no benefit after 100 days)	Days 1-100: 50% (no benefit after 100 days)	$0 Copay days 1 - 20; $184 Copay per additional day up to 100 days	$175 Copay per day up to 100 days	$0 Copay days 1-20, $176 Copay per day, days 21-100; $0 Copay days 100 and beyond	45% Coinsurance
Post-Discharge Meal Delivery	Yes	Yes	$0 cost post discharge 2 meals per day/56 meals maximum for qualified members	N/A	$0 cost post discharge 2 meals per day/56 meals maximum for qualified members	N/A	N/A	N/A	None	None
Vision Services	$40	$65	$0 copay with VSP provider Lenses covered 100%, up to $100 allowed for frames or contact lenses. See Evidence of Coverage for details	50% ($100 allowance for frames or contact lenses) See Evidence of Coverage for details.	$0 copay with VSP provider Lenses covered 100%, up to $100 allowed for frames or contact lenses. See Evidence of Coverage for details	50% ($100 allowance for frames or contact lenses) See Evidence of Coverage for details.	$40 Copay for Routine Eye Exam every 12 months (combined in and out of network) $40 Copay for Medicare-covered Eye Exams $0 Copay for eyewear after cataract surgery	$60 Copay for Routine Eye Exam every 12 months (combined in and out of network) $60 Copay for Medicare-covered Eye Exams $0 Copay for eyewear after cataract surgery	$0 copay eye exam with $120 allowance for glasses/contacts. Some restrictions apply. Plan pays 100% for eyeglasses and contacts following cataract surgery	50% Coinsurance eye exam with $120 allowance for glasses/contacts. Some restrictions apply. Plan pays 100% for eyeglasses and contacts following cataract surgery
Hearing Services	$40	$65	$0 routine hearing exam $699/$999 per aid Copay is for a Standard or Premium hearing aid. Limited to one per ear per year. Benefit limited to TruHearing. Providers	$150 routine hearing exam	$0 routine hearing exam $699/$999 per aid Copay is for a Standard or Premium hearing aid. Limited to one per ear per year. Benefit limited to TruHearing. Providers	$150 routine hearing exam	$0 Copay for Routine Hearing Exam every 12 months (combined in and out of network); $40 Copay for Medicare-covered Hearing Exams. $500 allowance for hearing aid(s) every 3 years through UnitedHealthcare Hearing	$0 Copay for Routine Hearing Exam every 12 months (combined in and out of network); $60 Copay for Medicare-covered Hearing Exams. Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered	$0 Copay Hearing Exam $699-$999 copay for each hearing aid, one per ear per year (TruHearing Advanced or Premium hearing aids only)	$45 Copay Hearing Exam $699-$999 copay for each hearing aid, one per ear per year (TruHearing Advanced or Premium hearing aids only)
Podiatry Services	$40	$65	Specialist copay - $45 Diabetic $0 copay 6 per year	50%	Specialist copay - $40 Diabetic $0 copay 6 per year	50%	$40 copay for Routine Podiatry (Up to 6 visits/plan year) $40 Copay for Medicare-covered Podiatry	$60 copay for Routine Podiatry (Up to 6 visits/plan year) $60 Copay for Medicare-covered Podiatry	$30 Copay	45% Coinsurance

* Payment to an out-of-network provider will be based on the amount a network provider would accept as payment in full. You may be billed by the provider for additional amounts.

SUMMARY COMPARISON OF UNIVERSITY OF UTAH MEDICARE ADVANTAGE PLAN OPTIONS
January 1, 2021 - December 31, 2021

*This brief summary is meant as an informal comparison of available **Medicare Advantage options** and is not meant to be a complete description of benefits, exclusions and limitations. Please refer to the detailed coverage information provided by each company for specific information on covered services, limitations, and any other contractual conditions. If a discrepancy arises between this information and the actual Plan Document or Evidence of Coverage, the Plan Document or Evidence of Coverage will prevail in all instances.*

Sponsor	Humana		Regence BlueCross BlueShield				UnitedHealthcare		University of Utah Health Insurance Plans	
Name of Plan	Group Medicare Employer Local Preferred Provider Organization (LPPO) 079-082 Rx 413		Regence Group Medicare Retiree MedAdvantage + Rx Primary PPO Plan		Regence Group Medicare Retiree MedAdvantage + Rx Classic Custom PPO Plan		Group Medicare Advantage (PPO)		Advantage U - Signature (PPO) provided through University of Utah Health Insurance Plans	
Covered Services (Cont.)										
	In Network	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network**
Dental Services	$40	$65	Preventive dental: two routine cleanings per year covered 100% (no $ maximum)	50%	Preventive dental: two routine cleanings per year covered 100% (no $ maximum) Comprehensive dental: 50% coinsurance up to $1,000 annual maximum Including: Class II: Fillings, endodontics, periodontics, oral surgeryClass III: Crowns, dentures, bridges, implants No waiting period	50%	$40 Copay (Medicare-covered services only)	$60 Copay (Medicare-covered services only)	Preventive - $0 copay Comprehensive - $1000 benefit coverage limit for combined in-network and out-of-network services coverage includes Extractions, Restorative, Periodontics	Preventive - $0 copay Comprehensive - $1000 benefit coverage limit for combined in-network and out-of-network services coverage includes Extractions, Restorative, Periodontics
Mental Health Services - Inpatient	100% after $343 per day (days 1-4)	100% after $495 per day (days 1-27)	Inpatient: $400 copay per day for days 1-4; 190-day lifetime maximum	50%; 190-day lifetime maximum	Inpatient: $350 copay per day for days 1-4; 190-day lifetime maximum	50%; 190-day lifetime maximum	$175 Copay per day (days 1 - 8 only); $0 Copay per day (days 9 - 190) 190-day lifetime maximum	40% Coinsurance per day (days 1 - 190) 190-day lifetime maximum	Days 1-4: $325 Days 5-90 $0 Prior Authorization Required	45% Coinsurance
Mental Health Services - Outpatient	80%	50%	$5/$40 copay depending on type of provider	50%	$0/$40 copay depending on type of provider	50%	$40 Copay per individual visit; $10 Copay per group visit; $55 Copay per day of Partial Hospitalization	$60 Copay per individual visit; $35 Copay per group visit; $55 Copay per day of Partial Hospitalization	$30 Copay	45% Coinsurance
Chemical Dependency Services	$40	$65	Inpatient: $400 copay per day for days 1-4; 190-day lifetime maximum Outpatient: $5/$45 copay depending on type of provider	Inpatient: 50%; 190-day lifetime maximum Outpatient: 50%	Inpatient: $350 copay per day for days 1-4; 190-day lifetime maximum Outpatient: $0/$40 copay depending on type of provider	Inpatient: 50%; 190-day lifetime maximum Outpatient: 50%	$40 Copay per individual visit; $10 Copay per group visit; $55 Copay per day of Partial Hospitalization	$60 Copay per individual visit; $35 Copay per group visit; $55 Copay per day of Partial Hospitalization	$30 Copay	45% Coinsurance
Gym Membership / Fitness Benefits	Yes	Yes	Free Gym Membership through Silver&Fit		Free Gym Membership through Silver&Fit		$0 membership fee - Fitness program through Renew Active		Silver&Fit and available Home edition	Silver&Fit and available Home edition
Other Benefits	See plan documentation	See plan documentation	Chiropractic - $20 copay 18 visits per year Physical, Occupational, and Speech Therapy - $30	Chiropractic - 50% Physical, Occupational, and Speech Therapy - 50%	Chiropractic - $20 copay 24 visits per year Physical, Occupational, and Speech Therapy - $25	Chiropractic - 50% Physical, Occupational, and Speech Therapy - 50%	24/7 NurseLine HouseCalls Renew (member-only Health & Wellness Experience) Programs for people with chronic or complex health needs		OTC, Member Rewards	See plan documentation
Foreign Travel Emergency Services	N/A	100% after $90 (limited to Medicare-covered emergency services)	Emergency $90 copay (waived if admitted within 48 hours)		Emergency $90 copay (waived if admitted within 48 hours)		Worldwide coverage for emergency department services. Worldwide coverage for urgently needed services.		Worldwide coverage for emergency room and urgent care.	
Prescription Medication Coverage										
	Included in Plan		**Included in Plan**		**Included in Plan**		**Included in Plan**		**Included in Plan**	
	30-Day Retail	**90-Day Mail Order**	**30-Day Supply Retail or Mail Order (3 months Supply Retail or Mail Order: Tiers 1 and 2: 2x Copay, Tier 3: 2.5x copay, and 4: Coinsurance)**		**30-Day Supply Retail or Mail Order (3 months Supply Retail or Mail Order: Tiers 1 and 2: 2x Copay, Tier 3: 2.5x Copay, Tier 4: Coinsurance)**		**30-Day Retail**	**90-Day Mail Order**	**30-Day Retail**	**90-Day Mail Order**
Deductible	$150 (Tier 1 is excluded from deductible)		$0 Ded. Tiers 1 & 2 $200 Ded. Tiers 3, 4 & 5		$0		$0		$200 (Tier 3-5 only)	$200 (Tier 3-5 only)
Initial Coverage Limit (Deductible to $4,130 total paid by member and plan)	Tier 1: $2 Tier 2: $47 Tier 3: $100 Tier 4: 30%	Tier 1: $0 Tier 2: $131 Tier 3: $290 Tier 4: NA	Prefered Pharmacy / Standard Pharmacy Tier 1 (Preferred Generics): $3 / $10 Tier 1 (Preferred Generics) mail order: $0 Tier 2 (Generics): $13 / $20 Tier 3 (Preferred Brand): $40 / $47 Tier 4 (Non-preferred): 40% / 45% Tier 5 (Specialty): 29%		Tier 1 (Preferred Generics): $5 Tier 2 (Generics): $15 Tier 3 (Preferred Brand): $45 Tier 4 (Non-preferred): 40% Tier 5 (Specialty):33%		Tier 1: $15 Tier 2: $15 Tier 3: $47 Tier 4: $100 Tier 5: $100	Tier 1: $30 Tier 2: $30 Tier 3: $94 Tier 4: $200 Tier 5: $200	Tier 1: $3 Tier 2: $10 Tier 3: $47 Tier 4: $100 Tier 5: 29%	Tier 1: $0 Tier 2: $20 Tier 3: $141 Tier 4: $300 Tier 5: 29%
Coverage Gap (after $4,130 total paid by member and plan)	Tier 1: 25% Tier 2: 25% Tier 3: 25% Tier 4: 25%	Tier 1: 25% Tier 2: 25% Tier 3: 25% Tier 4: N/A	25% Generics 25% Brand		Tier 1 (Preferred Generics): $5 Tier 2 (Non-preferred Generics): $15 Tier 3 (Preferred Brand-Name): $45 or 25% of drug cost if lower than Tier 1-3 copays Tier 4 (Non-preferred Brand-Name): 25% Tier 5 (Specialty):25%		Minimum CMS Coverage After your total drug costs reach $4,130 you pay 25% of the price (plus dispensing fee) for brand names drugs and 25% of the price for generic drugs.		25% Generics 25% Brand	
Catastrophic Level (after member out-of-pocket costs reach $6,550 total)	Greater of $3.70 for generic/multiple source drugs ($9.20 for all others) or 5% coinsurance		Greater of $3.70 for generic/multiple source drugs ($9.20 for all others) or 5% coinsurance		Greater of $3.70 for generic/multiple source drugs ($9.20 for all others) or 5% coinsurance		Greater of $3.70 for generic/multiple source drugs ($9.20 for all others) or 5% coinsurance		Greater of $3.70 for generic/multiple source drugs ($9.20 for all others) or 5% coinsurance	

This summary is provided for informational purposes only. The exact details of coverage are included in the legal plan documents that govern each plan. If there is any discrepancy between this comparison and the plan documents, the plan documents govern.

* Payment to an out-of-network provider will be based on the amount a network provider would accept as payment in full. You may be billed by the provider for additional amounts.