SUMMARY COMPARISON OF UNIVERSITY OF UTAH MEDICARE ADVANTAGE PLAN OPTIONS
January 1, 2023 - December 31, 2023

*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.*

Name of Plan	**Regence Group Medicare Retiree MedAdvantage + Rx Primary PPO Plan**		**Regence Group Medicare Retiree MedAdvantage + Rx Classic Custom PPO Plan**		**United HealthCare Group Medicare Advantage (PPO)**		**Advantage U - Signature (PPO) provided through University of Utah Health Insurance Plans**	
Contact	**Tina Perini (385) 489-1313 or tina@retireehealthsolutions.org**		**Tina Perini (385) 489-1313 or tina@retireehealthsolutions.org**		**(877) 714-0178 / 8am - 8pm daily https://uhcvirtualretiree.com/ra/**		**(855) 275-0374 / 8 am - 8 pm daily or Steve Bithell (801) 792-3268 Steve.Bithell@utah.edu**	
Monthly Premium	**$0**		**$69**		**$0**		**$0**	
Utah Counties in which coverage is available	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: Box Elder, Cache, Davis, Iron, Morgan, Salt Lake, Summit, Utah, Wasatch, 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: Davis, Salt Lake, Tooele, Utah, and Weber	
Provider Network	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, **Intermountain Healthcare (IHC) new for 2023**, 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**
Medical Deductible	$0	$0	$0	$0	None	None	None	None
Plan Year Out-of-Pocket Maximum	$5,900	$8,950 (in and out of network combined)	$5,500	$8,950 (in and out of network combined)	$4,500	$10,000 (annual combined in and out of network max)	$6,100	$11,300
Covered Services								
	In Network	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network**
Physician – Primary Care	$0	30%	$0	30%	$5 Copay	$35 Copay	$0 Copay	$0 Copay
Physician – Specialist	$40	30%	$35	30%	$30 Copay	$55 Copay	$25 Copay	$25 Copay
Virtual/Telephone Doctor Visits	$0	30%	$0	30%	$5 Copay	$35 Copay	$0 Copay PCP $25 Copay Specialist	Not Covered
Annual Routine Physical Exam	$0	30%	$0	30%	$0	40% Coinsurance	$0	$0
Urgent Care Clinic	$45		$40		$35 Copay worldwide (waived if admitted within 24 hours)		$45 Copay Clinic Visit $0 Copay Virtual Visit	$45 Copay
Emergency Room	$90		$90		$90 Copay worldwide (waived if admitted within 24 hours)		$90 Copay (In and Out-of-Network) waived if admitted	
Ambulance	$275 (air or ground)		$275 (air or ground)		$150 Copay		$235 Copay	
Inpatient Hospital Services	$400 per day 1-4	30%	$350 per day 1-4	30%	$275 Copay per day (days 1 - 6 only); $0 Copay after	40% Coinsurance	Days 1-4: $280 / per day Days 5-90: $0	45% Coinsurance
Outpatient Hospital Services	$300 ambulatory surgical center $350 hospital	30%	$225 ambulatory surgical center $300 hospital	30%	20% Coinsurance	40% Coinsurance	$325 Copay (Surgery)	45% Coinsurance
Skilled Nursing Facility Care (3-day hospital stay not required)	$0 copay per day for days 1 – 20 $188 copay per day for day 21 – 53 $0 copay per day for day 54– 100 (no benefit after 100 days)	Days 1-100: 30% (no benefit after 100 days)	$0 copay per day for days 1 – 20 $188 copay per day for day 21 – 51 $0 copay per day for day 52– 100 (no benefit after 100 days)	Days 1-100: 30% (no benefit after 100 days)	$0 Copay days 1 - 20; $196 Copay per additional day up to 100 days	$175 Copay per day up to 100 days	$0 Copay days 1-20, $196 Copay per day, days 21-100	45% Coinsurance
Post-Discharge Meal Delivery	$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	$0 copay for up to 30 days after each inpatient and SNF discharge: 28 home-delivered meals from Mom's Meals when referred by a UnitedHealthcare Engagement Specialist.	$0 copay for up to 30 days after each inpatient and SNF discharge: 28 home-delivered meals from Mom's Meals when referred by a UnitedHealthcare Engagement Specialist.	None	None
Vision Services	$0 copay with VSP provider Lenses covered 100%, up to $100 allowed for frames or contact lenses. See Evidence of Coverage for details	30% routine exam 50% lenses ($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	30% routine exam 50% lenses ($100 allowance for frames or contact lenses) See Evidence of Coverage for details	$0 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	$0 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	$0 routine hearing exam $699/$999 per aid Copay is for an Advanced 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 an Advanced 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 through providers other than UnitedHealthcare Hearing are not covered	$0 Copay Routine Hearing Exam $699-$999 copay for each hearing aid, one per ear per year (TruHearing Advanced or Premium hearing aids only)	$45 Copay Routine Hearing Exam $699-$999 copay for each hearing aid, one per ear per year (TruHearing Advanced or Premium hearing aids only)
Podiatry Services	Specialist copay - $40 Routine Diabetic copay - $0 (6 per year)	30%	Specialist copay - $40 Routine Diabetic copay - $0 (6 per year)	30%	$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	$25 Copay	$25 Copay

* 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.

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Covered Services (Cont.)								
	In Network	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network***	**In Network**	**Out-of-Network**
Dental Services	Preventive dental: two routine cleanings per year covered 100% (no $ maximum)	30%	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	30%	$40 Copay (Medicare-covered services only)	$60 Copay (Medicare-covered services only)	Preventive - $0 copay Comprehensive - $1500 benefit coverage limit for combined in-network and out-of-network services coverage includes Extractions, Restorative, Periodontics, Implants and Crowns	Preventive - $0 copay Comprehensive - $1500 benefit coverage limit for combined in-network and out-of-network services coverage includes Extractions, Restorative, Periodontics, Implants and Crowns
Mental Health Services - Inpatient	Inpatient: $400 copay per day for days 1-4; 190-day lifetime maximum for psychiatric hospital facility	30%; 190-day lifetime maximum for psychiatric hospital facility	Inpatient: $350 copay per day for days 1-4; 190-day lifetime maximum for psychiatric hospital facility	30%; 190-day lifetime maximum for psychiatric hospital facility	$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: $280 Days 5-90 $0 Prior Authorization Required	45% Coinsurance
Mental Health Services - Outpatient	$0/$30 copay depending on type of provider	30%	$0/$25 copay depending on type of provider	30%	$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	$10 Copay	$10 Copay
Chemical Dependency Services	Inpatient: $400 copay per day for days 1-4 Outpatient: $0/$30 copay depending on type of provider	30%	Inpatient: $350 copay per day for days 1-4 Outpatient: $0/$25 copay depending on type of provider	30%	$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	$25 Copay	$25 Copay
Gym Membership / Fitness Benefits	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	Chiropractic - $20 copay, 18 visits per year Physical, Occupational, and Speech Therapy - $30 copay $0 cost with Papa Pals, 48 hours per year (including transportation)	Chiropractic - 30% Physical, Occupational, and Speech Therapy - 30%	Chiropractic - $20 copay, 24 visits per year Physical, Occupational, and Speech Therapy - $25 copay $0 cost with Papa Pals, 48 hours per year (including transportation)	Chiropractic - 30% Physical, Occupational, and Speech Therapy - 30%	24/7 NurseLine HouseCalls Renew (member-only Health & Wellness Experience) Programs for people with chronic or complex health needs		OTC, Member Rewards, In-Home Support Services	See plan documentation
Foreign Travel 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 and 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**	
	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**	**100-Day Mail Order**
Deductible	$0 Ded. Tiers 1 & 2 $0 Ded. Tiers 3 & 4 insulin $200 Ded. Tiers 3, 4 & 5		$0		$0		$125 (Tier 3-5 only)	$125 (Tier 3-5 only)
Initial Coverage Limit (Deductible to $4,660 total paid by member and plan)	Prefered Pharmacy / Standard Pharmacy Tier 1 and Tier 2 mail order: $0 Tier 1 (Preferred Generics): $0 / $10 Tier 2 (Generics): $13 / $20 Tier 3 (Preferred Brand): $40 / $47 Tier 4 (Non-preferred): $100 Tier 5 (Specialty): 29% Tier 3 and Tier 4 insulin: $35 (deductible waived)		Tier 1 (Preferred Generics): $5 Tier 2 (Generics): $15 Tier 3 (Preferred Brand): $45 Tier 4 (Non-preferred): $100 Tier 5 (Specialty):33% Tier 3 and Tier 4 insulin: $35 (deductible waived)		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% You won't pay more than $35 for a one-month supply of any insulin covered by our plan. For Select Insulins, $28 copay for a one-month supply. Applies even if you haven't paid your deductible.	Tier 1: $0 Tier 2: $20 Tier 3: $141 Tier 4: $300 Tier 5: 29% You won't pay more than $35 for a one-month supply of any insulin covered by our plan. For Select Insulins, $28 copay for a one-month supply. Applies even if you haven't paid your deductible.
Coverage Gap (after $4,660 total paid by member and plan)	Tier 3 and Tier 4 insulin: $35 25% Generics 25% Brand		Tier 1 (Preferred Generics): $5 Tier 2 (Non-preferred Generics): $15 Tier 3 and Tier 4 insulin: $35 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 $4,660 you pay 25% of the price (plus dispensing fee) for brand name drugs and 25% of the price for generic drugs.		25% Generics 25% Brand	
Catastrophic Level (after member out-of-pocket costs reach $7,400 total)	Greater of $4.15 for generic/multiple source drugs ($10.35 for all others) or 5% coinsurance		Greater of $4.15 for generic/multiple source drugs ($10.35 for all others) or 5% coinsurance		Greater of $4.15 for generic/multiple source drugs ($10.35 for all others) or 5% coinsurance		Greater of $4.15 for generic/multiple source drugs ($10.35 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.

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