**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, exclusions, and other contractual conditions. If in any uncertainty exists between this information and the actual Plan Document or Evidence of Coverage, the Plan Document or Evidence of Coverage will prevail in all respects.

### Name of Plan
- **Regence Group Medicare Retirees Medicare Advantage + Rx Primary Plan**
- **Regence Group Medicare Retirees Medicare Advantage + Rx Classic Custom Plan**
- **UnitedHealthCare Group Medicare Advantage (PPO)**
- **Advantage U - Signature (PPO)**

#### Contact
- Tina Perini (385) 489-1513 or tina@retireehealthsolutions.org
- Tina Perini (385) 489-1513 or tina@retireehealthsolutions.org
- (877) 714-0178 / 8 am - 8 pm daily
- Steve Bithell (801) 792-3268

#### Monthly Premium
- $0
- $5
- $0
- $0

#### Provider Network
- Includes University of Utah Health, (HC), MountainStar, and TruHearing advanced providers and facilities, and nationwide through Blue Medicare Advantage PPO
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- Includes University of Utah Health, (HC), MountainStar, and TruHearing advanced providers and facilities, and in select countries throughout the United States
- Broad provider network, including all University Health Care, Intermountain Healthcare (HC) new for 2023, Mountain Stay, TruHearing providers & facilities, GingerRen,旅行er, and many others

#### Covered Services

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<tbody>
<tr>
<td>Name of Plan</td>
<td>$5,500</td>
<td>$5,095 (in and out of network combined)</td>
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<td>$10,000 (in and out of network max)</td>
<td>$6,100</td>
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#### Physician – Primary Care
- **In Network**
  - $0
  - 30%

- **Out-of-Network**
  - $5 Copay
  - 30%
  - $80 Copay
  - 35%

#### Physician – Specialist
- **In Network**
  - $40

- **Out-of-Network**
  - $50

#### Physical Therapy Services
- **In Network**
  - $30

- **Out-of-Network**
  - $50

#### Urgent Care Clinic
- **In Network**
  - $45

- **Out-of-Network**
  - $40

#### Skilled Nursing Facility Care (3-day hospital stay not required)
- **In Network**
  - $200 per day for days 1 - 20
  - $125 Copay per day for days 21 - 50
  - $60 Copay per day for days 51 - 100

#### Post-Discharge Meal Delivery
- **In Network**
  - $0

- **Out-of-Network**
  - $10 Copay worldwide

#### Vision Services
- **In Network**
  - $0 copay with VSP provider
  - $10 copay for Routine Eye Exam (Up to 12 months combined in and out of network)

#### Hearing Services
- **In Network**
  - $0 routine hearing exam
  - $149 routine hearing exam

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### Notes
- Payments to out-of-network providers 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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<tr>
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<th>Regence Group Medicare Retiree Medigap + Rx Primary PPO Plan</th>
<th>Regence Group Medicare Retiree Medigap + Rx Classic Custom PPO Plan</th>
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<th>Advantage U - Signature (PPO) provided through University of Utah Health Insurance Plans</th>
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<tbody>
<tr>
<td><strong>In Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>In Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>In Networks</strong></td>
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<td><strong>Preventive Services</strong></td>
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<tr>
<td>Dental Services</td>
<td>Preventive dental: Two routine cleanings per year (covered 100%) (to $5 maximum)</td>
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<td>Comprehensive dental: 50% co-pay up to $1,000 annual maximum (including Class II fillings, extractions, periodontics, oral surgery, Class III, IV fillings, bridges, implants)</td>
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<td>$490 Copay (Medicare covered services only)</td>
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<td><strong>Mental/Health Services - Inpatient</strong></td>
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<td></td>
<td>Inpatient: $400 Copay (out of pocket) for days 1-4</td>
<td>Inpatient: $400 Copay (out of pocket) for days 1-4</td>
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<td>100% of Medicare maximum for psychiatric hospital facility</td>
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<td></td>
<td>Tier 3: $141</td>
<td>Tier 3: $141</td>
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<td>Tier 5: 29%</td>
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<td>$415 Copay per individual visit</td>
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<td>Tier 3 and Tier 4 insulin: $35 (deductible waived)</td>
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<td><strong>Foreign Travel/Emergencies</strong></td>
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<td>Emergency $90 copay (waived if admitted within 48 hours)</td>
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<td>Worldwide coverage for emergency department services and worldwide coverage for urgent needed services</td>
<td>Worldwide coverage for emergency room and urgent care.</td>
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### Prescription/Medication Coverage

| Deductible | | | | | |
| 0/0/0 | | | | | |
| 0/0/0 (Tiers 1 and 2) | | | | | |
| 0/0/0 (Tiers 3, 4 and 5) | | | | | |

### Initial Coverage Limit

### Minimum CDs Coverage

### Catastrophic Level

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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