## SUMMARY COMPARISON OF UNIVERSITY OF UTAH MEDICARE ADVANTAGE PLAN OPTIONS

January 1, 2023 - December 31, 2023

### Plan Options

<table>
<thead>
<tr>
<th>Name of Plan</th>
<th>Regence Group Medicare Retiree MedAdvantage + Rx Primary PPO Plan</th>
<th>Regence Group Medicare Retiree MedAdvantage + Rx Classic Custom PPO Plan</th>
<th>UnitedHealthCare Group Medicare Advantage PPO</th>
<th>Advantage U - Signature (PPO) provided through University of Utah Health Insurance Plans (Discontinued on 12/31/2023)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact</strong></td>
<td>Tina Perini (801) 488-1131 or <a href="mailto:tinaperini@healthcare.utah.edu">tinaperini@healthcare.utah.edu</a></td>
<td>Tina Perini (801) 488-1131 or <a href="mailto:tinaperini@healthcare.utah.edu">tinaperini@healthcare.utah.edu</a></td>
<td>(877) 714-0178 / 8 am - 8 pm daily</td>
<td>(801) 273-4714 / 8 am - 8 pm daily or <a href="mailto:Steve.Bithell@utah.edu">Steve.Bithell@utah.edu</a> (801) 750-2598 <a href="mailto:Steve.Bithell@utah.edu">Steve.Bithell@utah.edu</a></td>
</tr>
<tr>
<td><strong>Health Plan</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Provider Network</strong></td>
<td>Includes University of Utah Health, HCI, MountainStar, and Steward providers and facilities, and nationwide through Blue Medicare Advantage PPO</td>
<td>Includes University of Utah Health, HCI, MountainStar, and Steward providers and facilities, and nationwide through Blue Medicare Advantage PPO</td>
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<td>Broad provider network, including all University Health Care, Intermountain Healthcare (HCI) new the DBS, Mountain Star, Steward providers &amp; Doctors, Granger, Rexwet, and many others.</td>
</tr>
</tbody>
</table>

### Covered Services

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician - Primary Care</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Physician - Specialist</strong></td>
<td>$40</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Oral Health/Dental</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$41</td>
<td>$41</td>
<td>$41</td>
<td>$41</td>
<td>$41</td>
<td>$41</td>
<td>$41</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>$405/day</td>
<td>$405/day</td>
<td>$405/day</td>
<td>$405/day</td>
<td>$405/day</td>
<td>$405/day</td>
<td>$405/day</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td>$280 to $285 per day</td>
<td>$280 to $285 per day</td>
<td>$280 to $285 per day</td>
<td>$280 to $285 per day</td>
<td>$280 to $285 per day</td>
<td>$280 to $285 per day</td>
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</tr>
<tr>
<td><strong>Post-Discharge Meal Delivery</strong></td>
<td>$20 per meal (in and out of network combined)</td>
<td>$20 per meal (in and out of network combined)</td>
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<td>$20 per meal (in and out of network combined)</td>
</tr>
<tr>
<td><strong>Optometry Services</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td>$0 per exam</td>
<td>$0 per exam</td>
<td>$0 per exam</td>
<td>$0 per exam</td>
<td>$0 per exam</td>
<td>$0 per exam</td>
<td>$0 per exam</td>
</tr>
<tr>
<td><strong>Nursing Services</strong></td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
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</table>

* 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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**Medical Deductible**

- **In Network:** $0
- **Out-of-Network:** $0

**Copay Per Day**

- **In Network:** $0
- **Out-of-Network:** $0

**Annual Routine Doctor Visits**

- **In Network:** $0 (6 per year)
- **Out-of-Network:** $188 copay per day

**Medicare-covered Eye Exam every 12 months (combined in and out of network)**

- **In Network:** None
- **Out-of-Network:** $45 copay for Routine Specialist.

**Annual Routine Physical Exam**

- **In Network:** None
- **Out-of-Network:** $45 copay for Routine Specialist.

**Inpatient Hospital Services**

- **In Network:** $405 per day (waived if admitted within 24 hours)
- **Out-of-Network:** $10,000 (annual max)

**Skilled Nursing Facility Care**

- **In Network:** $10,000 per year (in and out of network)
- **Out-of-Network:** $10,000 per year (in and out of network)

**Out-of-Network Services**

- **In Network:** None
- **Out-of-Network:** $325 Copay (Surgery)

**Post-Discharge Meal Delivery**

- **In Network:** $20 per meal (in and out of network)
- **Out-of-Network:** $20 per meal (in and out of network)

**Optometry Services**

- **In Network:** None
- **Out-of-Network:** None

**Hearing Services**

- **In Network:** None
- **Out-of-Network:** $0 per exam

**Emergency Room**

- **In Network:** $0
- **Out-of-Network:** $0

**Inpatient Hospital Services**

- **In Network:** $405 per day
- **Out-of-Network:** $405 per day

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**Provider Network**

- **In Network:** Includes University of Utah Health, HCI, MountainStar, and Steward providers and facilities, and nationwide through Blue Medicare Advantage PPO
- **Out-of-Network:** Includes University of Utah Health, HCI, MountainStar, and Steward providers and facilities, and nationwide through Blue Medicare Advantage PPO
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**Contact Information**

- **Tina Perini:** (801) 488-1131 or tinaperini@healthcare.utah.edu
- **Steve Bithell:** (801) 792-3268 or Steve.Bithell@utah.edu

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**Notes**

- This summary is meant as an informational 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 of Evidence of Coverage, the Plan Document or Evidence of Coverage will prevail in all instances.
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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<tr>
<td>In Network</td>
<td>Out-of-Network*</td>
<td>In Network</td>
<td>Out-of-Network*</td>
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**Dental Services**
- Preventive dental: two routine cleanings per year covered 100% (no $ maximum)
- Comprehensive: 50% (comprehensive up to $1,000 annual maximum including Class II fillings, endodontics, periodontics, oral surgery/Class III Crowns, dentures, bridges, implants. No waiting period.
- $450 Copay (Medicare covered services only)
- $600 Copay (Medicare covered services only)

**Mental Health Services - Inpatient**
- Inpatient: $430 copay per day for days 1-4
- Outpatient: $50 copay per day depending on type of provider

**Mental Health Services - Outpatient**
- Outpatient: $50 copay per day for days 1-4

**Chemical Dependence Services**
- Outpatient: $50 copay per day for days 1-4

**Coop Membership/ Fitness Benefits**
- Free Gym Membership through SilverFitness

**Other Benefits**
- Chiropractic: $20 copay, 10 visits per year
- Physical, Occupational, and Speech Therapy: $30 copay

**Foreign Travel/ Emergency Services**
- Emergency $80 copay (waived if admitted within 48 hours)
- Worldwide coverage for emergency department services and worldwide coverage for urgently needed services

**Description of Medicaid Coverage**
- In 30-Day Retail or Mail Order (3 months Supply Retail or Mail Order: Tiers 1 and 2, 2.5x Copay, Tier 3: 2.6x Copay, Tier 4: 4x Copay)
- In 30-Day Retail or Mail Order (3 months Supply Retail or Mail Order: Tiers 1 and 2, 2.6x Copay, Tier 3: 2.6x Copay, Tier 4: 4x Copay)
- In 30-Day Retail or Mail Order (30-Day Mail Order)
- In 180-Day Mail Order

**Initial Coverage Limit Deductible to $4,900** (full paid by member and plan)

**Coverage Gap** (after $4,900 total paid by member and plan)

**Catastrophic Level** (after member total out-of-pocket costs reach $1,420,000)
- Greater of $1,450 for generic/multiple source drugs ($1,675 for all others) or 50% coverage
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