SUMMARY COMPARISON OF UNIVERSITY OF UTAH MEDICARE ADVANTAGE PLAN OPTIONS
January 1, 2024 - December 31, 2024

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)**	
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/**	
Monthly Premium	**$0**		**$82**		**$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*	
Provider Network	Includes University of Utah Health, Intermountain Health, MountainStar, and Holy Cross providers and facilities, and nationwide through Blue Medicare Advantage PPO		Includes University of Utah Health, Intermountain Health, MountainStar, and Holy Cross providers and facilities, and nationwide through Blue Medicare Advantage PPO		Includes University of Utah Health, Intermountain Health and Holy Cross providers and facilities, and in select counties throughout the United States	
	In Network	**Out-of-Network**	**In Network**	**Out-of-Network**	**In Network**	**Out-of-Network**
Medical Deductible	$0	$0	$0	$0	$0	$0
Plan Year Out-of-Pocket Maximum	$6,700	$13,300 (in and out of network combined)	$5,900	$9,550 (in and out of network combined)	$4,500	$10,000 (annual combined in and out of network max)
Covered Services						
	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
Physician – Specialist	$45	30%	$35	30%	$30 Copay	$55 Copay
Virtual/Telephone Doctor Visits	$0	30%	$0	30%	$5 Copay	$35 Copay
Annual Routine Physical Exam	$0	30%	$0	30%	$0	40% Coinsurance
Urgent Care Clinic	$45		$40		$35 Copay worldwide (waived if admitted within 24 hours)	
Emergency Room	$100		$120		$90 Copay worldwide (waived if admitted within 24 hours)	
Ambulance	$300 (air or ground)		$275 (air or ground)		$150 Copay	
Inpatient Hospital Services	$410 per day 1-5	30%	$375 per day 1-5	30%	$275 Copay per day (days 1 - 6 only)	40% Coinsurance
Outpatient Hospital Services	$300 ambulatory surgical center $400 hospital	30%	$225 ambulatory surgical center $325 hospital	30%	20% Coinsurance	40% Coinsurance
Skilled Nursing Facility Care (3-day hospital stay not required)	$0 copay per day days 1 – 20, $203 copay per day days 21 – 54, $0 copay per day days 55 – 100 (no benefit after 100 days)	Days 1-100: 30% (no benefit after 100 days)	$0 copay per day days 1 – 20, $203 copay per day days 21 – 51, $0 copay per day days 52 – 100 (no benefit after 100 days)	Days 1-100: 30% (no benefit after 100 days)	$0 Copay days 1 - 20; $203 Copay per additional day up to 100 days	$175 Copay per day up to 100 days
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.
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
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
Podiatry Services	Specialist copay - $45 Diabetic routine footcare copay - $0 (6 per year)	30%	Specialist copay - $35 Diabetic routine footcare 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

* 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***
Dental Services	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 surgery Class III: Crowns, dentures No waiting period	30%	$40 Copay (Medicare-covered services only)	$60 Copay (Medicare-covered services only)
Mental Health Services - Inpatient	Inpatient: $387 copay per day for days 1-5; 190-day lifetime maximum for psychiatric hospital facility	30%; 190-day lifetime maximum for psychiatric hospital facility	Inpatient: $375 copay per day for days 1-5; 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
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
Chemical Dependency Services	Inpatient: $387 copay per day for days 1-5 Outpatient: $0/$30 copay depending on type of provider	30%	Inpatient: $375 copay per day for days 1-5 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
Gym Membership / Fitness Benefits	Free Gym Membership through Silver&Fit		Free Gym Membership through Silver&Fit		$0 membership fee - Fitness program through Renew Active	
Other Benefits	Chiropractic - $20 copay, limited to spinal manipulation for subluxation Physical, Occupational, and Speech Therapy - $30 copay Papa Pals not covered	Chiropractic - 30% Physical, Occupational, and Speech Therapy - 30%	Chiropractic - $20 copay, limited to spinal manipulation for subluxation Physical, Occupational, and Speech Therapy - $25 copay Papa Pals not covered	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 Healthy at Home Let's Move	
Foreign Travel Emergency Services	Emergency $100 copay (waived if admitted within 48 hours)		Emergency $120 copay (waived if admitted within 48 hours)		Worldwide coverage for emergency department services and worldwide coverage for urgently needed services	
Prescription Medication Coverage						
	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: Copay)		**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: Copay)**		**30-Day Retail**	**90-Day Mail Order**
Deductible	$0 Ded. Tiers 1 & 2 $0 Ded. Tiers 3 & 4 insulin $250 Ded. Tiers 3, 4 & 5		$0		$0	
Initial Coverage Limit (Deductible to $5,030 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): 28% You won't pay more than $35 for a 30-day supply or $105 for a 100-day supply for covered insulin products regardless or the cost-sharing tier.		Tier 1 (Preferred Generics): $5 Tier 2 (Generics): $15 Tier 3 (Preferred Brand): $45 Tier 4 (Non-preferred): $100 Tier 5 (Specialty):33% You won't pay more than $35 for a 30-day supply or $105 for a 100-day supply for covered insulin products regardless or the cost-sharing tier.		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
Coverage Gap (after $5,030 total paid by member and plan)	Tier 3 and Tier 4 insulin: $35 25% Generics 25% Brand		Tier 3 and Tier 4 insulin: $35 25% Generics 25% Brand		Minimum CMS Coverage After your total drug costs reach $5,030 you pay 25% of the price (plus dispensing fee) for brand name drugs and 25% of the price for generic drugs.	
Catastrophic Level (after member out-of-pocket costs reach $8,000 total)	After your yearly out-of-pocket drug costs reach $8,000, you pay nothing.		After your yearly out-of-pocket drug costs reach $8,000, you pay nothing.		During this payment stage, the plan pays the full cost for your covered drugs. Retiree pays nothing.	

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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