Subject: 2025 University of Utah Medicare retiree group plans—see instructions below to enroll

Thank you for considering Regence Medicare Advantage plans that are available from the University of Utah. To enroll in a plan, please follow these three steps:

Step 1: Review your eligibility and plan options

To join a Regence Medicare Advantage Retiree Group Plan, you or your Medicare-eligible dependent must be eligible for your former employer's retiree plan, have both Medicare Part A and Medicare Part B and live within the United States or District of Columbia.

Read the enclosed Summary of Benefits for these plans:

- Regence MedAdvantage + Rx Primary (PPO) - **$19 per month, per enrollee**
- Regence MedAdvantage + Rx Classic Option 1 (PPO) - **$111 per month, per enrollee**

**You must continue to pay your Medicare Part B premium*

Step 2: Complete your Enrollment Form using one of the following methods:

- Complete the form fillable application. Sign and date using either digital signature technology or a blue or black ink pen on a printed copy.
- Print and complete the application manually using a blue or black ink pen.

Step 3: Submit your Enrollment Form using one of the following methods:

- Mail: Regence MedAdvantage PO Box 1827 Medford, OR 97501
- Fax: 1-888-335-2988 (no cover sheet required)

Questions?

Call Regence Customer Service at 1-888-319-8904 (TTY: 711). Customer Service hours are 8 a.m. to 8 p.m., Monday through Friday (October 1 through March 31, our telephone hours are from 8 a.m. to 8 p.m., seven days a week). Or call your Human Resources department.

Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal.

You can submit a marketing complaint to us by calling the phone number on the back of your member ID card or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048, 24 hours a day/7 days a week. Please reference your agent's name if applicable.

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah MedAdvantage (PPO) Enrollment Request Form

PO Box 1827
Medford, OR 97501
1 (888) 319-8904
TTY 711
Fax Number: 1 (888) 335-2988

•PLEASE PRINT IN INK•

Please provide the following information:	
Employer or Trust Name: **University of Utah Retirees**	
Please check which plan you want to enroll in: ☐ Regence MedAdvantage + Rx Primary (PPO) ☐ Regence MedAdvantage + Rx Classic w/ Comp Dental and Option 1 Rx (PPO)	**Requested Effective Date:** ____ — ____ — ____ MM DD YYYY

LAST Name	FIRST Name	Middle Initital	☐ Mr. ☐ Mrs. ☐ Ms.
Birthdate: (mm/dd/yyyy)	Sex: ☐ M ☐ F	Home Phone Number	Medicare Number (Required)
Permanent Residence Street Address (P.O. Box is not allowed):			
City	State	ZIP Code	
Mailing Address (only if different from your Permanent Residence Address): Street Address:			
City	State	ZIP Code	
Emergency Contact:	Phone Number:	Relationship to You:	
Your e-mail address:			

By providing your email, you give permission to be contacted about future Medicare news and plan information via email. You may opt out of email communication at any time.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will be billed directly by Medicare or the Railroad Retirement Board. DO NOT pay Regence MedAdvantage the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your Social Security office, or call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778. You can also apply for extra help online at **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. **You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month or by having it deducted from your bank account.**

Please select a premium payment option:

☐ Get a bill (A billing statement will be sent in the mail)

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a preprinted VOIDED check or provide the following:

Account Holder Name: _____

If Account Holder name is NOT the name of the applicant on this application, please sign below to authorize deductions: ▶ _____

Bank Routing Number: _____

Bank Account Number: _____ Account Type: ☐ Checking ☐ Savings

If you don't select a payment option, you will get a bill each month.

Please read and answer these important questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Regence MedAdvantage?
   ☐ Yes ☐ No

If "yes", please list your other coverage:

Name of the other coverage: _____

ID Number for this coverage: _____

Group Number for this coverage: _____

2. Do you or your spouse work? ☐ Yes ☐ No

3. Are you the retiree? ☐ Yes ☐ No

4. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes" please provide the following information:

   Name of Institution: _____

   Address & Phone Number of Institution (number and street):

   _____

Please contact Regence MedAdvantage at 1 (888) 319-8904 (TTY users should call 711) if you need information in another format. Our telephone hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., seven days a week.

Please choose the name of a Primary Care Physician (PCP), clinic, or health center:

First and Last Name of PCP: _____

PCP Address: _____

PCP Phone Number: _____

The following questions 1-4 are optional
Answering these following 4 questions is your choice. You can't be denied coverage because you don't fill them out.
1. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ **I choose not to answer.** ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Cuban
2. What's your race? Select all that apply. ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Other Asian ☐ Vietnamese ☐ **I choose not to answer.** ☐ Asian Indian ☐ Filipino ☐ Korean ☐ Other Pacific Islander ☐ White ☐ Black or African American ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Samoan
3. What is your gender: Select one. ☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term: _____ ☐ **I choose not to answer**
4. Which of the following best represents how you think of yourself? Select one. ☐ Lesbian or gay ☐ Straight, this is, not gay or lesbian ☐ Bisexual ☐ I use a different term: _____ ☐ I don't know ☐ **I choose not to answer**

Employer or Trust Name
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Please continue on next page

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Please read and sign on page 6

By completing this enrollment application, I agree to the following:

Regence BlueCross BlueShield of Utah MedAdvantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

Once I am a member of Regence MedAdvantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Regence MedAdvantage when I get it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Regence MedAdvantage coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Regence MedAdvantage provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Regence MedAdvantage and other services contained in my Regence MedAdvantage Evidence of Coverage document will be covered. Without authorization, NEITHER MEDICARE NOR REGENCE MEDADVANTAGE WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Regence MedAdvantage, he/she may be paid based on my enrollment in Regence MedAdvantage.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Regence MedAdvantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give Medicare or their agents the information needed to run the Medicare program. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Regence MedAdvantage or by Medicare.

Your Signature*: _____ Date: _____
month/day/year

*If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Relationship to enrollee: _____

Address: _____ Phone Number: _____

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Regence MedAdvantage is a PPO with a Medicare contract. Enrollment in Regence MedAdvantage depends on contract renewal.

Employer or Trust Name
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Form 5364UT - Eff. 10/2024) v1

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Regence

Regence MedAdvantage + Rx Primary (PPO)

2025 Summary of Benefits

January 1, 2025 – December 31, 2025

for residents of groups based in Utah

For more information

Visit our website at **regence.com/mrg**.

Contact Customer Service at **1-888-319-8904** (TTY: 711). Customer Service hours are 8 a.m. to 8 p.m., Monday through Friday (October 1 through March 31, our telephone hours are from 8 a.m. to 8 p.m., seven days a week).

This document is available electronically and may be available in other formats.

What you need to know about this book

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the Evidence of Coverage (EOC).

Who can join?

To join a Regence Medicare Advantage Retiree Group Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for your employer's retiree plan and live within the United States. As long as you are eligible for your employer's retiree plan, you will have coverage in any state you live in (excluding U.S. territories).

Tips for comparing your Medicare benefits

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Which doctors, hospitals, and pharmacies can I use?

Regence participates in the Blue Medicare Advantage PPO Network Sharing Program. If you use a Regence MedAdvantage PPO network provider, or any other provider who participates in the PPO Network Sharing Program, you will receive in-network benefits for covered services. If you reside in a county or state that does not participate in the Blue Medicare Advantage PPO Network Program, you will still receive in-network benefits for covered services as long as your chosen provider accepts Medicare. If you choose to use an out-of-network provider when an in-network provider is available, you may pay more for your services, except in urgent and emergency situations.

Go to our website at **regence.com/mrg** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

When reviewing the following charts, you'll see the cost differences for in-network vs. out-of-network care and services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Regence MedAdvantage + Rx Primary

Plan costs & limits	
Annual deductible The amount you pay for medical services before the plan begins to pay.	$150
Maximum out-of-pocket responsibility Annual limit on your out-of-pocket costs for your Medicare-covered services. This amount does not include prescription drugs. If you reach the limit on out-of-pocket costs, we will pay the full cost for Medicare-covered services for the rest of the year.	$6,700 for services you receive from in-network providers. $10,100 for services you receive from in- and out-of-network providers combined.

Medical benefits	In-network	Out-of-network
Inpatient hospital coverage[1] Our plan covers an unlimited number of days per stay	$410 per day: days 1-5 $0 per day: days 6 and beyond	30%
Outpatient hospital services[1]		
Wound care services	$45	30%
All other services	20%	30%
Observation services	$400	30%
Ambulatory surgery center services[1]		
Wound care services	$45	30%
All other services	20%	30%
Doctor visits		
Primary care provider[3] *(deductible waived for in-network only)*	$0	30%
Specialist	$45	30%
Preventive care[3]		
Medicare-covered services: Abdominal aortic aneurysm screening Alcohol misuse screening and counseling	$0	30%

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum. 3- Services do not apply to the deductible.

Medical benefits	In-network	Out-of-network
Annual wellness visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease risk reduction visit Cardiovascular disease testing Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screenings Diabetes screenings HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling Vaccines (flu, pneumonia, COVID-19, Hepatitis B) Welcome to Medicare visit (one-time)		
Annual routine physical exam	$0	30%
Emergency care[3] Your copay is waived if admitted to the hospital within 48 hours. Emergency room visit	$125	$125
Worldwide emergency care	$125	$125
Urgently needed services[3] Urgent care visit	$45	$45
Virtual urgent care visits - through our virtual care provider Doctor On Demand	$0	Not covered

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum. 3- Services do not apply to the deductible.

Medical benefits	In-network	Out-of-network
Worldwide urgent care visit	$125	$125
Diagnostic services/labs/imaging		
HbA1C testing[3]	$0	30%
Lab services[1]	$25	30%
Outpatient x-rays	$20	30%
Diagnostic tests and procedures[1]	$25	30%
Diagnostic mammography[3]	$0	30%
Diagnostic radiology (MRI, CT, etc.)[1]	$300	30%
Hearing services		
Exam to diagnose and treat hearing and balance issues	$45	30%
Routine hearing exam[2,3] - 1 per calendar year, in-network services provided by TruHearing	$0	$150
Hearing aids[2,3] - 1 per ear per calendar year, aids must be provided by TruHearing	$499, $699, or $999 per aid	Not covered
Dental services		
Medicare-covered services	$45	30%
Vision services		
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	$0	30%
Routine exam[2,3] - 1 per calendar year, in-network services provided by VSP	$0	30%
Routine eyewear[2,3] - in-network services provided by VSP		
Lenses - standard basic single-vision, lined bifocal, lined trifocal or lenticular are covered	$0	50%
Frames or contacts - allowance for in- or out-of-network every calendar year	$100	$100

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum. 3- Services do not apply to the deductible.

Medical benefits	In-network	Out-of-network
Mental health services Inpatient psychiatric hospital[1] - 190-day lifetime maximum	$410 per day: days 1-5 $0 per day: days 6-190	30%: days 1-190
Outpatient mental health[1] - individual or group	$35	30%
Virtual mental health visits[3] - through our virtual care provider Doctor On Demand	$0	Not covered
Skilled nursing facility[1] Up to 100 days covered per benefit period	$10 per day: days 1-20 $214 per day: days 21-52 $0 per day: days 53-100	30%: days 1-100
Outpatient rehabilitation services[1] Occupational therapy	$40	30%
Physical and speech language therapy	$40	30%
Ambulance[1] Copay per each one-way Medicare-covered transport Ground ambulance	$300	$300
Air ambulance	$300	$300
Worldwide ground or air ambulance	$300	$300
Transportation	Not covered	Not covered
Medicare Part B drugs[1,3] *(deductible waived for in-network only)* Chemotherapy drugs	0%-20% (depending on the drug)	30%
Other Part B drugs	0% -20% (depending on the drug)	30%
Part B insulin	20% up to $35	30%

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum. 3- Services do not apply to the deductible.

Medical benefits	In-network	Out-of-network
Acupuncture Medicare-covered services - limited to treatment of chronic low back pain	$20	30%
Chiropractic Medicare-covered services - limited to manipulation of the spine to correct a subluxation	$20	30%
Diabetic services[3]		
Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour or LifeScan OneTouch	$0	50%
Continuous glucose monitor (CGM) and supplies[1] - in-network limited to Dexcom and Abbott FreeStyle Libre	$0	50%
Diabetes self-management training	$0	30%
Lancets, lancet devices, therapeutic shoes, and inserts	$0	50%
Diabetic routine footcare[2] - 6 visits per calendar year	$0	30%
Medicare diabetes prevention program (MDPP)	$0	$0
Durable medical equipment (DME)[1]	20%	50%
Fitness program[2,3] Fitness membership through the Silver&Fit program	$0	Not covered
Home delivered meals[2,3] Post discharge - 2 meals per day, up to 14 days, 28-meal limit per eligible episode	$0	Not covered
Outpatient substance use disorder services[1] Individual or group	$35	30%

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum. 3- Services do not apply to the deductible.

Prescription drugs

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you.

You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy. Long-term care facility residents pay the same as at a standard retail pharmacy and are limited to a 31-day supply.

Annual prescription (Part D) deductible stage	$0 for Tiers 1 and 2, Tiers 3 and 4 insulins, and most vaccines $300 for Tiers 3, 4 and 5

Initial coverage stage (the amount you pay until you have paid $2,000 for covered drugs)	**30-day**	**up to 100-day**
Tier 1: Preferred generic		
Preferred retail / Preferred mail order	$0	$0
Standard retail / Standard mail order	$10	$20
Tier 2: Generic		
Preferred retail / Preferred mail order	$13	$26 / $0
Standard retail / Standard mail order	$20	$40
Tier 3: Preferred brand		
Preferred retail / Preferred mail order	22%	22%
Standard retail / Standard mail order	25%	25%
Tier 4: Non-preferred drug		
Preferred retail / Preferred mail order	40%	40%
Standard retail / Standard mail order	43%	43%
Tier 5: Specialty		
Preferred retail / Preferred mail order	29%	N/A
Standard retail / Standard mail order	29%	N/A

Catastrophic coverage stage
After your yearly out-of-pocket drug costs reach $2,000, you pay nothing.

Supplemental drug coverage
Our plan Tier 1 - Preferred Generics include coverage for prescribed folic acid, vitamin B12, vitamin D and erectile dysfunction drugs. You pay the Initial coverage cost share during the Catastrophic coverage stage.

Insulin
You won't pay more than $35 for a 30-day supply or $87.50 for a 100-day supply for covered insulin products regardless of the cost-sharing tier, even if you haven't paid your deductible.

Part D vaccine
Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible.

Regence

Regence MedAdvantage + Rx Classic Opt 1 (PPO)

2025 Summary of Benefits

January 1, 2025 – December 31, 2025

for the University of Utah

For more information

Visit our website at **regence.com/mrg**.

Contact Customer Service at **1-888-319-8904** (TTY: 711). Customer Service hours are 8 a.m. to 8 p.m., Monday through Friday (October 1 through March 31, our telephone hours are from 8 a.m. to 8 p.m., seven days a week).

This document is available electronically and may be available in other formats.

Medical benefits	In-network	Out-of-network
Cardiovascular disease risk reduction visit Cardiovascular disease testing Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screenings Diabetes screenings HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling Vaccines (flu, pneumonia, COVID-19, Hepatitis B) Welcome to Medicare visit (one-time)		
Annual routine physical exam	$0	30%
Emergency care Your copay is waived if admitted to the hospital within 48 hours. Emergency room visit	$120	$120
Worldwide emergency care	$120	$120
Urgently needed services Urgent care visit	$40	$40
Virtual urgent care visits - through our virtual care provider Doctor On Demand	$0	Not covered
Worldwide urgent care visit	$120	$120
Diagnostic services/labs/imaging HbA1C testing	$0	30%

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum.

Medical benefits	In-network	Out-of-network
Lab services[1]	$10	30%
Outpatient x-rays	$10	30%
Diagnostic tests and procedures[1]	$10	30%
Diagnostic mammography	$0	30%
Diagnostic radiology (MRI, CT, etc.)[1]	$250	30%
Hearing services		
Exam to diagnose and treat hearing and balance issues	$35	30%
Routine hearing exam[2] - 1 per calendar year, in-network services provided by TruHearing	$0	$150
Hearing aids[2] - 1 per ear per calendar year, aids must be provided by TruHearing	$499, $699, or $999 per aid	Not covered
Dental services		
Medicare-covered services	$35	30%
Preventive services[2] (Class I) Oral evaluations, 2 per calendar year Prophylaxis (routine cleaning or periodontal maintenance), 2 per calendar year, any combination Bitewing x-rays, 1 set per calendar year Full mouth (FMX) or panoramic x-ray, 1 every 36 months Fluoride, 1 per calendar year	$0	50%
Basic (Class II) and Major (Class III) comprehensive dental services are covered up to a combined benefit maximum every calendar year	$1,000	
Basic comprehensive services[2] (Class II) Periodontal scaling and root planing services, 1 per quad every 24 months Restorative fillings, 2 per calendar year	50%	50%

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum.

Medical benefits	In-network	Out-of-network
Restorative crowns, 1 per calendar year and once per tooth every 5 years		
Major comprehensive services[2] (Class III) Dentures (full or partial, new), 1 every 5 years Endodontics (root canals), 1 per calendar year Extractions (including local anesthesia), 2 per calendar year Periodontal full mouth debridement, 1 every 3 years	50%	50%
Vision services Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	$0	30%
Routine exam[2] - 1 per calendar year, in-network services provided by VSP	$0	30%
Routine eyewear[2] - in-network services provided by VSP Lenses - standard basic single-vision, lined bifocal, lined trifocal or lenticular are covered Frames or contacts - allowance for in- or out-of-network every calendar year	$0 $100	50% $100
Mental health services Inpatient psychiatric hospital[1] - 190-day lifetime maximum	$395 per day: days 1-5 $0 per day: days 6-190	30%: days 1-190
Outpatient mental health[1] - individual or group	$25	30%
Virtual mental health visits - through our virtual care provider Doctor On Demand	$0	Not covered
Skilled nursing facility[1] Up to 100 days covered per benefit period	$10 per day: days 1-20 $214 per day: days 21-49 $0 per day: days 50-100	30%: days 1-100
Outpatient rehabilitation services[1] Occupational therapy	$25	30%

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum.

Medical benefits	In-network	Out-of-network
Physical and speech language therapy	$25	30%
Ambulance[1] Copay per each one-way Medicare-covered transport Ground ambulance	$275	$275
Air ambulance	$275	$275
Worldwide ground or air ambulance	$275	$275
Transportation	Not covered	Not covered
Medicare Part B drugs[1] Chemotherapy drugs	0%-20% (depending on the drug)	30%
Other Part B drugs	0% -20% (depending on the drug)	30%
Part B insulin	20% up to $35	30%
Acupuncture Medicare-covered services - limited to treatment of chronic low back pain	$20	30%
Chiropractic Medicare-covered services - limited to manipulation of the spine to correct a subluxation	$20	30%
Additional covered services[2] - limit of 15 visits per calendar year	$30	30%
Diabetic services Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour or LifeScan OneTouch	$0	50%
Continuous glucose monitor (CGM) and supplies[1] - in-network limited to Dexcom and Abbott FreeStyle Libre	$0	50%
Diabetes self-management training	$0	30%

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum.

Medical benefits	In-network	Out-of-network
Lancets, lancet devices, therapeutic shoes, and inserts	$0	50%
Diabetic routine footcare[2] - 6 visits per calendar year	$0	30%
Medicare diabetes prevention program (MDPP)	$0	$0
Durable medical equipment (DME)[1]	20%	50%
Fitness program[2] Fitness membership through the Silver&Fit program	$0	Not covered
Home delivered meals[2] Post discharge - 2 meals per day, up to 14 days, 28-meal limit per eligible episode	$0	Not covered
Outpatient substance use disorder services[1] Individual or group	$25	30%
Over the counter (OTC) items and home and bathroom safety devices (Blue FlexDollars™)[2] Allowance loaded to a pre-paid benefit card every calendar quarter. Allowance does not roll-over.	$20	

1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum.

Prescription drugs

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you.

You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy. Long-term care facility residents pay the same as at a standard retail pharmacy and are limited to a 31-day supply.

Annual prescription (Part D) deductible stage	$0

Initial coverage stage (the amount you pay until you have paid $2,000 for covered drugs)	**30-day**	**up to 100-day**
Tier 1: Preferred generic		
Standard retail / Standard mail order	$5	$10
Tier 2: Generic		
Standard retail / Standard mail order	$15	$30
Tier 3: Preferred brand		
Standard retail / Standard mail order	$45	$112.50
Tier 4: Non-preferred drug		
Standard retail / Standard mail order	40%	40%
Tier 5: Specialty		
Standard retail / Standard mail order	33%	N/A

Catastrophic coverage stage
After your yearly out-of-pocket drug costs reach $2,000, you pay nothing.

Insulin
You won't pay more than $35 for a 30-day supply or $105 for a 100-day supply for covered insulin products regardless of the cost-sharing tier.

Part D vaccine
Our plan covers most adult Part D vaccines at no cost to you.

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-888-319-8904.**

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Call **1-888-319-8904** to request a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2026.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Disclaimers

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association.

Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal.

Out-of-network/noncontracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

You can submit a marketing complaint to us by calling the phone number on the back of your member ID card or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048, 24 hours a day/ 7 days a week. Please reference your agent's name if applicable.

Utilization Management (UM) is the way we review the type and amount of care you're getting. This involves looking at the setting for your care and its medical necessity. Clinical professionals make decisions based on our clinical review criteria, guidelines, and medical policies. Examples of UM procedures include pre-service review (prior authorization), concurrent review (including urgent concurrent review) and post-service review. Find more information in our Member FAQ on **regence.com/medicare/resources/faq.**

The Silver&Fit® program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein. Other names may be trademarks of their respective owners.

Doctor On Demand is a separate company that provides telehealth services. Silver&Fit is a separate company that provides wellness and health information services. TruHearing is a separate company that provides discounted hearing products. VSP is a separate company that provides vision services.

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Regence BlueCross BlueShield of Utah - H4605

For 2025, Regence BlueCross BlueShield of Utah - H4605 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★½
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?

Contact Regence BlueCross BlueShield of Utah 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time at 888-319-8904 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain time. Current members please call 888-319-8904 (toll-free) or 711 (TTY).

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)