



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**](http://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 coverage¹ 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 services¹ Wound care services	\$45	30%
All other services	20%	30%
Observation services	\$400	30%
Ambulatory surgery center services¹ 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 care³ 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 care³ Your copay is waived if admitted to the hospital within 48 hours.		
Emergency room visit	\$125	\$125
Worldwide emergency care	\$125	\$125
Urgently needed services³		
Urgent care visit	\$45	\$45
Virtual urgent care visits - through our virtual care provider Doctor On Demand	\$0	Not covered

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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

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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 facility¹ 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 services¹		
Occupational therapy	\$40	30%
Physical and speech language therapy	\$40	30%
Ambulance¹ 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} (<i>deductible waived for in-network only</i>)		
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%

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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 services³ 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 services¹ Individual or group	\$35	30%

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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
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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.

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.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-541-8981. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-541-8981. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-541-8981。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-541-8981。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-541-8981. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-541-8981. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-541-8981 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-541-8981. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-541-8981 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-541-8981. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-541-8981. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी पश्च के जवाब देने के लिए हमारे पास मुफ्त दुभाकिया सेवाएँ उपलब्ध हैं. एक दुभाकिया प्राप्त करने के लिए, बस हमें 1-800-541-8981 पर फोन करें. कोई व्यक्ति जो कहन्दी बोता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-541-8981. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-541-8981. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-541-8981. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-541-8981. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-541-8981 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。