Advantage U for University of Utah Retirees (PPO) H4304-801

2023 Summary of Benefits

This is a summary of drug and health services covered by Advantage U for University of Utah Retirees (PPO) January 1, 2023 - December 31, 2023.

Advantage U

Summary of Benefits

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This is a summary of drug and health services covered by Advantage U for University of Utah Retirees (PPO) January 1, 2023 - December 31, 2023.

University of Utah Health Insurance Plans is a PPO with a Medicare contract. Enrollment in University of Utah Health Insurance Plans depends on contract renewal.

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, please request the "Evidence of Coverage" by calling **1-833-951-4345 (TTY 711)**.

To join Advantage U for University of Utah Retirees (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area and be an eligible retiree of the University of Utah. Our service area includes the counties of Davis, Salt Lake, Tooele, Utah and Weber in Utah.

Out-of-network/non-contracted providers are under no obligation to treat Advantage U 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.

This information is not a complete description of benefits.

This document is available in other formats such as audio and large print.

This document may be available in a non-English language.

For additional information, call us at **1-833-951-4345 (TTY 711)**. Customer Service hours are 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday. Alternate technologies (for example, voicemail) will be used on evenings, weekends and holidays.

Summary of Benefits

January 1, 2023 - December 31, 2023

Tips for comparing your Medicare choices:
This Summary of Benefits booklet gives you a summary of what Advantage U for University of Utah Retirees (PPO) covers and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **http://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 http://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**.

What drugs do we cover?

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan Formulary (list of Part D prescription drugs) and any restrictions on our website, www.AdvantageUMedicare.com/uouretirees.php
- Or, call us and we will send you a copy of the Formulary.

How will I determine my drug costs?

Our plans group 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.

The amount you pay depends on the drug's tier, day supply and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: The Deductible Stage, Initial Coverage, Coverage Gap and Catastrophic Coverage. If you have questions about the different benefit stages, please contact the Plan for more information or access the "Evidence of Coverage" on our website.

Advantage U for University of Utah Retirees (PPO) Phone Numbers and Website:

- If you have questions, call toll-free **1-833-951-4345 (TTY 711)**
  Customer Service hours are 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday. Alternate technologies (for example, voicemail) will be used on evenings, weekends and holidays.
- Website: **www.AdvantageUMedicare.com/uofuretirees.php**

Premiums and Benefits		What you should know
Monthly Plan Premium	$0	You must continue to pay your Part B premium
Deductible	$0	
Maximum Out Of Pocket Responsibility (does not include prescription drugs)	• $6,100 in-network or • $11,300 (combined in-network and out-of-network maximum out-of-pocket amount)	The most you pay for copays, coinsurance and other costs for Medicare covered services for the year

Benefits	In-Network	Out-of-Network	What you should know
Inpatient Hospital Coverage	$280 copay per day for days 1-4 $0 copay for days 5-90 $0 copay for additional days	45% coinsurance	Authorization rules apply
Outpatient Hospital Coverage			Authorization rules apply
• Ambulatory Surgery Center	$325 copay	45% coinsurance	
• Surgery	$325 copay	45% coinsurance	
• Services	20% coinsurance	45% coinsurance	Outpatient Services include procedures such as Hyperbaric Oxygen treatment, Transfusions and wound care.

Benefits	In-Network	Out-of-Network	What you should know
Doctor Visits • Primary *(includes telehealth)*	$0 copay	$0 copay	
• Specialist	$25 copay	$25 copay	
Preventive Care	$0 copay	$0 copay	
Emergency Care	$95 copay	$95 copay	If you are admitted to the hospital within 24 hours, you do not have to pay your share of cost for emergency care. Emergency care is available worldwide
Urgently Needed Services	$45 copay office visit $0 copay for Telehealth visit through an in-network provider	$45 copay office visit	Urgently needed services available worldwide with a $95 copay.

Benefits	In-Network	Out-of-Network	What you should know
Diagnostic Services/Labs/ Imaging			Authorization rules apply
Lab Services	$0 Copay	45% coinsurance	
Diagnostic tests and procedures	$0 Copay	45% coinsurance	
Outpatient X-rays	$5 Copay	45% coinsurance	
Diagnostic Radiology service			
• Mammogram (Diagnostic or Preventive)	$0 Copay	$0 copay	
• CT Scan or other Medicare-covered Radiological diagnostic service	$150 Copay	$150 Copay	
• MRI or other Advanced Imaging (i.e. MRA, PET and nuclear test)	$250 Copay	$250 Copay	
Hearing Services			
• Diagnostic hearing exam to diagnose and treat hearing and balance issues–Medicare Covered	$0 copay	45% coinsurance	
• Hearing exam (routine hearing exam)	$0 copay hearing exam (up to 1 every year) through network provider TruHearing™	$45 copay hearing exam (up to 1 every year)	In-network routine hearing exam offered through TruHearing™ providers only

Benefits	In-Network	Out-of-Network	What you should know
• Hearing aid	$699-$999 copay for each hearing aid, one per ear per year (TruHearing™ Advanced or Premium only)	$699-$999 copay for each hearing aid, one per ear per year (TruHearing™ Advanced or Premium only)	Coverage is limited to TruHearing™ aids only
Dental Services			
• Preventive Dental	$0 copay (up to 2 visits per year). Preventive Services May include: Cleaning, Oral Exam, Flouride treatment, Bitewing XRays (1 every 12 months)	$0 copay 2 visits per year (member responsible for OON cost above Dentaquest Rates	In-network Preventive and Comprehensive dental services offered through Dentaquest providers only
• Non-Medicare covered Comprehensive Dental	$0 copay, $1,500 benefit coverage limit. Comprehensive Dental Services limited to: Restorative, Extractions, Crowns, Implants and adjunctive periodontal. See EOC for further details	$0 copay, $1,500 benefit coverage limit. Comprehensive Dental Services limited to: Restorative, Extractions, Crowns, Implants and Adjunctive Periodontal. See EOC for further details (Member responsible for OON cost above Dentaquest Rates)	Authorization rules apply
• Medicare Covered Dental Services	$0 copay	45% coinsurance	

Benefits	In-Network	Out-of-Network	What you should know
Vision Services • Medicare Covered Exam to diagnose and treat diseases and conditions of the eye	$0 copay	45% coinsurance	
• Eyeglasses or contact lenses after cataract Surgery	$0 copay	45% coinsurance	
• Routine Eye Exam	$0 copay through a VSP Choice network provider	50% coinsurance	For in-network routine vision benefits, must use a VSP Choice network provider
• Eyeglasses - Frames - Lenses **OR**	$120 allowance for frames every two years $30 copay for Lenses every two years including: • Standard • Bifocal • Trifocal • Standard Progressive	$120 allowance for frames every two years 50% coinsurance	For in-network vision benefits, must use a VSP Choice network provider
• Elective Contact Lens Fitting, Exam and Lenses. • Visually Necessary Contact Lens (lens fitting, exam and lenses)	$0 copay $120 allowance for contact lenses every two years $30 copay	$0 copay $120 allowance for contact lenses every two years 50% coinsurance	**All Contact lenses are in lieu of Glasses (lenses and frames)**, for in-network benefits must use a VSP Choice in-network provider

Benefits	In-Network	Out-of-Network	What you should know
Mental Health Services			
•Inpatient Hospital Psychiatric	$280 copay per day for days 1-4 $0 copay for days 5-90 $0 copay for additional days	45% coinsurance	Authorization rules apply
• Outpatient Group Therapy	$10 copay	$10 copay	
• Outpatient Individual Therapy	$10 copay	$10 copay	
Skilled Nursing Facility	$0 copay for days 1-20 $196 copay for additional days	45% coinsurance	Authorization rules apply
Physical Therapy/ Speech Therapy/ Occupational Therapy	$25 copay	$25 copay	Authorization rules apply
Ambulance	$235	$235	
Transportation	Not covered	Not covered	
Medicare Part B Drugs			Authorization rules may apply
Part B Chemotherapy Drugs	20% coinsurance	45% coinsurance	
Other Part B Drugs	$28 copay or 20% coinsurance	45% coinsurance	For Select Insulins used with a pump, you pay a $28 copay for a one-month supply

Medicare Part D Coverage			
Deductible	This plan has a $125 deductible that applies to Tier 3, 4 and 5.		
Initial Coverage	After you pay your deductible, if applicable, up to the initial coverage limit of $4,660.		
Retail Cost-Sharing			
Tier	**30-Day Supply**	**60-Day Supply**	**100-Day Supply**
Tier 1 (Preferred Generics)	$3 copay	$6 copay	$0 copay
Tier 2 (Generics)	$10 copay	$20 copay	$20 copay
Tier 3 (Preferred Brands)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Drugs)	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Medications)	29% coinsurance	Not offered	Not offered

Medicare Part D Drugs Mail Order Cost-Sharing			
Tier	**30-Day Supply**	**60-Day Supply**	**100-Day Supply**
Tier 1 (Preferred Generics)	$3 copay	$6 copay	$0 copay
Tier 2 (Generics)	$10 copay	$20 copay	$20 copay
Tier 3 (Preferred Brands)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Drugs)	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Medications)	29% coinsurance	Not offered	Not offered

If you reside in a long-term care facility, you pay the same amount as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% coinsurance for covered brand name drugs and 25% coinsurance for covered generic drugs until your out-of-pocket costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: • 5% coinsurance, or • $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs.
Insulin	You won't pay more than $35 for a one-month supply of any insulin covered by our plan. For Select Insulins, $28 copay for a one-month supply. Applies even if you haven't paid your deductible.

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 **http://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**. This document is available in other formats such as Braille, large print or audio.

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