Salt Lake Community College

2022-2023 Benefit Annual Notices

You are an important part of SLCC, and we appreciate all you do. We are providing you with some **IMPORTANT NOTICES** that Salt Lake Community College is required to distribute to all benefit-eligible employees. We strongly encourage you to read through all these notices and contact us if you have questions.

Thank you,
The Benefits Team
Human Resources Office

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (866) 240-9580. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $600 individual / $1,200 family per plan year. Out-of-network: $2,000 individual / $4,000 family per plan year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $150 individual / $300 family per plan year for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $3,500 individual / $7,000 family per plan year. Out-of-network: $5,000 individual / $10,000 family per plan year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/UT/PVCU or call 1 (866) 240-9580 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay / office visit, deductible does not apply; $25 copay / retail clinic visit, deductible does not apply; $25 copay / expanded office services, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office, expanded office services and retail clinic visit only. Expanded office services include medical/surgical services and therapeutic injections. All other services are covered at the coinsurance specified, after deductible.
	Specialist visit	$35 copay / office visit, deductible does not apply; $35 copay / expanded office services, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 copay / per visit	40% coinsurance after $50 copay / per visit	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2022/UT/6tierLG	Preferred generic drugs & generic drugs	$7 copay / preferred retail and mail order prescription $7 copay / retail and mail order prescription 20% coinsurance for diabetic supplies		Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply for generic (including preferred) drugs, mail order drugs or self-administrable cancer chemotherapy drugs. Out-of-pocket limit: $2,000 per individual / $6,000 family per year. 90-day supply / retail prescription (1 copayment per 90-day supply for generic drugs / 1 copayment per 30-day supply for brand and specialty drugs) 90-day supply / mail order prescription 30-day supply / specialty drug retail prescription or self-administrable cancer chemotherapy drugs Coverage includes compound medications at 50% coinsurance, refer to your plan for further information. Cost shares for preferred brand insulin will not exceed $28 / 30-day supply retail prescription or $84 / 90-day supply mail order prescription, whether or not any applicable deductible has been met. Specialty drugs are not available through mail order. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. The first fill of specialty drugs may be provided at a retail pharmacy; additional refills must be provided by a specialty pharmacy. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance. *Your coinsurance for self-administrable cancer chemotherapy medications will not exceed $300.
	Preferred brand drugs	25% coinsurance* up to $150 copay maximum / retail prescription 25% coinsurance* up to $300 copay maximum / mail order prescription 20% coinsurance for diabetic supplies		
	Brand drugs	30% coinsurance* up to $175 copay maximum / retail prescription 30% coinsurance* up to $437.50 copay maximum / mail order prescription 20% coinsurance for diabetic supplies		
	Preferred specialty drugs & specialty drugs	10% coinsurance* up to $250 copay maximum / preferred retail prescription 15% coinsurance* up to $300 copay maximum / retail prescription		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Adoption coverage is paid at the in-network benefit, limited to $3,000 / pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$25 copay / visit, deductible does not apply	40% coinsurance	Copayment applies to each in-network outpatient visit only.
	Rehabilitation services	$25 copay / visit, deductible does not apply for outpatient services; 20% coinsurance for inpatient services	40% coinsurance	60 inpatient days / year 30 outpatient visits / year combined with neurodevelopmental visit limit Copayment applies to each in-network outpatient visit only. Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	$25 copay / visit, deductible does not apply	40% coinsurance	30 neurodevelopmental visits / year combined with outpatient rehabilitation visit limit Neurodevelopmental therapy limited to individuals under age 19. Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	20% coinsurance	40% coinsurance	60 inpatient days / year
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance, deductible does not apply	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or

- complications that result from an injury or illness resulting from active participation in illegal activities.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion (except in cases of rape, incest or to avert the death of the Member) • Acupuncture • Bariatric surgery	• Cosmetic surgery, except congenital anomalies • Dental care • Long-term care • Private-duty nursing	• Routine eye care • Routine foot care • Vision hardware • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care, spinal manipulations only • Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (866) 240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Utah Department of Insurance by calling 1 (801) 957-9200 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, 4315 S 2700 W, Suite 2300, Taylorsville, UT 84129; through the Internet at: www.insurance.utah.gov; or by E-mail at: healthappeals.uid@utah.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$600**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$356
Coinsurance	$2,094
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$3,111**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$600**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$377
Coinsurance	$819
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,974**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$600**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$310
Coinsurance	$275
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,185**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,700 individual (single coverage) / $3,400 family per plan year. Out-of-network: $3,500 individual (single coverage) / $7,000 family per plan year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $3,500 individual (single coverage) / $7,000 family per plan year. Out-of-network: $7,000 individual (single coverage) / $14,000 family per plan year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/UT/PVCU or call 1 (866) 240-9580 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay / office visit; $25 copay / retail clinic visit; $25 copay / expanded office services; 10% coinsurance for all other services	30% coinsurance	Copayment applies to each in-network office, expanded office services and retail clinic visit only, after deductible. Expanded office services include medical/surgical services and therapeutic injections. All other services are covered at the coinsurance specified, after deductible.
	Specialist visit	$35 copay / office visit; $35 copay / expanded office services; 10% coinsurance for all other services	30% coinsurance	
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2022/UT/6tierLG	Preferred generic drugs & generic drugs	$7 copay / preferred retail and mail order prescription $7 copay / retail and mail order prescription 10% coinsurance for diabetic supplies		Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply for drugs specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / mail order prescription 30-day supply / specialty drug retail prescription Specialty drugs (including preferred) are not available through mail order. Coverage includes compound medications, refer to your plan for further information. Cost shares for preferred brand insulin will not exceed $28 / 30-day supply retail prescription or $84 / 90-day supply mail order prescription, whether or not any applicable deductible has been met. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. The first fill of specialty drugs may be provided at a retail pharmacy; additional refills must be provided by a specialty pharmacy. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits.
	Preferred brand drugs	25% coinsurance up to $150 copay maximum / retail prescription 25% coinsurance up to $300 copay maximum / mail order prescription 10% coinsurance for diabetic supplies		
	Brand drugs	30% coinsurance up to $175 copay maximum / retail prescription 30% coinsurance up to $437.50 copay maximum / mail order prescription 10% coinsurance for diabetic supplies		
	Preferred specialty drugs & specialty drugs	10% coinsurance up to $250 copay maximum / preferred retail prescription 15% coinsurance up to $300 copay maximum / retail prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / office visit; 10% coinsurance for all other services	30% coinsurance	Copayment applies to each in-network office psychotherapy visit only, after deductible. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	10% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Adoption coverage is paid at the in-network benefit, limited to $3,000 / pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	None
	Rehabilitation services	10% coinsurance	30% coinsurance	60 inpatient days / year 30 outpatient visits / year combined with neurodevelopmental limit Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	10% coinsurance	30% coinsurance	30 neurodevelopmental visits / year combined with outpatient rehabilitation limit Neurodevelopmental therapy limited to individuals under age 18. Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	10% coinsurance	30% coinsurance	60 inpatient days / year
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion (except in cases of rape, incest or to avert the death of the Member) • Acupuncture • Bariatric surgery	• Cosmetic surgery, except congenital anomalies • Dental care • Long-term care • Private-duty nursing	• Routine eye care • Routine foot care • Vision hardware • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care, spinal manipulations only • Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (866) 240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Utah Department of Insurance by calling 1 (801) 957-9200 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, 4315 S 2700 W, Suite 2300, Taylorsville, UT 84129; through the Internet at: www.insurance.utah.gov; or by E-mail at: healthappeals.uid@utah.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,700**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$11
Coinsurance	$1,052
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,824**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,700**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$291
Coinsurance	$785
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$2,954**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,700**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$110
Coinsurance	$75
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,885**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (866) 240-9580. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $300 individual / $600 family per plan year. Out-of-network: $1,000 individual / $2,000 family per plan year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $75 individual / $225 family per plan year for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $3,200 individual / $6,500 family per plan year. Out-of-network: $5,000 individual / $10,000 family per plan year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/UT/PVCU or call 1 (866) 240-9580 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$12 copay / office visit, deductible does not apply; $12 copay / retail clinic visit, deductible does not apply; $12 copay / expanded office services, deductible does not apply; 0% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office, expanded office services and retail clinic visit only. Expanded office services include medical/surgical services and therapeutic injections. All other services are covered at the coinsurance specified, after deductible.
	Specialist visit	$17 copay / office visit, deductible does not apply; $17 copay / expanded office services, deductible does not apply; 0% coinsurance for all other services	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$25 copay / per visit	40% coinsurance after $25 copay / per visit	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2022/UT/6tierLG	Preferred generic drugs & generic drugs	$3.50 copay / preferred retail and mail order prescription $3.50 copay / retail and mail order prescription 20% coinsurance for diabetic supplies		Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply for generic (including preferred) drugs, mail order drugs or self-administrable cancer chemotherapy drugs. Out-of-pocket limit: $2,000 per individual / $6,000 family per year. 90-day supply / retail prescription (1 copayment per 90-day supply for generic drugs / 1 copayment per 30-day supply for brand and specialty drugs) 90-day supply / mail order prescription 30-day supply / specialty drug retail prescription or self-administrable cancer chemotherapy drugs Coverage includes compound medications at 50% coinsurance, refer to your plan for further information. Cost shares for preferred brand insulin will not exceed $28 / 30-day supply retail prescription or $84 / 90-day supply mail order prescription, whether or not any applicable deductible has been met. Specialty drugs are not available through mail order. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. The first fill of specialty drugs may be provided at a retail pharmacy; additional refills must be provided by a specialty pharmacy. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance.
	Preferred brand drugs	12.5% coinsurance up to $75 copay maximum / retail prescription 12.5% coinsurance up to $150 copay maximum / mail order prescription 0% coinsurance for diabetic supplies		
	Brand drugs	15% coinsurance up to $87.50 copay maximum / retail prescription 15% coinsurance up to $175 copay maximum / mail order prescription 0% coinsurance for diabetic supplies		
	Preferred specialty drugs & specialty drugs	5% coinsurance up to $125 copay maximum / preferred retail prescription 7.5% coinsurance up to $150 copay maximum / retail prescription		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$12 copay / office visit, deductible does not apply; 0% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	0% coinsurance	40% coinsurance	Adoption coverage is paid at the in-network benefit, limited to $3,000 / pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$12 copay / visit, deductible does not apply	40% coinsurance	Copayment applies to each in-network outpatient visit only.
	Rehabilitation services	$12 copay / visit, deductible does not apply for outpatient services; 0% coinsurance for inpatient services	40% coinsurance	60 inpatient days / year 30 outpatient visits / year combined with neurodevelopmental visit limit Copayment applies to each in-network outpatient visit only. Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	$12 copay / visit, deductible does not apply	40% coinsurance	30 neurodevelopmental visits / year combined with outpatient rehabilitation visit limit Neurodevelopmental therapy limited to individuals under age 19. Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	0% coinsurance	40% coinsurance	60 inpatient days / year
	Durable medical equipment	0% coinsurance	40% coinsurance	None
	Hospice services	No charge	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion (except in cases of rape, incest or to avert the death of the Member) • Acupuncture • Bariatric surgery	• Cosmetic surgery, except congenital anomalies • Dental care • Long-term care • Private-duty nursing	• Routine eye care • Routine foot care • Vision hardware • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care, spinal manipulations only • Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (866) 240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Utah Department of Insurance by calling 1 (801) 957-9200 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, 4315 S 2700 W, Suite 2300, Taylorsville, UT 84129; through the Internet at: www.insurance.utah.gov; or by E-mail at: healthappeals.uid@utah.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Specialist copayment	**$17**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$237
Coinsurance	$2,156
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,754**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$300**
Specialist copayment	**$17**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$267
Coinsurance	$505
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,250**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$300**
Specialist copayment	**$17**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$153
Coinsurance	$355
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$788**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Salt Lake Community College
Regence Expressions℠ ValueCare

Effective July 1, 2022 through June 30, 2023

Regence

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

This plan includes preventive and diagnostic services, as well as restorative and major services. After satisfaction of the deductible, this plan will provide payment for the services at the percentages listed below up to the calendar year maximum. Payment of benefits is based on a percentage of the Allowed Amount. Participating providers have agreed to accept the Allowed Amounts as payment for services. Services of a Nonparticipating provider are based on a percentage of the Allowed Amount. The Member will be responsible for any additional charges over the Allowed Amount.

Cost Share Details		Participating	Nonparticipating
Annual Deductible	The total deductible you pay per plan year	$0	
Annual Limit	The combined total for your deductible, coinsurance and copays per plan year Preventive dental services do not accumulate toward the overall annual limit.	$1,500 Individual	

Preventive and Diagnostic Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Cleanings and Examinations	Cleanings - 2 per plan year with a 3rd being covered with qualifying diagnosis Preventive oral examinations - 2 per plan year	0%
X-rays	Bitewing x-rays - 2 sets per plan year Complete intra-oral mouth x-ray - Once in a 3-year period Panoramic mouth x-ray - Once in a 3-year period	0%
Other Preventive Dental Services	Sealants (permanent bicuspids and molars only) for members under 15 years of age Space maintainers for members under 13 years of age Topical fluoride application - 2 per plan year for members under 23 years of age	0%

Basic Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Complex Oral Surgery	Including surgical extraction of teeth	20%
Emergency and Other Basic Dental Services	Emergency treatment for pain relief	20%
Endodontic Services	Services including root canal treatment, pulpotomy and apicoectomy	20%
Periodontal Services	Periodontal maintenance - 4 per plan year (in lieu of preventive cleanings) Debridement - Once in a 3-year period Scaling and root planing - 1 every plan year per quadrant	20%

Major Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Bridges (fixed partial dentures)	Replacement once per 5 years after placement	50%
Crowns, Inlays and Onlays	Replacement once (per tooth) 5 years after placement	50%
Dentures (full and partial)	Replacement 5 years after placement	50%
Implants (endosteal)		50%

Orthodontia Services (unless stated otherwise, a deductible applies)		What You Pay
Orthodontia Services	Members under 26 years of age $500 maximum limit per plan year $1,000 maximum limit per lifetime No waiting period	0%

This benefit summary provides a brief description of your plan benefits, limitations and/or exclusions under your plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND/OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY.** Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

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Salt Lake Community College
Regence Expressions℠ Dual

Effective July 1, 2022 through June 30, 2023

Regence

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

This plan includes preventive and diagnostic services, as well as restorative and major services. After satisfaction of the deductible, this plan will provide payment for the services at the percentages listed below up to the calendar year maximum. Payment of benefits is based on a percentage of the Allowed Amount. Participating providers have agreed to accept the Allowed Amounts as payment for services. Services of a Nonparticipating provider are based on a percentage of the Allowed Amount. The Member will be responsible for any additional charges over the Allowed Amount.

Cost Share Details		Participating	Nonparticipating
Annual Deductible	The total deductible you pay per plan year	$0	
Annual Limit	The combined total for your deductible, coinsurance and copays per plan year	$3,000 Individual	

Preventive and Diagnostic Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Cleanings and Examinations	Cleanings - 2 per plan year with a 3rd being covered with qualifying diagnosis Preventive oral examinations - 2 per plan year	0%
X-rays	Bitewing x-rays - 2 sets per plan year Complete intra-oral mouth x-ray - Once in a 3-year period Panoramic mouth x-ray - Once in a 3-year period	0%
Other Preventive Dental Services	Sealants (permanent bicuspids and molars only) for members under 15 years of age Space maintainers for members under 13 years of age Topical fluoride application - 2 per plan year for members under 23 years of age	0%

Basic Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Complex Oral Surgery	Including surgical extraction of teeth	0%
Emergency and Other Basic Dental Services	Emergency treatment for pain relief	0%
Endodontic Services	Services including root canal treatment, pulpotomy and apicoectomy	0%
Periodontal Services	Periodontal maintenance – 4 per plan year (in lieu of preventive cleanings) Debridement - Once in a 3-year period Scaling and root planing - 1 every plan year per quadrant	0%

Major Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Bridges (fixed partial dentures)	Replacement once per 5 years after placement	0%
Crowns, Inlays and Onlays	Replacement once (per tooth) 5 years after placement	0%
Dentures (full and partial)	Replacement 5 years after placement	0%
Implants (endosteal)		0%

Orthodontia Services (unless stated otherwise, a deductible applies)		What You Pay
Orthodontia Services	Members under 26 years of age $1,000 maximum limit per plan year $2,000 maximum limit per lifetime No waiting period	0%

This benefit summary provides a brief description of your plan benefits, limitations and/or exclusions under your plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND/OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY.** Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

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Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at **(1-866-240-9580)** for more information.

Newborns' and Mothers' Health Protection Act Notice

Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the Mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain Authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Availability of HIPAA Notice of Privacy Practices

To: Participants in the Salt Lake Community College Employee Health Plan

From: Human Resources

Re: Availability of Notice of Privacy Practices

The Salt Lake Community College Employee Health Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please go to http://i.slcc.edu/hr/benefits/required-ee-notices.aspx.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have 60 days from the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event and provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact Human Resources at 801-957-4210.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

SALT LAKE COMMUNITY COLLEGE

Policy #: 010-351024
VSP

Ameritas
fulfilling life.

Vision Plan Benefits

	VSP Choice Network	Out-of-Network
Annual Eye Exam	Covered in full	Up to $45
Single Vision Lenses	Covered in full	Up to $30
Bifocal Lenses	Covered in full	Up to $50
Trifocal Lenses	Covered in full	Up to $65
Lenticular Lenses	Covered in full	Up to $100
Progressive Lenses	See lens options	NA
Frames	$150	$70
Contacts (standard) fit & follow up exam	Member cost up to $60	$0
Contacts (elective)	Up to $150	Up to $120
Contacts (medically necessary)	Covered in full	Up to $ 210

Deductible

Annual Eye Exam	$20	$20
Eyeglass Lenses or Frames	$25	$25

Benefit Frequencies (months)

	Based on Date of Service
Exam/Lens/Frame	12/12/24

Member cost for lens options (May vary by prescription, options chosen and retail location)

Progressive Lenses	Up to provider's contracted fee for lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the progressive lens charge.	Up to Lined Bifocal allowance
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

TO: All SLCC Employees

FROM: Human Resources

Federal law requires that every employer, regardless of size, provide the MarketPlace (Exchange) Notice to all employees – regardless of hours worked or benefits eligibility.

Your coverage will not be affected if you are eligible to enroll in Salt Lake Community College's group health plan.

You can find more information to help you make your decision at www.healthcare.gov. You can also call (800) 318-2596. According to government regulations, we are not allowed to provide further information about the contents of this notice or assistance in evaluating your options for exchange coverage or the potential penalties under the law.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or

SLCC Benefits Department - 801-957-3877 or HR Front Desk 801-957-4210

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Salt Lake Community College	87-6000448
5. Employer address	**6. Employer phone number**
4600 S Redwood Road	801-957-4210

7. City	8. State	9. ZIP code
Salt Lake City	UT	84123

10. Who can we contact about employee health coverage at this job?	
Benefits Department - Jessica Doyle	
11. Phone number (if different from above)	**12. Email address**
801-957-3877	jdoyle27@slcc.edu

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

⊡ Some employees. Eligible employees are:

Full-time regular employees (75% FTE or more) hired in a designated benefits eligible position are eligible to participate in this plan.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your legal spouse or domestic partner with a Domestic Partnerships Agreement on file.
Your biological or adopted children and those of your spouse or domestic partner who are under age 26 or those over 26 who are incapable of self-support.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

MEDICARE ADVANTAGE PLAN

Salt Lake Community College sponsors a Medicare Advantage Plan available to retirees of the College. The plan is administered through **Regence Blue Cross Blue Shield**. This group plan offers lower premiums than an individual Advantage Plan.

hat s Medicare Ad antage ee If This Pri ate Market Alternati e to Traditional Medicare Could e or You

More American seniors are choosing Medicare Ad antage plans than e er before. ind out hy and hether they are a good fit for you.

Medicare Ad antage Plans also called Medicare Part C operate more like traditional health insurance than Original Medicare. Multiple pri ate insurers offer different Ad antage plans. If you choose to enroll in Medicare Part C, it ill replace your Part A co erage. o e er, Medicare Ad antage offers all of the ser ices that are included in Medicare Part A . Medicare Ad antage plans can also choose to pro ide additional benefits that are not offered by Parts A . You can bundle important benefits such as hearing aids and prescription drug co erage into your Part C plan.

ome people find Medicare Ad antage plans to be more con enient and affordable than Original Medicare. Your maximum out-of-pocket costs on all Part C plans are limited to no more than $6,700 per year and some are much less.

EMPLOYEE ASSISTANCE PROGRAM

Get help and support with life's challenges

How well we deal with life's challenges is a key component to healthy living. That's why your employer and Regence offer you an Employee Assistance Program (EAP). Designed to provide support and assistance for a wide variety of issues, the EAP can help you and your family stay healthy. The EAP is available at no extra cost to you as an employee and to anyone living in your household or dependent on your income.

The EAP offers access to many services at no cost to you and discounts on others:

Confidential counseling: Up to 8 counseling sessions (face-to-face, on the phone or video chat) for issues relating to relationships, anxiety, work stress and other common challenges.

24-hour crisis help: Toll-free access during a crisis situation.

Online consultations: Convenient access to online consultations with licensed counselors.

Tess, AI chatbot: 24/7 chatbot for emotional support and check-ins to boost wellness.

Peer support groups: Online support groups for addiction, depression, bipolar, parenting and anxiety.

Regence

uprisehealth

EAP & Work-Life Services

An Overview for Employees

Life presents us with challenges at work and at home on a daily basis. You do not have to face these challenges alone, even if you're far away.

We Are Here to Help

EAP benefits are available to all employees and their families at NO COST to you. The EAP offers confidential advice, support, and practical solutions to real-life issues. You can access these confidential services by calling the toll-free number and speaking with our care team, or accessing online.

EAP Services for Employees & Families

Confidential Counseling
Up to 4 face-to-face, video or telephonic counseling sessions for relationship and family issues, stress, anxiety, and other common challenges.

24-hour Crisis Help
Toll-free access for you or a family member experiencing a crisis.

Online Peer Support Groups
Online support groups for addiction recovery, anxiety, depression, frontline workers, grief and loss, parenting, and more.

Tess, AI Chat-bot
24/7 chatbot for emotional support and check-ins to boost wellness.