Regence

Regence MedAdvantage Retiree Rate Sheet

Salt Lake Community College Retirees

January 1, 2024 - December 31, 2024

Plan	Rate
Regence MedAdvantage + Rx Primary (PPO)	**$0**
Regence MedAdvantage + Rx Classic w/ Comp Dental (PPO)	**$58**

- You must continue to pay your Medicare Part B premium.
- Rate changes are effective January 1 of each year

Regence

Regence MedAdvantage + Rx Primary (PPO)

2024 Summary of Benefits

January 1, 2024 – December 31, 2024

for retirees of groups based in Utah

For more information

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

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

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

What you need to know about this book

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

Who can join?

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

Tips for comparing your Medicare benefits

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

Which doctors, hospitals, and pharmacies can I use?

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

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

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

Regence MedAdvantage + Rx Primary

Plan costs & limits	
Annual deductible	$0
Maximum out-of-pocket responsibility Annual limit on your out-of-pocket costs for your Medicare-covered services. This amount does not include prescription drugs. If you reach the limit on out-of-pocket costs, we will pay the full cost for Medicare-covered services for the rest of the year.	$6,700 for services you receive from in-network providers. $13,300 for services you receive from in- and out-of-network providers combined.

Medical benefits	In-network	Out-of-network
Inpatient hospital coverage[1] Our plan covers an unlimited number of days per stay	$410 per day: days 1-5 $0 per day: days 6 and beyond	30%
Outpatient hospital services[1]		
Wound care services	$45	30%
All other services	$400	30%
Ambulatory surgery center services[1]		
Wound care services	$45	30%
All other services	$300	30%
Doctor visits		
Primary care provider	$0	30%
Specialist	$45	30%
Preventive care Medicare-covered services: Abdominal aortic aneurysm screening Alcohol misuse screening and counseling Annual wellness visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease risk reduction visit Cardiovascular disease testing	$0	30%

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

Medical benefits	In-network	Out-of-network
Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screenings Diabetes screenings HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling Vaccines (flu, pneumonia, COVID-19, Hepatitis B) "Welcome to Medicare" visit (one-time)		
Annual routine physical exam	$0	30%
Emergency care Your copay is waived if admitted to the hospital within 48 hours.		
Emergency room visit	$100	$100
Worldwide emergency care	$100	$100
Urgently needed services		
Urgent care visit	$45	$45
Virtual urgent care visits - through our virtual care provider Doctor On Demand	$0	Not covered
Worldwide urgent care visit	$100	$100
Diagnostic services/labs/imaging		
HbA1C testing	$0	30%
Lab services[1]	$25	30%
Outpatient x-rays	$20	30%

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

Medical benefits	In-network	Out-of-network
Diagnostic tests and procedures[1]	$25	30%
Diagnostic mammography	$0	30%
Diagnostic radiology (MRI, CT, etc.)[1]	$275	30%
Hearing services Exam to diagnose and treat hearing and balance issues	$45	30%
Routine hearing exam[2] - 1 per calendar year, in-network services provided by TruHearing	$0	$150
Hearing aids[2] - 1 per ear per calendar year, aids must be provided by TruHearing	$699 or $999 per aid	Not covered
Dental services Medicare-covered services	$45	30%
Preventive and diagnostic dental services[2] Oral exams, bitewing and diagnostic x-rays, cleanings or periodontal maintenance, and fluoride, 2 every calendar year Periodontal scaling/root planing, 1 every calendar year Full- mouth or panoramic x-rays, 1 every 3 years	$0	50%
Vision services Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	$0	30%
Routine exam[2] - 1 per calendar year, in-network services provided by VSP	$0	30%
Routine eyewear[2] - in-network services provided by VSP Lenses - standard basic single-vision, lined bifocal, lined trifocal or lenticular are covered Frames or contacts - allowance for in- or out-of-network every calendar year	$0 $100	50% $100

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

Medical benefits	In-network	Out-of-network
Mental health services		
Inpatient psychiatric hospital[1] - 190-day lifetime maximum	$387 per day: days 1-5 $0 per day: days 6-190	30%: days 1-190
Outpatient therapy[1] - individual or group	$30	30%
Virtual mental health visits - through our virtual care provider Doctor On Demand	$0	Not covered
Skilled nursing facility[1] Up to 100 days covered per benefit period	$0 per day: days 1-20 $203 per day: days 21-54 $0 per day: days 55-100	30%: days 1-100
Outpatient rehabilitation services[1]		
Occupational therapy	$30	30%
Physical and speech language therapy	$30	30%
Ambulance[1] Copay per each one-way Medicare-covered transport		
Ground ambulance	$300	$300
Air ambulance	$300	$300
Worldwide ground or air ambulance	$300	$300
Transportation	Not covered	Not covered
Medicare Part B drugs[1]		
Chemotherapy drugs	0%-20% (depending on the drug)	30%
Other Part B drugs	0%-20% (depending on the drug)	30%
Part B insulin	20% up to $35	30%
Acupuncture		
Medicare-covered services - limited to treatment of chronic low back pain	$20	30%

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

Medical benefits	In-network	Out-of-network
Chiropractic Medicare-covered services - limited to manipulation of the spine to correct a subluxation	$20	30%
Diabetic services Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour and Breeze or LifeScan OneTouch	$0	50%
Continuous glucose monitor (CGM) and supplies[1] - in-network limited to Dexcom and Abbott FreeStyle Libre	$0	50%
Diabetes self-management training	$0	30%
Lancets, lancet devices, therapeutic shoes, and inserts	$0	50%
Diabetic routine footcare[2] - 6 visits per calendar year	$0	30%
Medicare diabetes prevention program (MDPP)	$0	$0
Durable medical equipment (DME)[1]	20%	50%
Fitness program[2] Fitness membership through the Silver&Fit program	$0	Not covered
Home delivered meals[2] Post discharge - 2 meals per day, up to 28 days, 56-meal limit per eligible episode	$0	Not covered
Chronic health needs - 2 meals per day, up to 56 days, 112-meal limit per eligible episode Requires enrollment in care management program The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.	$0	Not covered

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

Medical benefits	In-network	Out-of-network
Opioid treatment program services[1]	$0	30%
Outpatient substance abuse[1] Individual or group	$30	30%

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

Prescription drugs

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

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

Annual prescription (Part D) deductible stage	$0 for Tiers 1 and 2, Tiers 3 and 4 insulins, and most vaccines $250 for Tiers 3, 4 and 5

Initial coverage stage (the amount you pay until you and your plan have paid $5,030 for covered drugs)	**30-day**	**up to 100-day**
Tier 1: Preferred generic		
Preferred retail	$0	$0
Mail order	$0	$0
Standard retail	$10	$20
Tier 2: Generic		
Preferred retail	$13	$26
Mail order	$13	$0
Standard retail	$20	$40
Tier 3: Preferred brand		
Preferred retail	$40	$100
Mail order	$40	$100
Standard retail	$47	$117.50
Tier 4: Non-preferred drug		
Preferred retail	$100	$250
Mail order	$100	$250
Standard retail	$100	$250
Tier 5: Specialty		
Preferred retail / mail order	28%	N/A
Standard retail	28%	N/A

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

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

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

Coverage gap stage (the amount you pay after you **and** your plan have paid $5,030 for covered drugs)

After you enter the Coverage gap, you pay 25% of the plan's cost for covered brand name drugs, and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the Coverage gap.

You pay covered insulin products at the Initial coverage cost share during the Coverage gap stage.

Catastrophic coverage stage (the amount you pay after **your** total out-of-pocket costs reach $8,000)

After your yearly out-of-pocket drug costs reach $8,000, you pay nothing.

Pre-enrollment checklist

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

Understanding the Benefits

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

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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Regence MedAdvantage + Rx Classic (PPO) with Comp Dental

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Regence MedAdvantage + Rx Classic with Comp Dental

Plan costs & limits	
Annual deductible	$0
Maximum out-of-pocket responsibility Annual limit on your out-of-pocket costs for your Medicare-covered services. This amount does not include prescription drugs. If you reach the limit on out-of-pocket costs, we will pay the full cost for Medicare-covered services for the rest of the year.	$5,900 for services you receive from in-network providers. $9,550 for services you receive from in- and out-of-network providers combined.

Medical benefits	In-network	Out-of-network
Inpatient hospital coverage[1] Our plan covers an unlimited number of days per stay	$375 per day: days 1-5 $0 per day: days 6 and beyond	30%
Outpatient hospital services[1]		
Wound care services	$35	30%
All other services	$325	30%
Ambulatory surgery center services[1]		
Wound care services	$35	30%
All other services	$225	30%
Doctor visits		
Primary care provider	$0	30%
Specialist	$35	30%
Preventive care Medicare-covered services: Abdominal aortic aneurysm screening Alcohol misuse screening and counseling Annual wellness visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease risk reduction visit Cardiovascular disease testing	$0	30%

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

Medical benefits	In-network	Out-of-network
Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screenings Diabetes screenings HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling Vaccines (flu, pneumonia, COVID-19, Hepatitis B) "Welcome to Medicare" visit (one-time)		
Annual routine physical exam	$0	30%
Emergency care Your copay is waived if admitted to the hospital within 48 hours.		
Emergency room visit	$120	$120
Worldwide emergency care	$120	$120
Urgently needed services		
Urgent care visit	$40	$40
Virtual urgent care visits - through our virtual care provider Doctor On Demand	$0	Not covered
Worldwide urgent care visit	$120	$120
Diagnostic services/labs/imaging		
HbA1C testing	$0	30%
Lab services[1]	$10	30%
Outpatient x-rays	$10	30%

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

Medical benefits	In-network	Out-of-network
Diagnostic tests and procedures[1]	$10	30%
Diagnostic mammography	$0	30%
Diagnostic radiology (MRI, CT, etc.)[1]	$250	30%
Hearing services Exam to diagnose and treat hearing and balance issues	$35	30%
Routine hearing exam[2] - 1 per calendar year, in-network services provided by TruHearing	$0	$150
Hearing aids[2] - 1 per ear per calendar year, aids must be provided by TruHearing	$699 or $999 per aid	Not covered
Dental services Medicare-covered services	$35	30%
Preventive and diagnostic dental services[2] Oral exams, bitewing and diagnostic x-rays, cleanings or periodontal maintenance, and fluoride, 2 every calendar year Periodontal scaling/root planing, 1 every calendar year Full- mouth or panoramic x-rays, 1 every 3 years	$0	50%
Restorative dental services - comprehensive[2] Crowns, dentures, fillings, extractions, endodontics, certain other periodontics, and oral surgery	50% $1,000 benefit limit per year for covered services	50% $1,000 benefit limit per year for covered services
Vision services Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	$0	30%
Routine exam[2] - 1 per calendar year, in-network services provided by VSP	$0	30%

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

Medical benefits	In-network	Out-of-network
Routine eyewear[2] - in-network services provided by VSP Lenses - standard basic single-vision, lined bifocal, lined trifocal or lenticular are covered Frames or contacts - allowance for in- or out-of-network every calendar year	$0 $100	50% $100
Mental health services Inpatient psychiatric hospital[1] - 190-day lifetime maximum	$375 per day: days 1-5 $0 per day: days 6-190	30%: days 1-190
Outpatient therapy[1] - individual or group	$25	30%
Virtual mental health visits - through our virtual care provider Doctor On Demand	$0	Not covered
Skilled nursing facility[1] Up to 100 days covered per benefit period	$0 per day: days 1-20 $203 per day: days 21-51 $0 per day: days 52-100	30%: days 1-100
Outpatient rehabilitation services[1] Occupational therapy	$25	30%
Physical and speech language therapy	$25	30%
Ambulance[1] Copay per each one-way Medicare-covered transport Ground ambulance	$275	$275
Air ambulance	$275	$275
Worldwide ground or air ambulance	$275	$275
Transportation	Not covered	Not covered
Medicare Part B drugs[1] Chemotherapy drugs	0%-20% (depending on the drug)	30%

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

Medical benefits	In-network	Out-of-network
Other Part B drugs	0%-20% (depending on the drug)	30%
Part B insulin	20% up to $35	30%
Acupuncture Medicare-covered services - limited to treatment of chronic low back pain	$20	30%
Chiropractic Medicare-covered services - limited to manipulation of the spine to correct a subluxation	$20	30%
Additional covered services[2] - limit of 15 visits per calendar year	$20	30%
Diabetic services Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour and Breeze or LifeScan OneTouch	$0	50%
Continuous glucose monitor (CGM) and supplies[1] - in-network limited to Dexcom and Abbott FreeStyle Libre	$0	50%
Diabetes self-management training	$0	30%
Lancets, lancet devices, therapeutic shoes, and inserts	$0	50%
Diabetic routine footcare[2] - 6 visits per calendar year	$0	30%
Medicare diabetes prevention program (MDPP)	$0	$0
Durable medical equipment (DME)[1]	20%	50%
Fitness program[2] Fitness membership through the Silver&Fit program	$0	Not covered

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

Medical benefits	In-network	Out-of-network
Home delivered meals[2] Post discharge - 2 meals per day, up to 28 days, 56-meal limit per eligible episode	$0	Not covered
Chronic health needs - 2 meals per day, up to 56 days, 112-meal limit per eligible episode Requires enrollment in care management program The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.	$0	Not covered
Opioid treatment program services[1]	$0	30%
Outpatient substance abuse[1] Individual or group	$25	30%
Over the counter (OTC) items[2] Allowance given every three months	$20	
Personal emergency response system (PERS)[2] Includes 1 Lively Mobile Plus medical alert device and monthly monitoring services	$0	Not covered

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Prescription drugs

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

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

Annual prescription (Part D) deductible stage	$0 for Tiers 1 and 2, Tiers 3 and 4 insulins, and most vaccines $150 for Tiers 3, 4 and 5

Initial coverage stage (the amount you pay until you and your plan have paid $5,030 for covered drugs)	**30-day**	**up to 100-day**
Tier 1: Preferred generic		
Preferred retail	$0	$0
Mail order	$0	$0
Standard retail	$10	$20
Tier 2: Generic		
Preferred retail	$13	$26
Mail order	$13	$0
Standard retail	$20	$40
Tier 3: Preferred brand		
Preferred retail	$40	$100
Mail order	$40	$100
Standard retail	$47	$117.50
Tier 4: Non-preferred drug		
Preferred retail	$100	$250
Mail order	$100	$250
Standard retail	$100	$250
Tier 5: Specialty		
Preferred retail / mail order	30%	N/A
Standard retail	30%	N/A

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

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

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

Coverage gap stage (the amount you pay after you **and** your plan have paid $5,030 for covered drugs)

After you enter the Coverage gap, you pay 25% of the plan's cost for covered brand name drugs, and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the Coverage gap.

You pay covered insulin products at the Initial coverage cost share during the Coverage gap stage.

Catastrophic coverage stage (the amount you pay after **your** total out-of-pocket costs reach $8,000)

After your yearly out-of-pocket drug costs reach $8,000, you pay nothing.

Pre-enrollment checklist

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

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- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Disclaimers

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

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

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

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

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

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

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

Multi-Language Insert

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी पर्श्न के जवाब देने के िकए हमारे पास मुफ्त दुभाषिकया सेवाएँ उिपब्ध हैं. एक दुभाषिकया पर्ाप्त करने के िकए, बस हमें 1-800-541-8981 पर फोन करें. कोई व्यिक्त जो कहन्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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

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

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

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

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

Applications can be submitted two different ways:

Mail to:

Regence MedAdvantage
PO Box 1827
Medford OR 97501

Or FAX to:

1-888-335-2988
(no coversheet is necessary)

Regence

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

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

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

Salt Lake Community College

•PLEASE PRINT IN INK•

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

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

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

Employer or Trust Name:

SLCC

Please continue on next page

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

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

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

Please select a premium payment option:

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

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

Account Holder Name: _____

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

Bank Routing Number: _____

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

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

Employer or Trust Name

SLCC

Please continue on next page

Please read and answer these important questions

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

If "yes", please list your other coverage:

Name of the other coverage: _____

ID Number for this coverage: _____

Group Number for this coverage: _____

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

3. Are you the retiree? ☐ Yes ☐ No

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

   Name of Institution: _____

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

   _____

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

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

First and Last Name of PCP: _____

PCP Address: _____

PCP Phone Number: _____

Employer or Trust Name:
SLCC

Please continue on next page

Answering these following 2 questions is your choice. You can't be denied coverage because you don't fill them out.

1. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

2. What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ **I choose not to answer.**
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan

Please read and sign on page 5

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

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

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

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

Katie Keil - 000000407115 - 0105076-0004

Tina Davis - 000000407104 - 0108057-0000

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

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

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

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

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

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

Name: _____ Relationship to enrollee: _____

Address: _____ Phone Number: _____

Office Use Only

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

Plan ID#: _____

Effective Date of Coverage: _____

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

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

Employer or Trust Name
SLCC

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IMPORTANT INFORMATION:

2024 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Regence BlueCross BlueShield of Utah - H4605

For 2024, Regence BlueCross BlueShield of Utah - H4605 received the following Star Ratings from Medicare:

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

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

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

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

The number of stars show how well a plan performs.

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

Get More Information on Star Ratings Online

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

Questions about this plan?

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