Salt Lake Community College
Regence HSA Healthplan 3.0SM
$1,700 Deductible

Effective July 1, 2024 through June 30, 2025

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

Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible you pay per plan year	$1,700 Individual $3,400 Family	$3,500 Individual $7,000 Family
Annual Prescription Deductible	The total deductible you pay per plan year for prescription medications	Shared with In-Network medical	
Annual Out-of-Pocket Maximum	The combined total for your deductible(s), coinsurance and copays per [calendar / plan] year. Ambulance, blood bank, emergency room services, and Prescription Medications apply towards the In-Network amount.	$3,500 Individual $7,000 Family	$7,000 Individual $14,000 Family

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.

The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed $7,000, including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Member.

Be aware that your actual costs for Covered Services provided by an Out-of-Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network providers can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

Medical Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
Primary Care Visits (for Illness or Injury)		$25 copay per visit	30%
Specialist Visits		$35 copay per visit	30%
Urgent Care Visits		$35 copay per visit	30%
Other Professional Services		10%	30%
Preventive Care / Immunizations	Preventive Employee Wellness Incentives available	Covered in full	30%
Radiology and Laboratory - Outpatient		10%	30%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	10%	30%
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment	10%, In-Network deductible applies	
Ambulatory Surgical Center		10%	30%
Emergency Room	Facility and professional services	10%, In-Network deductible applies	
Hearing Aids and Evaluations	$2,500 limit every plan year Excludes: routine hearing exams, assistive hearing technology systems, batteries or cords	10%	30%
Hearing Examinations	1 exam per plan year Routine hearing examination	10%	30%
Home Health Care		10%	30%
Home Infusion Therapy	$50,000 limit every plan year for Parenteral Nutrition	$25 copay per visit	30%
Hospice Care		10%	30%
Hospital Care		10%	30%
Infertility (diagnosis and treatment)	$5,000 limit per lifetime	10%	30%
Injury to Teeth	$1,000 limit every plan year	10%	30%
Maternity Care		10%	30%
Mental Health / Substance Use Disorder - Inpatient		10%	30%
Mental Health / Substance Use Disorder - Outpatient	In addition to this benefit, see Employee Assistance Program option	$25 copay per visit	30%
Neurodevelopmental Therapy	30 visits per plan year, combined with Outpatient Rehabilitation Available only for children up to age 18	10%	30%
Nutritional Counseling	Diabetic Nutritional Counseling Only	10%	30%
Orthotics	$200 limit every plan year	10%	30%
Rehabilitation Services - Inpatient	60 days per plan year	10%	30%

Medical Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
Rehabilitation Services - Outpatient	30 visits per plan year, combined with Neurodevelopmental Therapy	10%	30%
Skilled Nursing Facility	60 days per plan year	10%	30%
Spinal Manipulations	20 spinal manipulations per plan year	10%	30%
Temporomandibular Joint (TMJ) Disorders	$500 limit per lifetime	10%	30%
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility (includes Mental Health visits)	**Vendor:** $10 copay per visit	Not Covered
		In-Network non-Vendor Provider: $10 copay per visit	30%

Prescription Medication Benefits (*unless stated otherwise, a deductible applies*)		What You Pay
Tier 1	90-day supply for retail or home delivery	$7 retail prescription* $7 home delivery prescription
Tier 2	90-day supply for retail or home delivery	$7 retail prescription* $7 home delivery prescription
Tier 3^	90-day supply for retail or home delivery	25% up to $150 maximum retail prescription 25% up to $300 maximum home delivery prescription
Tier 4	90-day supply for retail or home delivery	30% up to $175 maximum retail prescription 30% up to $437.50 maximum home delivery prescription
Tier 5	30-day supply for retail	10% up to $250 maximum participating pharmacy retail prescription
Tier 6	30-day supply for retail	15% up to $300 maximum participating pharmacy retail prescription

**1 copay per 30-day supply*
Deductible waived on retail or home delivery prescriptions for medications on the Optimum Value Medication List (OVML) located on Our website
^***Insulin Cost Share Cap:*** *Retail or home delivery: $28 cap on Claimant cost share per 30-day supply, deductible waived; $84 cap on Claimant cost share up to 90-day supply, deductible waived*
You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance
More information about prescription drug coverage, including tier specific information, is available at https://regence.com/go/2024/UT/6tierLG

Value-Added Services	
Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service.	
Employee Assistance Program (EAP)	EAP is short-term, confidential counseling with no out-of-pocket expense (8 mental health counseling visits per issue).
Kidney Health Management	If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD).
Mobile APP	Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing.
Nurse Advice	You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care 24/7. However, if You are experiencing a medical emergency, immediately call 911 instead.
Pregnancy Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions, the Pregnancy Program can help.
Regence Advantages	Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services.
Regence Empower	Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle.

Out-of-Area Services

Outside of the service area, Claimants have In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global™ Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. Out-of-Network, You may be balance billed. Call 1 (800) 810 BLUE (2583) to learn how to get access.

Frequently Asked Questions	
How is my privacy protected?	Regence is committed to the confidentiality and security of Your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of Your personal information. You can view Our full privacy practices online at regence.com.
What if I need access to specialty care? Do I need a referral?	You can receive care from any in-network provider without a referral. For some services, prior authorization may be required.
Is there a cost for "Covered in full"?	No, if Your benefit is covered in full there is no copay or deductible.

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 Claimants under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and Claimants.

Customer Service: 1 (866) 240-9580 - TTY: 711 | 2890 East Cottonwood Parkway, Salt Lake City, UT 84121 | regence.com

NONDISCRIMINATION NOTICE

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

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

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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