Regence

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

Salt Lake Community College Medical Plan: Preferred℠

Effective July 1, 2018 through June 30, 2019

	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
Annual Costs		
Coinsurance	20%	40%
Deductible per Plan Year	$400 Individual / $800 Family	$1,000 Individual / $2,000 Family
Out-of-Pocket Maximum per Plan Year	$3,200 Individual / $6,500 Family	$5,000 Individual / $10,000 Family
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 Services		
Unless stated otherwise, a deductible applies		
Primary Care (for illness or injury)	$35 copay per visit (deductible waived)	40%
Specialist	$45 copay per visit (deductible waived)	40%
Urgent Care	$50 copay per visit (deductible waived)	40%
Other Professional Services	20%	40%
Preventive Care/Immunizations • Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA)	0% coinsurance (deductible waived)	40%
Ambulance Services	20%	20%
Ambulatory Surgical Center	20%	40%
Emergency Room (Including Professional Charges)	20%	20%
Hearing Exam • Limit: 1 exam per Plan Year	$35 copay per visit (deductible waived)	40%
Home Health Care	$35 copay per visit (deductible waived)	40%
Home Infusion Therapy • Limit: $50,000 per Plan Year for Parenteral Nutrition	$35 copay per visit (deductible waived)	40%
Hospice Care	20% (deductible waived)	40%
Hospital Care	20%	40%
Infertility (Diagnosis & Treatment) • Limit: $5,000 per Lifetime	$35 copay per visit (deductible waived)	40%
Injury to Teeth • Limit: $1,000 per Plan Year	20%	40%
Maternity Care	20%	40%

	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
Mental Health/Substance Use Disorder Therapy Services - Inpatient	20%	40%
Mental Health/Substance Use Disorder Therapy / Non-Therapy Services - Outpatient	$35 copay per visit (deductible waived)	40%
Neurodevelopmental Therapy – Outpatient • Limit: 30 visits per Plan Year combined with Outpatient Rehabilitation • Children up to age 18	$35 copay per visit (deductible waived)	40%
Nutritional Counseling • Limit: Diabetic nutritional counseling only	20%	40%
Orthotics – Foot • Limit: $200 per Plan Year	20%	40%
Radiology and Laboratory – Outpatient Minor	20%	40%
Radiology and Laboratory – Outpatient Major	$50 copay per visit	40%
Rehabilitation Services • Limit: 60 Inpatient days per Plan Year • Limit: 30 Outpatient visits per Plan Year combined with Outpatient Neurodevelopmental Therapy	$35 copay per visit (deductible waived)	40%
Skilled Nursing Facility (SNF) Care • Limit: 60 days per Plan Year	20%	40%
Spinal Manipulations • Limit: 20 visits per Plan Year	$35 copay per visit (deductible waived)	40%
Telehealth	$10 copay per visit (deductible waived)	Not covered
Temporomandibular Joint (TMJ) Disorders • Limit: $500 per Lifetime	20%	40%

Prescription Medication Services – Administered by VRx	
Coverage is limited to a 34-day supply or 100-unit doses, whichever is greater for retail, 90-day supply for mail order and 30-day supply for Specialty. Unless stated otherwise, a deductible applies.	
Deductible per Plan Year	$100 Individual / $300 Family
Out of Pocket per Plan Year	$2,000 Individual / $6,000 Family
Generic • Deductible waived	$7 retail prescription $7 mail order prescription
Preferred Brand	25% retail prescription up to $150 maximum 25% mail order prescription up to $300 maximum
Nonpreferred Brand	30% retail prescription up to $175 maximum 30% mail order prescription up to $437.50 maximum
Specialty	10% generic / preferred brand up to $250 maximum 15% nonpreferred brand up to $300 maximum

Please note: This benefit summary provides a brief description or illustration of your health care plan benefits, limitations and/or exclusions under your health care plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our website, 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.

1 (866) 240-9580 - **TTY: 711**
MS CS B32B, PO Box 1827 Medford, OR 97501-9884
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, koji' hódíilnih 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.

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: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको 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: ຖ້າ ' າ ທ ' ານເວ ົ້ າພາສາ ລາວ, ການບ ໍ ລ ິ ການຊ ' ວຍເຫ ຼ ອດ ້ ານພາສາ, ໂດຍ ' ເສ ັ ຽຄ ' າ, ແມ ' ນມ ີ ພ ້ ອມໃຫ ້ ທ ' ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

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)