



Regence

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



Oregon Fire Chiefs Association

Medical Plan 2

Effective July 1, 2019 through June 30, 2020

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	\$1,000 Individual \$3,000 Family	\$1,000 Individual \$3,000 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	\$4,000 Individual \$8,000 Family	\$6,000 Individual \$12,000 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 Benefits (unless stated otherwise, a deductible applies)		What You Pay	
Primary Care Visits (for Illness or Injury)		\$20, deductible waived	40%
Specialist Visits		\$20, deductible waived	40%
Urgent Care Visits		\$20, deductible waived	40%
Other Professional Services		20%	40%
Preventive Care/Immunizations	<ul style="list-style-type: none"> 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) Childhood Immunizations covered at no cost 	0%, deductible waived	40%
Ambulance Services	<ul style="list-style-type: none"> 6 visits per calendar year 	20%	20%
Biofeedback	<ul style="list-style-type: none"> 10 visits per lifetime 	\$20, deductible waived	40%
Complementary Care	<ul style="list-style-type: none"> Chiropractic spinal manipulations and acupuncture services from any licensed provider \$2,000 limit per calendar year 	\$20, deductible waived	\$20, deductible waived
Durable Medical Equipment & Prosthetics		20%	40%
Emergency Room (Including Professional Charges)		\$100 copay per visit, deductible waived	\$100 copay per visit, deductible waived
Hearing Aids & Evaluations	<ul style="list-style-type: none"> One hearing aid per ear every 36 months for members under age 26 	20%	40%
Hospice Care	<ul style="list-style-type: none"> 30 days of respite care per lifetime 	20%	40%
Hospital Care		20%	40%
Maternity Care		20%	40%
Mental Health/Substance Use Disorder - Inpatient		20%	40%
Mental Health/Substance Use Disorder - Outpatient		\$20 copay per outpatient office/psychotherapy visit, deductible waived	40%
Neurodevelopmental Therapy - Outpatient	<ul style="list-style-type: none"> 30 visits per calendar year Children under the age of 18 	\$20, deductible waived	40%
Nutritional Counseling	<ul style="list-style-type: none"> 5 visits per lifetime 	20%	40%
Palliative Care	<ul style="list-style-type: none"> 30 visits per calendar year 	20%	40%

Radiology and Laboratory - Outpatient		20%, deductible waived	40%
Advanced Imaging	• CT, PET, MRA, SPECT, Bone Density, MRI	20%	40%
Rehabilitation Services - Inpatient	• 30 days per calendar year	20%	40%
Rehabilitation Services - Outpatient	• 30 visits per calendar year	\$20, deductible waived	40%
Skilled Nursing Facility (SNF) Care	• 60 days per calendar year	20%	40%
Telehealth		\$0 copay per session, deductible waived	Not covered
Therapeutic Injections		20%	40%

Vision Benefits		What You Pay	
Routine Eye Exam	• 1 per calendar year	\$20 copay, deductible waived	\$20 copay, deductible waived
Hardware		No charge up to \$300 maximum per year	No charge up to \$300 maximum per year

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.

1 (866) 240-9580 - TTY: 711 | 100 SW Market Street, Portland, OR 97201 | 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>.

