Regence

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

Oregon Fire Chiefs Association

Medical Plan 3 - REDMOND FIRE

Effective July 1, 2021 through June 30, 2022

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	$2,000 Individual $6,000 Family	$2,000 Individual $6,000 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$6,000 Individual $12,000 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)		$25, deductible waived	40%
Specialist Visits		$25, deductible waived	40%
Urgent Care Visits		$25, 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%, deductible waived	40%
Acupuncture and Spinal Manipulations	• Chiropractic spinal manipulations and acupuncture services from any licensed provider • $2,000 limit per calendar year	$25, deductible waived	$25, deductible waived
Ambulance Services	• 6 visits per calendar year	20%	20%
Biofeedback	• 10 visits per lifetime	$25, deductible waived	40%
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	• One hearing aid per ear every 36 months for members under age 26	20%	40%
Hospice Care	• 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		$25 copay per outpatient office/psychotherapy visit, deductible waived	40%
Neurodevelopmental Therapy - Outpatient	• 30 visits per calendar year • Children under the age of 18	$25, deductible waived	40%
Newborn Home Visits	• Within 6 months of age, at least one visit during first 3 months, with up to 3 more available	0%, deductible waived	Not covered
Nutritional Counseling	• 5 visits per lifetime	20%	40%
Palliative Care	• 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	$25, deductible waived	40%
Skilled Nursing Facility (SNF) Care	• 60 days per calendar year	20%	40%
Telehealth		$0 copay per session, deductible waived	40%
Therapeutic Injections		20%	40%

Vision Benefits	**What You Pay**	
Routine Eye Exam	Not Covered	Not Covered
Hardware	Not Covered	Not Covered

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

Regence

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

Oregon Fire Chiefs Association

Pharmacy Plans

Effective July 1, 2021 through June 30, 2022

Option 1

Prescription Medication Benefits		What You Pay
Annual Deductible	The total deductible you pay per calendar year	$0
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
Preferred Generic	90-day supply for retail or mail order	$2 retail prescription* / $3 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Generic	90-day supply for retail or mail order	$10 retail prescription* / $15 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Preferred Brand^	90-day supply for retail or mail order	$20 retail prescription* / $30 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Brand	90-day supply for retail or mail order	$50 retail prescription* / $75 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Preferred Specialty	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication
Specialty	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication

**1 copay per 30 day supply*
^$100 cap on member cost share per 30 day retail supply insulin, deductible waived
^$300 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived
More information about prescription drug coverage is available at https://regence.com/go/2021/OR/6tierLG

Option 2 - REDMOND FIRE

Prescription Medication Benefits		What You Pay
Annual Deductible	The total deductible you pay per calendar year	$0
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
Preferred Generic	90-day supply for retail or mail order	$2 retail prescription* / $3 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Generic	90-day supply for retail or mail order	$10 retail prescription* / $15 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Preferred Brand^	90-day supply for retail or mail order	$30 retail prescription* / $45 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Brand	90-day supply for retail or mail order	$50 retail prescription* / $75 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Preferred Specialty	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication
Specialty	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication

**1 copay per 30 day supply*
^$100 cap on member cost share per 30 day retail supply insulin, deductible waived
^$300 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived
More information about prescription drug coverage is available at https://regence.com/go/2021/OR/6tierLG

Option 3

Prescription Medication Benefits		What You Pay
Annual Deductible	The total deductible you pay per calendar year	$0
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
Preferred Generic	90-day supply for retail or mail order	$2 retail prescription* / $3 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Generic	90-day supply for retail or mail order	$10 retail prescription* / $15 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Preferred Brand^	90-day supply for retail or mail order	$40 retail prescription* / $60 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Brand	90-day supply for retail or mail order	$60 retail prescription* / $90 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Preferred Specialty	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication
Specialty	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication

**1 copay per 30 day supply*
^$100 cap on member cost share per 30 day retail supply insulin, deductible waived
^$300 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived
More information about prescription drug coverage is available at https://regence.com/go/2021/OR/6tierLG

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.

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