Regence

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

Oregon Fire Chiefs Association

Medical Plan 4V

Effective July 1, 2020 through June 30, 2021

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	$1,500 Individual $4,500 Family	$1,500 Individual $4,500 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$4,500 Individual $9,000 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 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) • Childhood Immunizations covered at no cost	0%, deductible waived	40%
Acupuncture and Chiropractic 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%
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	• 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.

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。

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 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. ໂທຣ 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)

Oregon Fire Chiefs Association

Pharmacy Copay Plan Summary

Effective July 1, 2019

Option 1

	1-30 Day Supply Retail	90 Day Supply Mail
Value Tier	**$ 2**	**$ 3**
Generic Medications	**$ 10**	**$ 15**
Preferred Medications	**$ 20**	**$ 30**
Non-Preferred Medications	**$ 50**	**$ 75**
Specialty Medications	**$ 50**	**N/A**

Option 2

	1-30 Day Supply Retail	90 Day Supply Mail
Value Tier	**$ 2**	**$ 3**
Generic Medications	**$ 10**	**$ 15**
Preferred Medications	**$ 30**	**$ 45**
Non-Preferred Medications	**$ 50**	**$ 75**
Specialty Medications	**$ 50**	**N/A**

Option 3

	1-30 Day Supply Retail	90 Day Supply Mail
Value Tier	**$ 2**	**$ 3**
Generic Medications	**$ 10**	**$ 15**
Preferred Medications	**$ 40**	**$ 60**
Non-Preferred Medications	**$ 60**	**$ 90**
Specialty Medications	**$ 50**	**N/A**

Maximum Out of Pocket (MOOP): Please refer to your medical plan summary for details.

Specialty Medications: Specialty medications must be ordered through Caremark Specialty Pharmacy, limited to a 30 day supply and require prior authorization or step therapy for preferred products.

Generic Policy: If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand co-pay plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.

DRUGS COVERED*

- Legend Drugs (drugs that require a prescription) **Exceptions**: See Exclusion list below.
- Compound medications of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding $300 per script will require prior authorization.
- Contraceptives: Oral, Transdermal, Intravaginal, Implants/IUD and Injectable; extended cycle products are subject to 3x retail copays for a 90 day supply
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes/lancets
- Prescription Vitamins
- Topical Acne Agents (prior authorization required over age 34)
- Androgens (prior authorization required)
- ADD/ADHD Medications
- Narcolepsy Medications (prior authorization required)
- Oral/Intranasal/Topical Fentanyl Products (prior authorization required)
- Growth Hormones (prior authorization required)
- Migraine medications (quantity limits apply)
- Influenza Agents (quantity limits apply)
- Antiemetics (quantity limits apply)
- Extended Release Controlled Substances-Opioid Analgesics (quantity limits apply)
- Prescription and OTC smoking cessation (two 12 week programs per plan year) OTC requires prescription
- Glumetza/Fortamet and Zegerid (Prior authorization required)

EXCLUSIONS*

- Biological, blood products, serums, immunoglobulin, and Non-ACA immunization agents
- Cosmetic agents (Anti-wrinkle agents, Depigmenting agents, Hair growth stimulants and removal products)
- Compounded prescriptions that use ingredients such as bulk chemicals, high cost powders, and compound kits
- Topical Analgesic Pain Patches
- Anabolic Steroids
- Infertility Medications
- Impotency Medications
- New to market drugs, including line extensions and new strengths until clinically reviewed
- Anti-obesity/Appetite suppression
- Over the counter (OTC) medications
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Patient assistance programs may not apply to deductible and out of pocket accumulations.

*** This is not an inclusive list but is a representation of the most commonly used medications.**

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits.

NOTE: Be on the lookout for additional pharmacy plan information to come