



Regence

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



Oregon Fire Chiefs Association

HSA PV Plan

Effective July 1, 2025 through June 30, 2026

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per Plan year	\$3,300 Individual \$6,600 Family	\$6,000 Individual \$12,000 Family

Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per Plan year	\$6,000 Individual \$12,000 Family	\$7,000 Individual \$14,000 Family
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The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed \$6,850, 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	
Primary Care Visits (for Illness or Injury)	Visiting a Blue Distinction Total Care (BDTC) provider will result in a lower out-of-pocket expense for most office visits Coinsurance waived for first 3 primary care/behavioral health visits after deductible has been met	20% coinsurance	50% coinsurance
Specialist Visits		20% coinsurance	50% coinsurance
Urgent Care Visits		20% coinsurance	50% coinsurance
Other Professional Services		20% coinsurance	50% coinsurance
Preventive Care/Immunizations		0% coinsurance, deductible waived	50% coinsurance
Acupuncture	• Limit: 30 visits per Plan year	20% coinsurance	50% coinsurance
Ambulance Services		20% coinsurance	20% coinsurance
Ambulatory Surgical Center		20% coinsurance	50% coinsurance
Emergency Room (Including Professional Charges)		20% coinsurance	20% coinsurance
Hearing Aids & Evaluations	• 1 hearing aid per ear, every Plan year	20% coinsurance	50% coinsurance
Hearing Examinations	• Limit: 1 exam per Plan year	20% coinsurance	50% coinsurance
Home Health Care	• Limit: 140 visits per Plan year	20% coinsurance	50% coinsurance
Hospice Care	• Limit: 30 inpatient or outpatient respite care days per lifetime	20% coinsurance	50% coinsurance
Hospital Care		20% coinsurance	50% coinsurance
Infertility (Diagnosis, treatment, and assisted reproduction)	• \$5,000 limit per lifetime • Dollar limit shared with pharmacy	20% coinsurance, deductible waived	50% coinsurance
Massage Therapy	• Limit: 12 visits per Plan year • Licensed Massage Therapists Only	20% coinsurance	50% coinsurance
Maternity Care		20% coinsurance	50% coinsurance
Behavioral Health - Inpatient	• Mental health, behavioral health, or substance abuse services.	20% coinsurance	50% coinsurance
Behavioral Health - Outpatient	Coinsurance waived for first 3 primary care/behavioral health visits after deductible has been met	20% coinsurance	50% coinsurance

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
	<ul style="list-style-type: none"> Mental health, behavioral health, or substance abuse services. 		
Neurodevelopmental Therapy	<ul style="list-style-type: none"> Limit: 30 visits per Plan year 	20% coinsurance	50% coinsurance
Newborn Home Visits	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Limit: 5 visits per lifetime 	20% coinsurance	50% coinsurance
Radiology and Laboratory - Outpatient		20% coinsurance	50% coinsurance
Advanced Imaging	<ul style="list-style-type: none"> CT, PET, MRA, SPECT, Bone Density, MRI 	20% coinsurance	50% coinsurance
Rehabilitation Services - Inpatient	<ul style="list-style-type: none"> Limit: 30 days per Plan year 	20% coinsurance	50% coinsurance
Rehabilitation Services - Outpatient	<ul style="list-style-type: none"> Limit: 30 visits combined per Plan year 	20% coinsurance	50% coinsurance
Skilled Nursing Facility (SNF) Care	<ul style="list-style-type: none"> Limit: 60 days per Plan year 	20% coinsurance	50% coinsurance
Spinal Manipulations		20% coinsurance	50% coinsurance
Vendor Telehealth – MDLIVE		10% coinsurance	N/A
Virtual Care - Telehealth		10% coinsurance	50% coinsurance

VSP Vision Benefits		What You Pay	
Routine Eye Exam	<ul style="list-style-type: none"> Limit: 1 per Plan year 	\$25 copay, deductible waived	No charge up to \$45
Contact Lens Fitting	<ul style="list-style-type: none"> Limit: 1 per Plan year 	No charge	Applies to the hardware limit
Hardware		No charge up to \$250 maximum per year	No charge up to \$250 maximum per year

Prescription Medication Benefits (unless stated otherwise, a deductible applies)		What You Pay
Annual Deductible	The total deductible you pay per Plan year	Shared with medical
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per Plan year	Shared with medical
Tier 1	30-day supply for retail, 90-day supply for mail order	20% coinsurance, retail or mail order prescription
Tier 2	30-day supply for retail, 90-day supply for mail order	20% coinsurance, retail or mail order prescription
Tier 3	30-day supply for retail, 90-day supply for mail order	20% coinsurance, retail or mail order prescription
Tier 4	30-day supply for retail	20% coinsurance
Compound Medications	30-day supply for retail	50% coinsurance

\$35 cap on member cost share per 30 day retail supply insulin, deductible waived
\$105 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/2024/OR/4tier>

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](https://www.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](https://www.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@regencecom

Customer Service for all other plans

Civil Rights Coordinator

MS CS B32B, PO Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regencecom

You can also file a civil rights complaint with the US 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:

US 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 jii'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 ដោយមិនគិតល្អល គឺអាចមានសំរាប់បម្រើអ្នក។ 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)

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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)

ប្រគល់: បើសិនជា អ្នកនិយាយ ភាសា ខ្មែរ, ការបំរើការជំនួយផ្នែកភាសា, ដោយមិនគិតល្អល គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 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 بہ 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 فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711)