Regence HSA Healthplan

Regence BlueCross BlueShield of Oregon

$2,500 Single Coverage Deductible / $5,000 Family Coverage Deductible
Preferred Provider Plan Network

Your Regence HSA Healthplan provides coverage for services provided by In-Network and Out-Of-Network physicians and other professional providers as listed below. Once enrolled, the **Preferred Provider Plan Network** is the panel of providers for which you will receive the greatest benefits. For assistance in locating an In-Network physician or provider please visit our Web site at **www.or.regence.com**. **Please note**: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Please refer to your benefits booklet for a complete list of benefits and the limitations and exclusions that apply.

Benefit Features	In-Network Provider Benefit	Out-Of-Network Provider Benefit
Lifetime maximum benefit	$2,000,000	
Deductible per calendar year	$2,500 single coverage $5,000 family coverage	
Out-of-pocket maximum amount per calendar year including deductible	$5,000 single coverage $10,000 family coverage	None
After the out-of-pocket maximum is met each calendar year, we pay	100%	N/A

Please note: The single coverage deductible and out-of-pocket maximum both apply when an individual is enrolled without dependents. The family coverage deductible and out-of-pocket maximum both apply when an individual and one or more dependents are enrolled. When family coverage applies, the entire family deductible must be met before benefits begin for any family member.

Preventive Care Services	**Deductible Waived - We Pay**	
Immunizations for adults and children	80%	60%
Well-baby and well-child care including related lab and x-ray services	80%	60%
Women's exams including Pap tests and mammograms	80%	60%
Adult routine physical exams including related lab and x-ray services	80%	60%
Professional Services	**After Deductible - We Pay**	
Office visits, in-office procedures and urgent care	80%	60%
Diagnostic x-ray and laboratory services	80%	60%
Therapeutic injections such as allergy shots	80%	60%
Surgery	80%	60%
Maternity care	80%	60%
Hospital Services	**After Deductible - We Pay**	
Emergency room care for medical emergency	80%	
Emergency room for medical non-emergency	80%	60%
Inpatient stay including maternity and rehabilitation	80%	60%
Inpatient and residential mental illness/chemical dependency	80%	60%
Outpatient services including surgery, diagnostic radiology and lab	80%	60%
Other Services	**After Deductible - We Pay**	
Ambulance	80%	
Prescription medication including mail-order	80% (90-day supply maximum allowance)	
Rehabilitation including occupational, speech and physical therapy	80%	60%
Skilled nursing facility, home health and hospice care	80%	60%
Durable medical equipment and supplies	80%	60%

Additional Benefits and Information	
BlueCard® program	Provides savings nationwide by using physicians and other professional providers of the Blue Cross and/or Blue Shield Plan in the area where you receive the service. Using providers outside of the Blue Cross and/or Blue Shield Plan may likely result in greater out of pocket expenses. Find a provider near you at **www.bcbs.com**.
myRegence.com	**myRegence.com** is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to **www.myRegence.com** and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.

Please see page 2 for limitations and exclusions >

Limitations and Exclusions

This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Please refer to your benefits booklet for a complete list of benefits and the limitations and exclusions that apply. Once enrolled, your benefits booklet can be viewed online at our Web site, **www.or.regence.com**.

Mental Illness and Chemical Dependency Schedule	
Mental Illness Treatment	
Inpatient and Residential/partial-hospitalization Care	8 days per calendar year
Outpatient Care	12 visits per calendar year
Chemical Dependency Treatment	
Inpatient, Residential/partial hospitalization, and Outpatient Care	$14,000 per 24 consecutive months

These Benefits Are Limited

- We provide transplant coverage only to those who have been covered by us, or another insurer with similar transplant coverage, for a total of at least 12 months (or since birth), providing there is no lapse between the two coverages. Benefits are based on the recipient's eligibility, not the donor's. Our payment for certain covered transplant services and supplies is limited to a lifetime maximum of $250,000 per enrollee.
- Inpatient rehabilitation care is limited to $15,000 per calendar year.
- Outpatient rehabilitation care is limited to $1,500 per calendar year.
- Neurodevelopmental therapy is limited to $1,500 per calendar year. Some plans have an age limit. Please refer to your benefits booklet for details.
- Home health care is limited to 130 visits per calendar year.
- Skilled nursing facility care is limited to 100 days per stay.
- Ground and air ambulance combined is limited to $5,000 per calendar year for non-emergencies.
- Temporomandibular joint disorder benefit is limited to $1,000 per calendar year and $5,000 per lifetime.
- Dental care is limited to the treatment of an accidental injury to natural teeth or fractured jaw and limited to $1,000 per calendar year. Diagnosis must be made within 6 months and treatment within 12 months of injury.
- Hospitalization for medically necessary dental care is limited to $1,000 per calendar year.
- Growth hormone benefit, when eligible according to the benefits booklet, is limited to $20,000 per calendar year.
- Acupuncture is limited to 12 treatments per calendar year.
- Spinal manipulation is limited to 10 treatments per calendar year.
- Preexisting conditions will not be covered during a waiting period after enrollment. You may receive credit from prior medical coverage. See your benefits booklet or employer for details.

These Pharmacy Benefits Are Not Covered

- Nonprescription medications, prescription medications with no proven therapeutic indication and prescription medications that are not medically necessary.
- Prescription medications for smoking cessation.
- Prescription medications for weight loss or treatment of obesity.
- Medications prescribed for cosmetic purposes and for treatment of hair loss or removal regardless of cause.
- Prescription medications for the treatment of impotence regardless of cause and for the treatment of infertility.

Prostate and Colorectal Cancer Screening

Covered services include medically necessary prostate and colorectal cancer screenings. Please refer to your benefits booklet for how cancer screenings are covered.

Emergency Care Guidelines

Covered services include the medical examination and ancillary tests required in determining the extent of an emergency medical condition. Examples include:

Suspected heart attack	Serious burn
Loss of consciousness	Poisoning
Bleeding that does not stop	Severe pain

These Services And Supplies Are Not Covered

- Expenses incurred before coverage begins or after coverage ends.
- Services provided by a member of your immediate family.
- Treatment not medically necessary (except as may be specifically provided).
- Eye exams, eye exercises, eyeglasses, routine foot care and hearing aids (except as specified in the benefits booklet).
- Self-help or training, instructional and physical exercise programs.
- Appliances or equipment primarily for comfort or convenience, custodial care and private duty nursing.
- Surgery or treatment (including any later complications) for obesity or weight control.
- Surgery to alter the refractive character of the eye.
- Orthopedic shoes.
- Cosmetic/reconstructive services, supplies and medications, including complications resulting from such services (except as specified in the benefits booklet).
- Orthognathic services.
- Services and supplies for family planning (except sterilization), artificial insemination, in vitro fertilization, diagnosis and treatment of infertility or surgery to correct voluntary sterilization.
- Dental exams and treatments (except as specified in the benefits booklet).
- Counseling or treatment in the absence of illness (except as specified in the benefits booklet).
- Experimental and investigational treatment, procedures, equipment, medications, devices and supplies.
- Third party liability, motor vehicle coverage and work-related conditions.
- Services and supplies to diagnosis or treat paraphilia.
- Services and supplies to diagnosis or treat gender identity disorders (including sex change procedures).
- Treatment of mental illness for which there is no effective cure.

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

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Toll-free, all areas 1 (800) 228-0978

TDD Line for people with hearing impairments 1 (800) 382-1003

www.or.regence.com