Traditional Plan

Regence BlueCross BlueShield of Oregon

Your Traditional Plan provides coverage for services provided by participating physicians and other professional providers as listed below. For assistance in locating a participating provider near you, please refer to your Traditional and Preferred Provider Directory or visit our Web site at **www.or.regence.com**. Participating providers will not charge you more than the fees they have filed or contracted with us. Nonparticipating providers may charge you more than our maximum allowable fees.

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	
Lifetime maximum benefit	$2,000,000
Deductible per calendar year	None
We pay covered expenses up to this amount each calendar year	$7,500 per person ($15,000 per family)
Your maximum coinsurance of covered expenses each calendar year	$3,750 per person ($7,500 per family)
After your maximum coinsurance is met each calendar year, we pay	100%
Preventive Services	**We Pay**
Immunizations for adults and children	100%
Well-baby exam to age 2	100% after $15 copayment
Routine physical exam including related diagnostic radiology and lab	100% after $15 copayment
Annual women's exam including Pap test and mammogram	100% after $15 copayment
Vision and hearing exams through age 18	100% after $15 copayment
Dental preventive care for ages 3 through 12	100% after $15 copayment
Professional Services	
Office visits including urgent care	50%
Therapeutic injections including allergy shots	50%
Maternity care	50%
Diagnostic radiology and lab	50%
Surgery	50%
Hospital Services	
Inpatient hospital stay including maternity and rehabilitation	50%
Outpatient surgery	50%
Emergency room care for medical emergency	50%
Other Services	
Ambulance	50%
Mental illness/chemical dependency	50%
Rehabilitation including occupational, speech, and physical therapy	50%
Durable medical equipment and supplies	50%
Prescription medications	Member pays $15 copay or 50%, whichever is greater

Additional Information	
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.

See page 2 for limitations and exclusions >

IMPORTANT! Oregon state law specifies the benefits, limitations, and exclusions of this plan. A brief summary of the limitations and exclusions appear on the back of this page. A double asterisk (**) denotes some of the limitations on services that are different from those found in most health insurance plans.

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**.

Preventive Care Schedule	
Well-baby Care	
Newborn	Nursery care, including initial exam
First two years	7 well-baby exams
Physical Exams	
Age 2-6	Every calendar year
Age 7-18	Every 2 calendar years
Age 19-34	Every 4 calendar years
Age 35+	Every 2 calendar years
Women's Exams	
Annual breast & pelvic	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year
Immunizations (Not covered for travel or passport purposes)	
All ages	As indicated by provider
Eye and Hearing Exams	
Through age 18	Every 2 calendar years
Preventive Dental Exams	
Ages 3-12	Every 12 months (18 months for bitewing x-rays)

Chemotherapy Prescription Medication Information

Covered services include medically necessary self-administered chemotherapy medications, including oral medications. Please refer to your benefits booklet for how prescription medications are covered.

These Benefits Are Limited

- Residential care treatment for mental health conditions is limited to 45 days per calendar year per enrollee.
- Mental health treatment for parent-child relational problems, neglect or abuse of child, and bereavement is limited to children five years of age or younger.
- Palliative care (alleviation of symptoms) is limited to treatment of end stage HIV, terminal illness, extremely low birth weight newborns, anencephalic newborns, ALS, and other conditions specified in contract.**
- Transplant benefit payments are based on the recipient's eligibility, not the donor's.
- Orthognathic services are subject to a 50% copayment and coverage is based on criteria established by Regence BlueCross BlueShield of Oregon.
- Inpatient rehabilitation benefits are limited to 30 inpatient days per calendar year. Benefits are increased to 60 days per calendar year for head and spinal cord injuries or stroke. Neurodevelopmental therapy is limited to children age 17 and under.
- Outpatient rehabilitation benefits are limited to 30 sessions per calendar year. Benefits are increased to 60 sessions per calendar year for head and spinal cord injuries or stroke. Neurodevelopmental therapy is limited to children age 17 and under. Physical exercise programs are not included.
- Skilled Nursing Facility care is limited to 20 days per condition per calendar year.
- Infertility services are subject to a 50% copayment. Refer to **Services And Supplies Not Covered**.
- Home health care is limited to 60 days per condition per calendar year.
- Dental care is limited to the treatment of an accidental injury to natural teeth or a fractured jaw. Diagnoses must be made within 6 months and treatment within 12 months after the injury.

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

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.

Services And Supplies Not Covered

- Ongoing treatment for muscle strains, sprains, tendonitis, low back pain without spinal cord involvement, and other conditions determined by the Oregon Health Services Commission to have minimal effectiveness.**
- Treatment for temporomandibular joint disorder (TMJD).**
- Services related to or supporting in-vitro fertilization, reversal of sterilization procedures, and impotence medications.**
- Custodial care, personal hygiene, and other forms of supervised self-care.
- Services and supplies provided for obesity or weight reduction, including complications arising from such treatment.
- Mental health treatment for conditions and diagnosis that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.
- Services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners.
- Treatment, surgery, or counseling services for sexual reassignment.
- Mental health treatment for paraphilia for all ages.
- Developmental learning disabilities for age 18 and older.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Treatment(s), procedures, equipment, medications, devices, and supplies that are experimental or investigational.
- Treatment for addiction to tobacco, tobacco products, nicotine substitutes, or foods.
- Appliances or equipment primarily for personal comfort or convenience, and therapeutic devices including eyeglasses and hearing aids (except as specified in the benefits booklet).
- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Self-help training or instructional programs (except where specifically listed).
- Acupuncture, naturopathy, faith healing services, and homeopathy even when provided by plan participants (except where specifically listed).

****Denotes some important limitations and exclusions on services that are different from those found in most health insurance plans.**

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

Regence BlueCross BlueShield of Oregon
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