



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

Regence BlueCross BlueShield of Oregon

Preferred Provider Plan

Your Preferred Provider Plan provides coverage for services provided by Preferred Provider Plan Network and Non-Preferred physicians and other professional providers as listed below. For assistance in locating a **Preferred Provider Plan 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 | Preferred Provider Benefit | Non-Preferred Provider Benefit |
|---|--|--------------------------------|
| Lifetime maximum benefit | \$2,000,000 | |
| Individual deductible per calendar year | \$500 | |
| Maximum family deductible per calendar year | \$1,500 | |
| We pay covered expenses up to this amount | \$10,000 | |
| After \$10,000 in covered expenses each calendar year, we pay | 100% | |
| Maximum amount of covered expenses you pay each calendar year per person (your maximum coinsurance) | \$1,000 | \$2,000 |
| <p>Important note: Covered expenses paid at 100% and copayments do not accumulate toward your deductible or maximum coinsurance. Copayments will continue to be collected after your maximum coinsurance has been met.</p> | | |
| Preventive Care Services | We Pay | |
| Immunizations all ages (deductible waived) | 100% after \$10 copay | 100% after \$10 copay |
| Well-baby care (deductible waived) | 90% | 80% |
| Annual women's exam including Pap test and mammogram (subject to deductible) | 90% | 80% |
| Professional Services | After Deductible - We Pay | |
| Office visits | 90% | 80% |
| Diagnostic radiology and lab | 90% | 80% |
| Therapeutic injections including allergy shots | 90% | 80% |
| Maternity care | 90% | 80% |
| Surgery | 90% | 80% |
| Hospital Services | After Deductible - We Pay | |
| Inpatient stay including maternity and rehabilitation | 90% | 80% |
| Inpatient and residential mental illness/chemical dependency stay | 90% | 80% |
| Outpatient surgery | 90% | 80% |
| Emergency room care (copay waived if admitted to hospital or other facility on an inpatient basis) | 90% after \$100 copay | 80% after \$100 copay |
| Other Services | After Deductible - We Pay | |
| Ambulance | 90% | 80% |
| Rehabilitation including occupational, speech, and physical therapy | 90% | 80% |
| Skilled nursing facility, home health, and hospice care | 90% | 80% |
| Durable medical equipment and supplies | 90% | 80% |
| 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. | |

See page 2 for limitations and exclusions >

Limitations and Exclusions

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| Preventive Care Schedule | |
|--|-------------------------------------|
| Immunizations (Not covered for travel or passport purposes) | |
| All ages | As indicated by provider |
| Well-baby care | |
| Newborn | Nursery care including initial exam |
| First two years | 7 well-baby exams |
| Women's exam | |
| Annual breast & pelvic | Every calendar year |
| Mammograms | As indicated by provider |

| 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. |

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.
- Chiropractic services, acupuncture, massage therapy, and naturopathy are eligible only when provided by Washington Supplemental Providers and are subject to plan limits.
- 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 30 inpatient days per calendar year.
- Outpatient rehabilitation benefits including massage therapy 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 30 sessions per calendar year.
- Skilled Nursing Facility care is limited to 100 days per stay.
- Home health care is limited to 180 visits per calendar year.
- Dental care is limited to the treatment of an accidental injury to natural teeth or a fractured jaw. Diagnosis must be made within 6 months and treatment within 12 months of the injury.
- Nutritional counseling is covered for the initial visit and two follow up visits per condition.
- Ground ambulance is limited to 500 miles per calendar year for non-emergencies.
- 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.

| Mental Illness and Chemical Dependency Schedule | |
|---|------------------------------------|
| Mental Illness Treatment | |
| Inpatient and Residential Partial-Hospitalization care | 30 days per calendar year |
| Outpatient care | 7 visits per calendar year |
| Chemical Dependency Treatment | |
| Inpatient, Residential Partial-Hospitalization, and Outpatient care | \$14,500 per 24 consecutive months |

| 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 | |

Services And Supplies Not Covered

- Services provided by a member of the patient's immediate family.
- Services or supplies that are not medically necessary.
- Services related to or supporting infertility and reversal of sterilization procedures.
- Orthognathic surgery.
- 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.
- Services or supplies for the treatment of gender identity disorders.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Experimental or investigational treatment, procedures, equipment, devices, and supplies.
- 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.
- 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, instructional programs, and physical exercise programs (except where specifically listed).



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

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

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