

# Regence Breakthru<sup>SM</sup> 50



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

Regence BlueCross BlueShield of Oregon

Your Regence Breakthru 50 Plan 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. The **Supplemental Provider Listing** is the panel of providers for your acupuncture and spinal manipulation benefit. For assistance in locating an In-Network physician or provider please visit our Web site at [www.or.regence.com](http://www.or.regence.com).

**Please note:** This benefit summary provides a brief description of your health care plan benefits and it not a guarantee of payment. Please refer to your contract 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	
Calendar year deductible options per individual	\$2,500 or \$5,000	
Calendar year deductible per family	Maximum of 3 individual deductibles	
Maximum coinsurance per individual per calendar year	\$10,000	None
Maximum coinsurance per family per calendar year	Maximum of 3 individual coinsurance maximums	None
After the maximum coinsurance is met each calendar year, we pay	100%	N/A
<b>Please note:</b> Covered expenses paid at 100% and copays do not accumulate toward the deductible. Covered expenses paid at 100%, copays, and deductibles do not apply to the out-of-pocket maximum.		
<b>Professional Services</b>		<b>After Deductible - We Pay</b>
Office visits and other office procedures	50%	50%
Diagnostic radiology and lab	50%	50%
Therapeutic injections including allergy shots	50%	50%
Surgery	50%	50%
<b>Hospital Services</b>		<b>After Deductible - We Pay</b>
Emergency room care for medical emergency (copay waived if admitted to hospital or other facility on an inpatient basis)	50% after \$100 copay	
Emergency room care for non-emergency	50% after \$100 copay	50% after \$100 copay
Inpatient hospital stay including mental illness	50%	50%
Inpatient rehabilitation	50%	50%
Outpatient hospital services	50%	50%
<b>Other Services</b>		<b>After Deductible - We Pay</b>
Ambulance	50%	
Rehabilitation including occupational, speech, and physical therapy	50%	50%
Acupuncture and spinal manipulations	50%	50%
Skilled nursing facility, home health, and hospice care	50%	50%
Durable medical equipment and supplies	50%	50%
<b>Additional Benefits and Information</b>		
Regence Rx Discount program	Provides a discount program for prescriptions. All you need to do is show your member ID card at any participating pharmacy. Find a Participating Pharmacy at <a href="http://www.regencerox.com">www.regencerox.com</a> .	
BlueCard <sup>®</sup> program	Provides savings nationwide by using Participating 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 <a href="http://www.bcbs.com">www.bcbs.com</a> .	
myRegence.com	<b>myRegence.com</b> 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 <a href="http://www.myRegence.com">www.myRegence.com</a> 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 contract for a complete list of benefits and the limitations and exclusions that apply. Once enrolled, your contract can be viewed online at our Web site, [www.or.regence.com](http://www.or.regence.com).

### 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	

### Prostate and Colorectal Cancer Screening

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

### These Benefits Are Limited

- Outpatient mental illness is limited to 12 visits per calendar year.
- Inpatient mental illness is limited to 8 days per calendar year.
- Acupuncture is limited to 12 treatments per calendar year.
- Spinal manipulation is limited to 10 treatments per calendar year.
- Inpatient rehabilitation care is limited to \$4,000 per calendar year.
- Outpatient rehabilitation care is limited to \$2,000 per calendar year.
- Skilled nursing facility care is limited to 30 days per calendar year.
- Home health care is limited to 130 days per calendar year.
- Hospice care is limited to a 6 month maximum.
- Durable medical equipment is limited to \$2,500 per calendar year.
- Ground and air ambulance combined is limited to \$2,000 per calendar year (does not apply to emergent use).
- Growth hormone benefit, when eligible according to the contract, is limited to \$25,000 per calendar year.
- 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.
- There is a nine-month waiting period for removal of tonsils or adenoids with or without myringotomy, otitis media, allergies, sterilization, and preexisting conditions. We will reduce the duration of the waiting period if there is prior creditable coverage. See contract for further details.

### Services And Supplies Not Covered

- Services provided by a member of your immediate family.
- Services or supplies that are not medically necessary.
- Treatment for alcoholism and chemical dependency.
- Routine physical examinations including routine annual Pap test, routine immunizations, tests, and screening procedures.
- Foot care such as treatment for corns, calluses, removal of nails, other routine foot care, and orthopedic shoes.
- Treatment related to pregnancy, prenatal care, or delivery of a newborn, including routine newborn nursery care, including any complications related to maternity care.
- Treatment for obesity or weight control including surgery or any other treatment provided for obesity or weight control, and any complications arising out of such treatment.
- Surgery to alter the refractive character of the eye.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Orthognathic services.
- Services and supplies for family planning (except sterilization), artificial insemination, in vitro fertilizations, diagnosis and treatment of infertility or surgery to correct voluntary sterilization.
- Dental services or supplies (unless otherwise noted).
- Physical exercise programs
- Services or supplies for the treatment of personality and gender identity disorders.
- Self-help, training, and instructional programs for behavior modification.
- Counseling or treatment in the absence of illness.
- Immunizations for the sole purpose of travel or passports.
- Custodial care including routine nursing care and private duty nursing.
- Experimental and investigational treatment, procedures, equipment, devices, and supplies.
- Appliances or equipment primarily for personal comfort or convenience.
- The fitting, provision, or replacement of hearing aids.
- Eye examinations including eye exercises and the fitting, provision, or replacement of eyeglasses.



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Toll-free, all areas 1 (800) 365-3155

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

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