Blue Selections PPO

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

Regence BlueCross BlueShield of Oregon

Your Blue Selections PPO 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. For assistance in locating a Preferred physician and provider please refer to your provider directory or 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 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	
Individual deductible options per calendar year	$1,000, $2,500, $5,000	
Family deductible per calendar year	Maximum of three family members	
Maximum amount of covered expenses you pay each calendar year per person	$4,000	$8,000
After the maximum amount is met each calendar year, we pay	100%	
Important note: The deductible and covered expenses paid at 100% do not accumulate toward the maximum amount.		
Basic Services	**Deductible Waived - We Pay**	
Immunizations all ages	100% after $10 copay	
Well-baby exam to age 2	100% after $20 copay	
Annual women's exam including Pap test and mammogram	100% after $20 copay	
Office and urgent care visits for illness and injury	100% after $20 copay	
Therapeutic injections and allergy shots	100% after $20 copay	
Alternative care office visits	100% after $20 copay	Not Covered
Other Office and Professional Services	**After Deductible - We Pay**	
Surgical procedures	80%	60%
Maternity care	80%	60%
Diagnostic radiology and lab	80%	60%
Other alternative care services	80%	Not Covered
Hospital Services	**After Deductible - We Pay**	
Inpatient stay including maternity, rehabilitation, and mental illness	80%	60%
Visits and consultations in hospital	80%	60%
Outpatient surgery	80%	60%
Emergency room care for medical emergency (copay waived if admitted to hospital or other facility on an inpatient basis)	80% after $100 copay	
Emergency room care for non-emergency	80% after $100 copay	60% after $100 copay
Other Services	**After Deductible - We Pay**	
Ambulance	80%	
Outpatient rehabilitation (physical, speech, and occupational therapy)	80%	60%
Outpatient durable medical equipment and supplies	80%	60%
Transplant	100% (contracted facility)	60% (non-contracted facility)
Prescription and Vision Benefits	**No Deductible - We Pay**	
Outpatient prescription medications (does not apply toward your medical maximum coinsurance)	50%	
Vision exams (limited to once every 24 months per enrollee)	100% after $20 copay (Participating vision provider)	60%
Vision hardware (limited to once every 24 months per enrollee)	100% Up to allowances shown on page 2	

Additional Benefits and Information	
BlueCard® 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 **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 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.**

Preventive Care Schedule	
Immunizations (Not covered for travel or passport purposes)	
All ages	As indicated by physician
Well-baby Exams	
Up to age 2	As indicated by physician
Women's Exam	
Annual breast & pelvic	Every calendar year
Mammograms	As indicated by physician

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.

Vision Hardware Allowances	
Frames	Up to $85
Single Vision Lenses (pair)	Up to $96
Bifocal Lenses (pair)	Up to $134
Trifocal Lenses (pair)	Up to $180
Contacts in lieu of lenses & frames	Up to $181

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). Please refer to your contract for details on creditable coverage. Benefits are based on the recipient's eligibility, not the donor's. Our payment for all covered transplant services and supplies is limited to a lifetime maximum of $350,000 per enrollee. Covered services and supplies for the first 90-day period following the transplant will accrue towards the transplant lifetime maximum.
- 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 for children age six 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. Physical exercise programs are not included. Neurodevelopmental therapy is limited to 30 inpatient days per calendar year for children age six and under.
- Skilled Nursing Facility care is limited to 100 days per stay.
- Home health care is limited to 180 visits per calendar year.
- Ground and air ambulance combined is limited to $5,000 per calendar year (does not apply to emergent use).
- 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.
- The following will be covered only after nine months of enrollment: preexisting conditions, allergies, otitis media (ear infections), removal of tonsils and adenoids, alcoholism, and sterilization procedures. You may receive credit from prior creditable medical coverage, providing there is a less than 63-day lapse between the two coverages.

Mental Illness and Alcoholism Treatment Schedule	
Mental Illness Treatment Setting	
Inpatient Care or residential/partial hospitalization	30 days per calendar year
Outpatient Care	7 visits per calendar year
Alcoholism Treatment Setting	
Inpatient Care, Residential Care, and Outpatient Care	Combined $4,500 allowance every 24 consecutive months for all levels of care

Services And Supplies Not Covered

- Services provided by a member of your immediate family.
- Charges in excess of the amount allowed according to the terms of the contract.
- 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.
- Chronic or long-term psychotherapy (services provided in excess of crisis intervention or short-term therapy).
- Services or supplies for the treatment of personality disorders and gender identity disorders.
- 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.
- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Off-the-shelf orthotics or orthotics that are not medically necessary.
- Self-help training or instructional programs.

These Pharmacy Benefits Are Limited

- The maximum quantity for pharmacy purchased medications is a 34-day supply. Some medications may be limited by quantity rather than day supply.
- Some medications may require preauthorization by the health plan.
- Compound medications are only covered when one ingredient is a federal legend or state restricted medication.

Pharmacy Benefits Not Covered

- Impotence and infertility medications.
- Experimental/investigational medications
- Medications prescribed for cosmetic purposes.
- Smoking cessation products.

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

Regence BlueCross BlueShield of Oregon
Toll-free, all areas 1 (800) 365-3155
TDD Line for people with hearing impairments 1 (800) 382-1003
www.or.regence.com