

Blue Selections Premier Plan



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 Premier 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 an In-Network physician or 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 is 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	\$500*, \$1,000, \$2,500, \$5,000, \$7,500	
Family deductible per calendar year	Maximum of three family members	
Maximum amount of covered expenses you pay each calendar year per person (maximum coinsurance)	\$4,000	\$8,000
Family maximum coinsurance per calendar year	Maximum of three family members	
After your maximum coinsurance is met each calendar year, we pay	100%	100%
Important note: Your deductible and/or copayments do not accumulate toward your maximum coinsurance. Your maximum coinsurance accumulates separately for In-Network and Out-Of-Network providers. Copayments will continue to be collected after your maximum coinsurance has been met.		
*\$500 deductible is not available for policies with an April 1, 2009 effective date or later. Existing members are not affected.		
Preventive Care Services and Office Visits		Deductible Waived - We Pay
Immunizations for adults and children	100% after \$20 copay	100% after \$40 copay
Well-baby care to age 2 and well-child care	100% after \$20 copay	100% after \$40 copay
Annual women's exam including Pap test and mammogram	100% after \$20 copay	100% after \$40 copay
Adult routine physical exams	100% after \$20 copay	100% after \$40 copay
Office visits including office visits at urgent care	100% after \$20 copay	100% after \$40 copay
Other Professional Services		After Deductible - We Pay
Therapeutic injections such as allergy shots	80%	60%
Surgery	80%	60%
Maternity care	80%	60%
Diagnostic radiology and laboratory tests	80%	60%
Hospital Services		After Deductible - We Pay
Inpatient stay including maternity, rehabilitation, and mental health	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%
Skilled nursing facility, home health and hospice care	80%	60%
Durable medical equipment and supplies	80%	60%
Transplant	80%	60%
Prescription and Vision Benefits		No Deductible - We Pay
Generic prescription medications	100% after \$10 copay	
All other covered expenses for prescription medications	50%	
Vision exam once per calendar year	100% after \$20 copay	60%
Vision hardware (lenses, frames and contacts)	100% up to \$250 maximum allowance per calendar year	
Additional Benefits and Information		
Accident care	Deductible is waived for treatment of accidental injuries when treatment is received within 90 days of the injury. Coinsurance, limitations, and exclusions still apply.	
Accidental death	Provides \$25,000 for you and your enrolled adult spouse or domestic partner, \$5,000 for each enrolled dependent or a subscriber under the age of 18.	
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 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 care*	
Up to age 2	As indicated by physician
Well-child care*	
Age 2+	Every calendar year
Adult routine physical exams*	
All ages	Every calendar year
Women's exam including Pap test and mammogram	
Annual breast & pelvic	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year
*Includes related lab and x-ray services	

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.

Emergency Care Guidelines						
Covered services include the medical examination and ancillary tests required in determining the extent of an emergency medical condition. Examples include:						
<table border="1" style="width: 100%;"> <tr> <td>Suspected heart attack</td> <td>Serious burn</td> </tr> <tr> <td>Loss of consciousness</td> <td>Poisoning</td> </tr> <tr> <td>Bleeding that does not stop</td> <td>Severe pain</td> </tr> </table>	Suspected heart attack	Serious burn	Loss of consciousness	Poisoning	Bleeding that does not stop	Severe pain
Suspected heart attack	Serious burn					
Loss of consciousness	Poisoning					
Bleeding that does not stop	Severe pain					

Chemotherapy Prescription Medication Information
Covered services include medically necessary self-administered chemotherapy medications, including oral medications. Please refer to your contract for how prescription medications are covered.

These Benefits Are Limited

- Inpatient care for mental illness is limited to 30 days per calendar year.
- Treatment for alcoholism is limited to \$4,500 in any period of 24 months. This includes all levels of care; Inpatient, Residential and Outpatient care.
- 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 24 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 all covered transplant services and supplies is limited to a lifetime maximum of \$250,000 per enrollee.
- 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.
- Skilled Nursing Facility care is limited to 100 days per stay.
- Home health care is limited to 130 visits per calendar year.
- Temporomandibular joint disorder benefit is limited to \$1,000 per calendar year.
- The following will be covered only after twelve months of enrollment: elective procedures, allergies, and sterilization procedures. Additionally, pre-existing conditions will be covered only after six months of enrollment. You may receive credit from prior creditable medical coverage, providing there is a less than 63-day lapse between the two coverages.

Services And Supplies Not Covered

- Acupuncture, massage or massage therapy.
- Self-help or training (including behavior modification), instructional and physical exercise programs.
- Cosmetic/reconstructive services and supplies, including complications resulting from such services (except as specified in the contract).
- Counseling or treatment in the absence of illness (except as specified in the contract).
- Custodial care and private duty nursing.
- Dental exams and treatments (except as specific in the contract) and orthodontic treatment.
- Experimental and investigational treatment, procedures, equipment, medication, devices and supplies.
- Family planning, artificial insemination, in vitro fertilization, diagnosis and treatment of infertility or surgery to correct voluntary sterilization.
- Services to diagnosis or treat gender identity disorders (including sex change procedures).
- Growth hormones (except as specified in the contract).
- Developmental or learning disabilities for age 18 and older.
- Motor vehicle coverage or other insurance liability, third party liability and work-related conditions.
- Orthognathic services.
- Off the shelf orthopedic shoes and orthopedic inserts.
- Outpatient treatment for mental illness.
- Services to diagnosis or treat paraphilia.
- Treatment of personality disorders.
- Mental exams, eye exercises, hearing aids, and routine foot care (except as specified in the contract).
- Appliances or equipment primarily for comfort or convenience.
- Services provided by a member of your immediate family.
- Surgery to alter the refractive character of the eye.
- Treatment before enrollment begins or after coverage ends.
- Surgery or treatment for obesity or weight control (including any later complications).
- Treatment not medically necessary.
- Treatment for drug abuse or drug addiction.

These Pharmacy Benefits Are Limited

- The maximum quantity for pharmacy purchased medications is a 30-day supply. Some medications may be limited by quantity rather than day supply.
- Some medications may require prior authorization 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.



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

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

www.or.regence.com