PPO Portability Plan
Prevailing Option

Regence BlueCross BlueShield of Oregon

Your PPO Portability 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 medical deductible per calendar year	$750	$750
Maximum number of individual deductibles per calendar year per family	3	3
Maximum amount of covered expenses you pay each calendar year per person (coinsurance)	$3,000	$6,000
After your maximum coinsurance is met each calendar year, we pay	100%	100%
Important note: Covered expenses paid at the 100% level, or any deductible and/or copayments do not accumulate toward your maximum coinsurance. Your deductible and 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.		
Preventive Care Services	**After Deductible - We Pay**	
Immunizations for adults and children	80%	Not Covered
Well-baby exam to age 2	80%	Not Covered
Annual women's exam	80%	Not Covered
Routine physical exam for children and adults	80%	Not Covered
Professional Services	**After Deductible - We Pay**	
Office visits including mental illness/chemical dependency	80%	60%
Therapeutic injections including allergy shots	80%	60%
Maternity care	80%	60%
Surgery	80%	60%
Diagnostic radiology and lab including Pap test and mammogram	80%	60%
Hospital Services	**After Deductible - We Pay**	
Inpatient stay including maternity, rehabilitation, and mental illness/chemical dependency	80%	60%
Outpatient surgery	80%	60%
Emergency room care (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	100% (contracted facility)	60% (non-contracted facility)
Prescription Benefits (separate from medical)	**We Pay**	
Individual prescription deductible per calendar year	No deductible	
Maximum amount you pay each calendar year	No maximum	
Generic prescription medications	100% after $20 copay	
Preferred prescription medications	100% after $40 copay	
Non-preferred prescription medications	100% after $60 copay	

Additional 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

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 occupation or travel purposes)	
All ages	As indicated by physician
Well-baby exam	
Up to age 2	As indicated by physician
Women's exam	
Annual breast & pelvic	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year
Routine physical exam	
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

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:

Suspected heart attack	Serious burn
Loss of consciousness	Poisoning
Bleeding that does not stop	Severe pain

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.
- 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.
- Inpatient and outpatient rehabilitation benefits are limited to a combined 30 session maximum 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.
- Home health care is limited to 180 visits per calendar year.
- Skilled Nursing Facility care is limited to 100 days per stay.
- Ground ambulance is limited to 300 miles per calendar year and air ambulance is limited to $5,000 per calendar year.
- Dental care is limited to treatment of an accidental injury to natural teeth or fractured jaw. Diagnosis must be made within 6 months and treatment within 12 months of injury.

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 prior authorization by the health plan.
- Compound medications are only covered when one ingredient is a federal legend or state restricted medication.

Services And Supplies Not Covered

- Acupuncture, massage, and massage therapy.
- Cosmetic/Reconstructive services and supplies, including complications resulting from such services.
- Counseling or treatment in the absence of illness.
- Custodial care including routine nursing care and rest cures.
- Experimental and investigational treatments, procedures, equipment, medications, devices, and supplies.
- Family planning services and supplies including artificial insemination, in vitro fertilization, diagnosis and treatment of infertility, or surgery to correct voluntary sterilization.
- 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.
- Mental health treatment for paraphilia for all ages.
- Developmental and learning disabilities for age 18 and older.
- Motor vehicle coverage, other insurance liability, and third party liability.
- Orthognathic surgery.
- Physical exercise programs, instruction programs, and self-help or training programs, including those to stop smoking control weight, or provide general fitness.
- Routine physical examinations, mental examinations, eye examinations or eye exercises (except where specifically listed).
- 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.
- Services provided by a member of your immediate family.
- Surgery to alter the refractive character of the eye.
- The fitting, provision, or replacement of eyeglasses and hearing aids, including implantable hearing aids and the surgical procedure to implant them (except as specified in the contract).
- Treatment for obesity or weight control including complications resulting from such treatment.
- Treatment of impotence regardless of cause.
- Treatment not medically necessary.
- Treatment, surgery, or counseling services for sexual reassignment.

Pharmacy Benefits Not Covered

- Nonprescription medications.
- Prescription medications with no proven therapeutic indication or that are not medically necessary.
- Prescription medications for smoking cessation.
- Prescription medications for weight loss or treatment of obesity.
- Prescription medications for treatment of infertility.
- Medications prescribed for cosmetic purposes.
- Prescription medications for treatment of impotence regardless of cause.

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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