PUBLIC EMPLOYEES'
PEBB
BENEFIT BOARD

Regence

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

Regence BlueCross BlueShield of Oregon

PPO Plan

Effective January 1, 2009

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 refer to your provider directory or visit our Web site at **www.or.regence.com**.

Benefit Features	Preferred Provider Benefit	Non-Preferred Provider Benefit
Lifetime maximum benefit	$2,000,000	
Deductible per calendar year	None	
Maximum out-of-pocket per calendar year (covered expenses paid at 100% and copays do not accumulate toward the maximum out-of-pocket)	$1,000 Per Individual $3,000 Per Family	$2,000 Per Individual $6,000 Per Family
Preventive Care Services	**Member Responsibility**	
Immunizations all ages	0%	0%
Well-baby care	0%	30%
Routine periodic health appraisals including related lab and x-ray	0%	30%
Annual women's exam including Pap test and mammogram	0%	30%
Hearing examinations (does not apply toward the maximum out-of-pocket)	15%	30%
Professional Services		
Office visits and therapeutic injections including allergy shots	15%	30%
Outpatient mental illness/chemical dependency	15%	30%
Diagnostic radiology and lab	15%	30%
Maternity care	15%	30%
Surgery	15%	30%
Chiropractic, naturopathic, and acupuncturist care (does not apply toward the maximum out-of-pocket)	30%	
Hospital Services		
Inpatient stay including maternity and rehabilitation	15%	30%
Inpatient and residential mental illness/chemical dependency stay	15%	30%
Outpatient surgery	15%	30%
Emergency room care for medical emergency	15%	15%
Emergency room care for non-emergency	15%	30%
Other Services		
Ambulance	20%	
Skilled nursing and home health care	15%	30%
Durable medical equipment and supplies	15%	30%
Rehabilitation including occupational, speech, and physical therapy	15%	30%
Infertility (does not apply toward the maximum out-of-pocket)	50%	50%

Prescription Medications (does not apply toward the maximum out-of-pocket)	**Retail (34-day supply)**	**Mail Order (90-day supply)**
Generic medications	$5	$12.50
Preferred Brand medications	$15	$37.50
Non-Preferred Brand medications	Greater of $50 or 50% (plus the difference between generic and brand for multi source brands)	Greater of $125 or 50% (plus the difference between generic and brand for multi source brands)

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.

Please see page 2 for limitations, exclusions, and the preventive care frequency schedule >

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 benefits booklet for a complete list of benefits and the limitations and exclusions that apply. Once enrolled, your benefits booklet can be viewed online at our Web site, **www.or.regence.com.**

Preventive Care Frequency Schedule

Immunizations	
All ages	As indicated by provider
Well-baby care	
Newborn	Nursery care including initial exams
First two years	8 well-baby exams
Annual women's examinations	
Annual breast & pelvic	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year
Routine periodic health appraisals	
Age 2-18	Once every three years
Age 19-34	Once every five years
Age 35-59	Once every two years
Age 60+	Once every year
Hearing examinations	
All ages	Once every 12 months

These Pharmacy Benefits Are Limited

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

These Pharmacy Benefits Are Not Covered

- Non-prescription medications
- Prescription medications with no proven therapeutic indication or that are not medically necessary.
- Prescription mediation for weight loss, treatment of obesity, infertility, Impotence, or cosmetic purposes.
- Experimental or investigational medications.

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 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 60 sessions per calendar year. Neurodevelopmental therapy is limited to children age 17 and under.
- Skilled Nursing Facility care is limited to 180 days per calendar year.
- Home health care is limited to 180 visits per calendar year.
- Infertility services are limited to artificial insemination, including services related to or supporting artificial insemination, when medically necessary.
- 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.
- Hearing aids are limited to $4,000 every 4 years.
- Ground ambulance is limited to 500 miles per calendar year.

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.

Chemotherapy Prescription Medication Information

Covered services include medically necessary self-administered chemotherapy medications, including oral medications. Please refer to your benefits booklet for how prescription medications are covered.

Services And Supplies Not Covered

- Services provided by a member of the patient's immediate family.
- Treatment not medically necessary.
- Routine tests and screening procedures except as specifically listed.
- Eye examinations, the fitting, provision or replacement of eyeglasses and eye exercises.
- Self-help, training, and instructional programs including physical exercise programs.
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education (except as specified in the benefits booklet).
- Treatment for obesity or weight control including complications arising from such treatment except as specifically listed in the contract.
- Surgery to alter the refractive character of the eye.
- Massage or massage therapy.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Orthognathic services including surgery.
- Infertility medications, in vitro and in vivo fertilization, or GIFT and ZIFT procedures, including services related to or supporting in vitro fertilization, and reversal of sterilization procedures.
- Dental examinations, dental treatment, and orthodontic treatment except as specifically listed.
- Custodial care.
- Counseling or treatment in the absence of illness.
- Experimental or investigational services including treatments, procedures, equipment, medications, devices, and supplies.
- 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.
- Developmental learning disabilities for age 18 and older.
- 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.
- Treatment, surgery, or counseling services for sexual reassignment.
- Mental health treatment for paraphilia for all ages.

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) 228-0978

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

www.or.regence.com