

Plan I-B PPP Rx2

Effective August 1, 2008

Your Preferred Provider Plan provides coverage for services provided by Preferred and Non-Preferred physicians and other professional providers as listed below. For assistance in locating a **Preferred Provider Plan Network** physician or other professional provider please visit our Web site at www.myregence.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 benefits booklet for a complete list of benefits and the limitations and exclusions that apply.

Benefit Features	Preferred Provider Benefit	Non-Preferred Provider Benefit
Lifetime maximum benefit		\$2,000,000
Individual deductible per calendar year		\$200
Maximum family deductible per calendar year		\$600
We pay a percentage of covered expenses up to this amount		\$10,000
After \$10,000 of covered expenses each calendar year, we pay		100%
Maximum amount you pay each calendar year per person including deductible	\$2,200	\$4,200
Important note: Covered expenses paid at 100% and copayments do not accumulate toward your deductible or out-of-pocket maximum. Copayments will continue to be collected after your out-of-pocket maximum has been met. If two family members have met the out-of-pocket maximum, other enrolled family members need only meet any remaining family deductible to have covered expenses paid at 100% for the remainder of the calendar year.		
Preventive Care Services (see schedule on back)		Deductible Waived - We Pay
Annual women's exam including Pap and mammogram		100% after \$15 copay
Well-baby care up to age 2		100%
Routine physical exams including related lab and X-ray		100%
Routine immunizations through age 18		100% after \$5 copay
Routine immunizations age 19+ (deductible applies)	80%	60%
Professional Services		After Deductible - We Pay
Office visits including mental health/chemical dependency	80%	60%
Diagnostic radiology and lab	80%	60%
Therapeutic injections including allergy shots	80%	60%
Maternity care	80%	60%
Surgery	80%	60%
Chiropractic care (12 visit allowance per calendar year)		80%
Hospital Services		After Deductible - We Pay
Inpatient stay including maternity, mental health, chemical dependency and rehabilitation	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	60% after \$100 copay
Other Services		After Deductible - We Pay
Ambulance		80%
Rehabilitation including occupational, speech, and physical therapy		80%
Home health care		80%
Hospice (deductible waived)		100%
Additional accident (deductible waived for 90 days from injury date)	80%	60%
Durable medical equipment and supplies	80%	60%
Prescription Medications		Pharmacy Purchased (34-day supply) Mail Order (90-day supply)
Individual deductible per calendar year (separate from medical)		\$0
Out-of-pocket maximum per person per calendar year		\$2,500
Generic medication	\$10 copay	\$20 copay
Preferred medication	\$20 or 20%, whichever is greater	\$40 or 20%, whichever is greater
Non-Preferred medication	\$40 or 20%, whichever is greater	\$80 or 20%, whichever is greater
Additional Benefits		
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 .	



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 Schedule*	
Immunizations	
All ages	As indicated by provider
Well-baby care	
Newborn	Nursery care including initial exam
First two years	As indicated by provider
Women's exam	
Examination	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year
Routine physical exam including related lab and X-ray	
Age 2-18	Every 3 calendar years (\$200 allowance)
Age 19-34	Every 5 calendar years (\$250 allowance)
Age 35-59	Every 2 calendar years (\$250 allowance)
Age 60+	Every calendar year (\$250 allowance)
*Not covered for travel or employment purposes	
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.	

These Pharmacy Benefits Are Limited

- The maximum quantity for pharmacy purchased medications is a 34-day supply. The maximum quantity for mail order purchased medications is a 90-day supply. 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 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 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 180 visits per calendar year.
- 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.
- Ground ambulance is limited to 500 miles per calendar year.
- Chiropractic care is limited to 12 visits per calendar year and to the treatment of musculoskeletal disorders only.

These Pharmacy Benefits Are Not Covered

- Impotence, infertility, and experimental/investigational medications.
- Medications prescribed for cosmetic purposes (including, but not limited to Retin-A for anyone 26 years of age or over, Renova, Lamisil, Sporanox, and topical minoxidil).
- Smoking cessation products.
- Prescriptions purchased at a Non-Participating pharmacy.

Services And Supplies Not Covered

- Services provided by a member of the patient's 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.
- 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.
- 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.
- Developmental learning disabilities for age 18 and older.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Experimental and investigational treatment, procedures, equipment, devices, and supplies.
- 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 (except as specified in the benefits booklet).
- Hearing examinations and eye exercises.
- Surgery to alter the refractive character of the eye.
- Self-help training, instructional programs, and physical exercise programs (except where specifically listed).
- Below are services not covered by this medical plan unless your employer purchased them as part of your benefit package. Check with your group administrator.
 - Vision Care
 - Alternative Care



EASE EAP 1 (800) 654-9778
 CareGuide 1 (866) 245-2453
 Free & Clear 1 (800) 292-2336

Smoking Cessation: Oregon Quit Line 1 (877) 270-STOP

www.cisbenefits.org



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.myregence.com