

Medical Plan

Effective Date: April 1, 2012

Benefit Summary

Annual Maximum Benefit	\$2,000,000
In-Network Deductible per calendar year	\$250 Per Claimant \$750 Per Family (3 times the Claimant amount)
Out-of-Network Deductible per calendar year	\$500 Per Claimant \$1,500 Per Family (3 times the Claimant amount)
In-Network Maximum coinsurance per calendar year	\$2,000 Per Claimant \$6,000 Per Family (3 times the Claimant amount)
Out-of-Network Maximum coinsurance per calendar year	\$6,000 Per Claimant \$18,000 Per Family (3 times the Claimant amount)
After the maximum coinsurance is met, the Plan pays	100% for the remainder of the calendar year except where noted

Understanding Your Benefits

- The Plan will begin to pay benefits for covered services in any calendar year only after your deductible is satisfied. Your deductible applies for all services unless otherwise specified. **You have two Deductibles, one for services received by In-Network providers and a separate one for services received by Out-of-Network providers.** Copayments do not count toward the deductible.
- Once you have satisfied any applicable deductible and any applicable copayment, the Plan pays a percentage of the allowed amount for covered services. When payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Claimant Responsibility).

You Select Your Provider and Control Your Out-of-Pocket Expenses

- **In-Network (Preferred).** You choose to see a preferred provider and save the most in your out-of-pocket expenses. Choosing a preferred provider means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. You can find a list of providers at the Claims Administrator Website or by calling Customer Service.
- **Out-of-Network (Participating).** You choose to see a participating provider and your out-of-pocket expenses will generally be higher than if you choose preferred provider. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services.
- **Out-of-Network (Non-Participating).** You choose to see a provider that does not have a participating contract with the Claims Administrator and your out-of-pocket expenses will generally be higher than In-Network. Also, choosing this category means you may be billed for balances beyond any deductible, copayment, and/or coinsurance. This is sometimes referred to as balance billing.

Covered Medical Services (Per Claimant)	After Deductible - You Pay In-Network	After Deductible - You Pay Out-of-Network
Office Visits <ul style="list-style-type: none"> ▪ Each office visit including therapeutic injections and allergy shots ▪ For illness or injury 	\$25 copay (deductible waived)	40%
Preventive Care <ul style="list-style-type: none"> ▪ Preventive care services include routine well-baby care, routine physical examinations, routine immunizations and routine health screenings ▪ Provider counseling for tobacco use cessation ▪ Preventive care immunizations for children 	0% (deductible waived)	Participating 0% (deductible waived) Non-Participating 40%
Outpatient Laboratory and Radiology Services	20% (deductible waived)	40%

Covered Medical Services (Per Claimant)	After Deductible - You Pay In-Network	After Deductible - You Pay Out-of-Network
Professional Services ▪ Surgery, inpatient visits and diagnostic procedures	20%	40%
Ambulance Services	20%	20%
Durable Medical Equipment	20%	40%
Emergency Room (Including Professional Charges) ▪ Copay waived if admitted directly to a hospital or facility on an inpatient basis	\$150 copay per visit and 20% (deductible waived)	\$150 copay per visit and 20% (deductible waived)
Hearing Aids (For Eligible Dependents see Plan Document) ▪ Hearing evaluations and hearing aids	20%	40%
Hospital Care ▪ Inpatient, Outpatient and Ambulatory Service Facility	20%	40%
Maternity Care	20%	40%
Mental Health/Chemical Dependency Services - Inpatient, Residential and Outpatient	20% (deductible waived for outpatient services)	40% (deductible waived for outpatient services)
Neurodevelopmental Therapy ▪ Covered for children age 17 and under ▪ Inpatient: No limit ▪ Outpatient: 25 visit limit per calendar year	20%	40%
Nutritional Counseling ▪ 3 visit limit per Claimant lifetime	20%	40%
Rehabilitation Services ▪ Inpatient: 30 day limit per calendar year ▪ Outpatient: 25 visit limit per calendar year	20%	40%
Skilled Nursing Facility (SNF) Care ▪ 100 inpatient day limit per calendar year	20%	40%
Temporomandibular Joint (TMJ) Disorders	50%	50%
Tobacco Use Cessation ▪ \$500 per Claimant lifetime maximum benefit	20%	40%

Prescription Medication Benefits

Covered Prescription Medication Services (Per Claimant)	Copay Generic	Copay Formulary Brands	Copay Non-Formulary Brands
Prescription Medications from a Pharmacy ▪ 30-day supply for each prescription	\$20	\$40	\$60
Maintenance Medications from a Mail-Order Supplier ▪ 90-day supply for each prescription	\$30	\$60	\$90
Important note: Brand-name medications for tobacco use cessation are covered when obtained with a prescription order and limited to \$500 per Claimant lifetime.			

Please note: This summary provides a brief description of the Plan benefits, limitations, and exclusions and is not a guarantee of payment. Once enrolled, you can view the Plan benefits online at the Claims Administrator Website, www.myRegence.com. Please refer to the Plan for a complete list of benefits, the limitations and exclusions that apply, and a definition of medical necessity.

BlueCard[®] Program (Out of Area Services)

The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at www.bcbs.com or call 1 (800) 810-BLUE (2583).

General Exclusions

The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service for: 1) an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury, as required by federal law; 2) a preventive service as specified under the preventive care benefit; or 3) services and supplies furnished in an emergency room for stabilization of a patient.

Medical Exclusions

Alternative Care including acupuncture, chiropractic care, massage or massage therapy and the services of an acupuncturist, a chiropractor, a massage therapist and a naturopath.

Counseling in the absence of illness

Dental Services except as specifically provided under the repair of teeth benefit, the Plan does not cover dental services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before your effective date under the Plan or after your termination under the Plan, except as may be provided under the other continuation options of the Plan.

Growth Hormone Therapy except as provided under the prescription medication benefits.

Hearing Care: Except as specifically provided under the hearing aids benefit, the Plan does not cover hearing care, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

Infertility: Treatment of infertility, except to the extent covered services are required to diagnose such condition, including all assisted reproductive technologies and fertility drugs and medications.

Investigational Services: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures.

Mental Health Treatment For Certain Conditions including diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages. Additionally, the Plan will not cover any "V code" diagnoses except the following when medically necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger.

Motor Vehicle Coverage and Other Insurance Liability

Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing or duplicating medical reports and chart notes, itemized bills or claim forms and visits or consultations that are not in person, including telephone consultations and email exchanges.

Non-Duplication of Medicare: When, by law, this coverage would not be primary to Medicare had you properly enrolled in Medicare when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare, regardless of whether or not you choose to accept those benefits.

Obesity or Weight Reduction/Control: Medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Reversals of Sterilizations including services and supplies related to reversals of sterilization.

Self-Help, Self-Care, Training or Instructional Programs including diet and weight monitoring services, childbirth-related classes including infant care and breast feeding classes, instruction programs including those to learn how to stop smoking and programs that teach a person how to use durable medical equipment or how to care for a family member.

Services and Supplies Provided by a Member of Your Family

Services and Supplies That Are Not Medically Necessary

Sexual Dysfunction: 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 when mental health services are covered benefits under the Plan.

Sexual Reassignment Treatment and Surgery: Treatment, surgery or counseling services for sexual reassignment.

Third-Party Liability: Services and supplies for treatment of illness or injury for which a third party is or may be responsible.

Tobacco Addiction Treatment except as specifically provided under the benefits, the Plan does not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

Vision Care: Routine eye exam and vision hardware, except as specifically provided under the vision benefits section of this Plan. Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversal or revisions of surgical procedures which alter the refractive character of the eye.

Medical Exclusions

Work-Related Conditions: Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if a Participant is exempt from state or federal workers' compensation law.

Prescription Medication Exclusions

Acne Medication for the treatment of acne in Claimants over age 39.

Biological Sera, Blood or Blood Plasma

Cosmetic Purposes: Prescription medications used for cosmetic purposes including, removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin.

Devices or Appliances (coverage for devices and appliances may otherwise be provided under the medical benefit).

Foreign Prescription Medications except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States.

Growth Hormones unless they are preauthorized under the Plan.

Nonprescription Medications: Medications that by law do not require a prescription order.

Onychomycosis: Prescription medications for the treatment of onychomycosis (nail fungus), unless they are preauthorized under the Plan.

Prescription Medications Dispensed in Connection with Participation in a Clinical Trial

Prescription Medications For Treatment of Infertility

Prescription Medications Not within a Provider's License: Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

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