Regence Breakthru[SM] 80

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

Regence BlueCross BlueShield of Oregon

Your Regence Breakthru 80 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. The **Participating (PAR) Vision Network** is the panel of providers for your vision examination benefit and the **Supplemental Provider Listing** is the panel of providers for your acupuncture and spinal manipulation benefit. For assistance in locating an In-Network physician or provider please 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 it 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	
Calendar year deductible options per individual	$500* or $1,500**	
Calendar year deductible per family	Maximum of 3 individual deductibles	
Maximum coinsurance per individual per calendar year	$2,500	None
Maximum coinsurance per family per calendar year	Maximum of 3 individual coinsurance maximums	None
After the maximum coinsurance is met each calendar year, we pay	100%	N/A

Please note: Covered expenses paid at 100%, copays, prescription medications, preventive care, and vision services do not accumulate toward the deductible. Covered expenses paid at 100%, deductibles, copays, prescription medications, and vision services do not apply to the coinsurance maximum.

*$500 deductible is not available for policies with an October 1, 2008 effective date or later. Existing members are not affected.

**$1,500 deductible is not available for policies with a March 1, 2009 effective date or later. Existing members are not affected.

Office Visits and Preventive Care Services	Deductible Waived - We Pay	
Office visits, including outpatient treatment for mental illness	100% after $20 copay	100% after $40 copay
Immunizations all ages[+]	100%	50%
Well-baby exam to age 2[+]	100%	50%
Annual women's examination including Pap test[+]	100%	50%
Mammograms that accompany the annual women's exam	80%	50%
Adult and child routine physical examinations[+]	100%	50%

[+]All preventive care services including related laboratory tests, screening procedures, and X-rays are limited to $400 per calendar year.

Other Professional Services	After Deductible - We Pay	
Surgery and other office procedures	80%	50%
Diagnostic radiology and lab	80%	50%
Therapeutic injections including allergy shots	80%	50%
Maternity care including newborn care	80%	50%

Hospital Services	After Deductible - We Pay	
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	50% after $100 copay
Inpatient hospital stay including maternity, rehabilitation, and mental illness	80%	50%
Outpatient hospital services	80%	50%

Other Services	After Deductible - We Pay	
Ambulance	80%	
Rehabilitation including occupational, speech, and physical therapy	80%	50%
Acupuncture and spinal manipulations	80%	50%
Skilled nursing facility, home health, and hospice care	80%	50%
Durable medical equipment and supplies	80%	50%

Vision Services	No Deductible - We Pay	
Routine eye examination once per calendar year	100% after $20 copay	50%
Vision hardware (includes frames, lenses, and contact lenses)	100% up to $250 calendar year maximum	

Prescription Medications - We Pay	Generic	Formulary	Non-Formulary
Pharmacy purchased medications	100% after $10 copay	70%	50%
Mail order purchased medications	100% after $30 copay	70%	50%

Please note: There is a separate $3,000 annual limit for all prescription medications however, once this limit is reached, the Regence Rx Discount Program applies. Find a Participating Pharmacy and the Preferred Medication List/Formulary at **www.regencerx.com.**

Additional Benefits and Information	
BlueCard® program	Provides savings nationwide by using Participating 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.**

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	

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.

These Pharmacy Benefits Are Limited

- The maximum quantity for pharmacy purchased medications is a 30-day supply.
- The maximum quantity for mail order purchased medications is a 90-day supply.
- Compound medications are only covered when one ingredient is a federal legend or state restricted medication.

These Benefits Are Limited

- Acupuncture is limited to 12 treatments per calendar year.
- Spinal manipulation is limited to 10 treatments per calendar year.
- Inpatient rehabilitation care is limited to $4,000 per calendar year.
- Outpatient rehabilitation care is limited to $2,000 per calendar year.
- Skilled nursing facility care is limited to 30 days per calendar year.
- Home health care is limited to 130 days per calendar year.
- Hospice care is limited to a 6 month maximum.
- Durable medical equipment is limited to $2,500 per calendar year. The yearly maximum for durable medical equipment and supplies does not apply to diabetic equipment and supplies.
- Ground and air ambulance combined is limited to $2,000 per calendar year (does not apply to emergent use).
- 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 12 months (or since birth). Please refer to your contract for details on creditable coverage. 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 $350,000 per enrollee. Covered services and supplies for the first 90-day period following the transplant will accrue towards the transplant lifetime maximum.
- There is a nine-month waiting period for removal of tonsils or adenoids with or without myringotomy, otitis media, allergies, sterilization, and preexisting conditions (not including prenatal care). We will reduce the duration of the waiting period if there is prior creditable coverage. See contract for further details.

These Pharmacy Benefits Are Not Covered

- Medications that are not medically necessary
- Nonprescription medications.
- Impotence and infertility medications.
- Experimental/investigational medications.
- Medications prescribed for cosmetic purposes.
- Medications for weight loss or treatment of obesity.
- Smoking cessation products.
- Medications dispensed by excluded pharmacies.

Services And Supplies Not Covered

- Services provided by a member of your immediate family.
- Services or supplies that are not medically necessary.
- Treatment for alcoholism and chemical dependency.
- Foot care such as treatment for corns, calluses, removal of nails, and other routine foot care, except when indicated for diabetic patients.
- Treatment for obesity or weight control including surgery or any other treatment provided for obesity or weight control, and any complications arising out of such treatment.
- Surgery to alter the refractive character of the eye.
- Off-the-shelf orthotics or orthotics that are not medically necessary.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Orthognathic services.
- Services and supplies for family planning (except sterilization), artificial insemination, in vitro fertilizations, diagnosis and treatment of infertility or surgery to correct voluntary sterilization.
- Dental services or supplies (unless otherwise noted).
- Physical exercise programs
- Services or supplies for the treatment of personality and gender identity disorders.
- Self-help, training, and instructional programs for behavior modification.
- Counseling or treatment in the absence of illness.
- Immunizations for the sole purpose of travel or passports.
- Custodial care including routine nursing care and private duty nursing.
- Experimental and investigational treatment, procedures, equipment, devices, and supplies.
- Appliances or equipment primarily for personal comfort or convenience.
- The fitting, provision, or replacement of hearing aids.
- Treatment of eyes or special procedures such as orthoptics and vision training or eye exercises.

Regence BlueCross BlueShield of Oregon
Toll-free, all areas 1 (800) 365-3155
TDD Line for people with hearing impairments 1 (800) 382-1003
www.or.regence.com