

Blue Selections PPO



Your Blue Selections PPO Plan provides coverage for services provided by Preferred and Non-Preferred physicians and other professional providers as listed below. Under this plan, benefits for Preferred providers are greater than benefits for Non-Preferred providers. Once enrolled, the **Preferred Provider Plan Network** is the panel of providers for which you will receive the greatest benefits. For assistance in locating a Preferred physician and 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	
Individual deductible options per calendar year	\$1,000, \$2,500, \$5,000	
Family deductible per calendar year	Maximum of three family members	
We pay covered expenses up to this amount (stoploss)	\$20,000	
After \$20,000 of covered expenses is met each calendar year, we pay	100%	
Maximum amount of covered expenses you pay each calendar year per person (coinsurance and copayments)	\$4,000	\$8,000

Important note: The deductible and covered expenses paid at 100% do not accumulate toward the stoploss amount.

Basic Services (Preventive Care and Professional Office Visits)	Deductible Waived We Pay	
Immunizations all ages	100% after \$10 copayment	
Well-baby exam to age 2	100% after \$20 copayment	
Annual women's exam including Pap test and mammogram	100% after \$20 copayment	
Office and urgent care visits	100% after \$20 copayment	
Therapeutic injections and allergy shots	100% after \$20 copayment	

Other Office and Professional Services	After Deductible We Pay	
Surgical procedures	80%	60%
Maternity care	80%	60%
Diagnostic radiology and lab	80%	60%

Hospital Services		
Inpatient hospital stay including maternity and rehabilitation	80%	60%
Mental illness admission	80%	60%
Visits and consultations in hospital	80%	60%
Outpatient surgery	80%	60%
Emergency room care for medical emergency (copayment waived if admitted to hospital)	80% after \$100 copayment	
Emergency room care for non-emergency	80% after \$100 copayment	60% after \$100 copayment

Other Services		
Ambulance	80%	
Outpatient rehabilitation (physical, speech, and occupational therapy)	80%	60%
Outpatient durable medical equipment and supplies	80%	60%
Alternative care i.e. chiropractic, naturopathy, and acupuncture	80%	Not covered
Transplant services	100% (contracted facility)	60% (non-contracted facility)

Prescription and Vision Benefits	No Deductible	
Outpatient prescription medications (does not apply toward your medical maximum coinsurance)	50%	
Vision exams (limited to once every 24 months per enrollee)	100% after \$20 copayment	60%
Vision hardware (limited to once every 24 months per enrollee)	100% Up to allowances	

Additional Benefits	
Special Beginnings®	Provides a maternity program designed to promote healthy prenatal care through education and support
BlueCard® program	Provides savings nationwide. To receive the best benefit, please use BlueCard PPO providers of the Blue Cross and/or Blue Shield Plan in the area where you receive the service. Find a provider near you at www.bcbs.com .

This summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Please refer to page 2 for additional information regarding schedules, limitations, and exclusions that may apply to the benefits above.

Blue Selections PPO Limitations and Exclusions

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

Preventive Care Schedule	
Immunizations (Not covered for travel or passport purposes)	
All ages	As indicated by physician
Well-baby Exams	
Up to age 2	As indicated by physician
Women's Exam	
Annual breast & pelvic	Every calendar year
Mammograms	As indicated by physician

Mental Illness and Alcoholism Treatment Schedule	
Mental Illness Treatment Setting	
Inpatient Care	30 days per calendar year
Residential Care	Not covered
Outpatient Care	Not covered
Alcoholism Treatment Setting	
Inpatient Care, Residential Care, and Outpatient Care	Combined \$4,500 allowance every 24 consecutive months for all levels of care

These Benefits Are Limited

- 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), providing there is no lapse between the two coverages. 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 \$250,000 per enrollee.
- 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.
- 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. Physical exercise programs are not included.
- Skilled Nursing Facility care is limited to 14 days. If authorized by the health plan, the benefit may be increased up to 100 days.
- Home health care is limited to 180 visits per calendar year.
- Ground and air ambulance combined is limited to \$5,000 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.
- The following will be covered only after nine months of enrollment: preexisting conditions, allergies, otitis media (ear infections), removal of tonsils and adenoids, alcoholism, and sterilization procedures. You may receive credit from prior creditable medical coverage, providing there is a less than 63-day lapse between the two coverages.

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

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	

Vision Hardware Allowances	
Frames	Up to \$85
Single Vision Lenses (pair)	Up to \$96
Bifocal Lenses (pair)	Up to \$134
Trifocal Lenses (pair)	Up to \$180
Contacts in lieu of lenses & frames	Up to \$181

Services And Supplies Not Covered

- Services provided by a member of your 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.
- Chronic or long-term psychotherapy (services provided in excess of crisis intervention or short-term therapy).
- Services or supplies for the treatment of personality disorders and gender identity disorders.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Treatment(s), procedures, equipment, medications, devices, and supplies that are experimental or investigational.
- 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.
- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Self-help training or instructional programs.

Pharmacy Benefits Not Covered

- Impotence and infertility medications.
- 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.



An Independent Licensee of the Blue Cross and Blue Shield Association

Toll-free, all areas 1 (800) 777-3168

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

www.or.regence.com