

Regence BreakthruSM 80



An Independent Licensee of the Blue Cross and Blue Shield Association

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.

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.			
Office Visits and Preventive Care Services			
Deductible Waived - We Pay			
Office visits	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			
Office procedures	80%	50%	
Diagnostic radiology and lab	80%	50%	
Therapeutic injections including allergy shots	80%	50%	
Surgery	80%	50%	
Maternity care including newborn care	80%	50%	
Hospital Services			
After Deductible - We Pay			
Emergency room care for medical emergency	80% after \$100 copay (copay waived if admitted)		
Emergency room care for non-emergency	80% after \$100 copay	50% after \$100 copay	
Inpatient hospital stay including maternity	80%	50%	
Inpatient rehabilitation	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.regencerox.com .			
Additional Benefits			
Special Beginnings [®]	Provides a maternity program designed to promote healthy prenatal care through education and support.		
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. Find a provider near you at www.bcbs.com .		

Limitations and Exclusions

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	

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.
- 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), providing there is no lapse between the two coverages. Benefits are based on the recipient's eligibility, not the donor's. Our payment for certain covered transplant services and supplies is limited to a lifetime maximum of \$250,000 per enrollee.
- 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, chemical dependency, and mental health.
- Foot care such as treatment for corns, calluses, removal of nails, other routine foot care, and orthopedic shoes.
- 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.
- 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.

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. 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.



Regence
BlueCross BlueShield
of Oregon

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Toll-free, all areas 1 (800) 228-0978

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

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Regence BreakthruSM 70



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Your Regence Breakthru 70 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.

Benefit Features	In-Network Provider Benefit	Out-Of-Network Provider Benefit	
Lifetime maximum benefit	\$2,000,000		
Calendar year deductible options per individual	\$1,000 or \$3,000		
Calendar year deductible per family	Maximum of 3 individual deductibles		
Maximum coinsurance per individual per calendar year	\$5,000	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.			
Office Visits and Preventive Care Services			
Deductible Waived - We Pay			
Office visits	100% after \$30 copay	100% after \$40 copay	
Immunizations all ages*	70%	50%	
Well-baby exam to age 2*	70%	50%	
Annual women's examination including Pap test*	70%	50%	
Mammograms that accompany the annual women's exam	70%	50%	
Adult and child routine physical examinations*	70%	50%	
*All preventive care services including related laboratory tests, screening procedures, and X-rays are limited to \$200 per calendar year.			
Other Professional Services			
After Deductible - We Pay			
Office procedures	70%	50%	
Diagnostic radiology and lab	70%	50%	
Therapeutic injections including allergy shots	70%	50%	
Surgery	70%	50%	
Maternity care including newborn care	70%	50%	
Hospital Services			
After Deductible - We Pay			
Emergency room care for medical emergency	70% after \$100 copay (copay waived if admitted)		
Emergency room care for non-emergency	70% after \$100 copay	50% after \$100 copay	
Inpatient hospital stay including maternity	70%	50%	
Inpatient rehabilitation	70%	50%	
Outpatient hospital services	70%	50%	
Other Services			
After Deductible - We Pay			
Ambulance	70%		
Rehabilitation including occupational, speech, and physical therapy	70%	50%	
Acupuncture and spinal manipulations	70%	50%	
Skilled nursing facility, home health, and hospice care	70%	50%	
Durable medical equipment and supplies	70%	50%	
Vision Services			
No Deductible - We Pay			
Routine eye examination once per calendar year	100% after \$30 copay	50%	
Vision hardware (includes frames, lenses, and contact lenses)	100% up to \$150 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.regencerox.com .			
Additional Benefits			
Special Beginnings [®]	Provides a maternity program designed to promote healthy prenatal care through education and support.		
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. Find a provider near you at www.bcbs.com .		

Limitations and Exclusions

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	

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.
- 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), providing there is no lapse between the two coverages. Benefits are based on the recipient's eligibility, not the donor's. Our payment for certain covered transplant services and supplies is limited to a lifetime maximum of \$250,000 per enrollee.
- 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, chemical dependency, and mental health.
- Foot care such as treatment for corns, calluses, removal of nails, other routine foot care, and orthopedic shoes.
- 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.
- 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.

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. 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.



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

www.or.regence.com

Regence BreakthruSM 50



Your Regence Breakthru 50 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 **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.

Benefit Features	In-Network Provider Benefit	Out-Of-Network Provider Benefit
Lifetime maximum benefit	\$2,000,000	
Calendar year deductible options per individual	\$2,500 or \$5,000	
Calendar year deductible per family	Maximum of 3 individual deductibles	
Maximum coinsurance per individual per calendar year	\$10,000	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% and copays do not accumulate toward the deductible. Covered expenses paid at 100%, copays, and deductibles do not apply to the out-of-pocket maximum.		
Professional Services		
After Deductible - We Pay		
Office visits and other office procedures	50%	50%
Diagnostic radiology and lab	50%	50%
Therapeutic injections including allergy shots	50%	50%
Surgery	50%	50%
Hospital Services		
After Deductible - We Pay		
Emergency room care for medical emergency	50% after \$100 copay (copay waived if admitted)	
Emergency room care for non-emergency	50% after \$100 copay	50% after \$100 copay
Inpatient hospital stay	50%	50%
Inpatient rehabilitation	50%	50%
Outpatient hospital services	50%	50%
Other Services		
After Deductible - We Pay		
Ambulance	50%	
Rehabilitation including occupational, speech, and physical therapy	50%	50%
Acupuncture and spinal manipulations	50%	50%
Skilled nursing facility, home health, and hospice care	50%	50%
Durable medical equipment and supplies	50%	50%
Additional Benefits		
Regence Rx Discount program	Provides a discount program for prescriptions. All you need to do is show your member ID card at any participating pharmacy. Find a Participating Pharmacy at www.regencerox.com .	
Special Beginnings [®]	Provides a maternity program designed to promote healthy prenatal care through education and support.	
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. Find a provider near you at www.bcbs.com .	

Limitations and Exclusions

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	

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.
- Ground and air ambulance combined is limited to \$2,000 per calendar year (does not apply to emergent use).
- Growth hormone benefit, when eligible according to the contract, is limited to \$25,000 per calendar year.
- 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 certain covered transplant services and supplies is limited to a lifetime maximum of \$250,000 per enrollee.
- There is a nine-month waiting period for removal of tonsils or adenoids with or without myringotomy, otitis media, allergies, sterilization, and preexisting conditions. We will reduce the duration of the waiting period if there is prior creditable coverage. See contract for further details.

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, chemical dependency, and mental health.
- Routine physical examinations including routine annual Pap test, routine immunizations, tests, and screening procedures.
- Foot care such as treatment for corns, calluses, removal of nails, other routine foot care, and orthopedic shoes.
- Treatment related to pregnancy, prenatal care, or delivery of a newborn, including routine newborn nursery care, including any complications related to maternity care.
- 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.
- 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.
- Eye examinations including eye exercises and the fitting, provision, or replacement of eyeglasses.

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