

BlueClassicSM \$300 Deductible Plan / Participating Network

Your BlueClassicSM Plan provides coverage for services provided by In-Network and Out-Of-Network physicians and other professional providers as listed below. Once enrolled, the **Participating Network** is the panel of providers for which you will receive the greatest benefits. 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 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	In-Network Provider Benefit	Out-Of-Network Provider Benefit
Lifetime maximum benefit	\$2,000,000	
Individual deductible per calendar year	\$300	
Maximum number of individual deductibles per family	3	
Amount of covered expenses you pay each calendar year per person (your maximum coinsurance)	\$1,000	\$6,000
After your maximum coinsurance is met each calendar year, we pay	100%	100%

Important note: Covered expenses paid at the 100% level, or any deductible and/or copayments do not accumulate toward your maximum coinsurance. Your maximum coinsurance accumulates separately for In-Network and Out-Of-Network providers. Copayments will continue to be collected after your maximum coinsurance has been met.

Preventive Care Services and Professional Office Visits	Deductible Waived We Pay	After Deductible We Pay
Immunizations for adults and children	100% after \$10 copay (deductible waived)	
Well-baby exam to age 2	100% after \$20 copay	70%
Annual women's exam including Pap test and mammogram	100% after \$20 copay	70%
Routine physical exam including related diagnostic radiology and lab (up to a \$200 maximum allowance)	100% after \$20 copay	Not Covered
Office exam by a personal physician (see page 2 for description)	100% after \$20 copay	70%
Initial office exam for maternity care	100% after \$20 copay	70%
Office exam by a specialist (see page 2 for description)	100% after \$40 copay	70%

Other Office and Professional Services	After Deductible - We Pay	
Surgical and other office procedures	90%	70%
Maternity care after the initial visit	90%	70%
Diagnostic radiology and lab	90%	70%
Therapeutic injections including allergy shots	Deductible waived - first \$500	70%
	90%	70%

Hospital Services	After Deductible - We Pay	
Inpatient stay including maternity, mental health, chemical dependency and rehabilitation	90%	70%
Visits and consultations in hospital	90%	70%
Outpatient surgery	90%	70%
Emergency room care for medical emergency (copay waived if admitted to hospital or other facility on an inpatient basis)	90% after \$100 copay	
Emergency room care for non-emergency	90% after \$100 copay	70% after \$100 copay

Other Services	After Deductible - We Pay	
Ambulance	80%	
Rehabilitation including occupational, speech, and physical therapy	90%	70%
Skilled nursing facility, home health, and hospice care	90%	70%
Durable medical equipment and supplies	90%	70%

Additional Benefits and Information	
Accidental death	Provides \$25,000 for you and your enrolled spouse or domestic partner, \$5,000 for each enrolled dependent
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 .
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.

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 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 (Not covered for travel or passport purposes)

All ages As indicated by physician

Well-baby exam

Up to age 2 As indicated by physician

Women's exam

Annual breast & pelvic Mammograms Every calendar year

Age 35-40 Once during this time

Age 40+ Every calendar year

Routine physical exam

Age 2-6 Every calendar year

Age 7-18 Every 2 calendar years

Age 19-34 Every 4 calendar years

Age 35+ Every 2 calendar years

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.

Description of Personal Physician and Specialist

A personal physician is a family, general, or internal medicine practitioner; a pediatrician; a nurse practitioner; or an obstetrician and/or gynecologist. A specialist is all other physicians such as a cardiologist, oncologist, etc.

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. Our payment for certain 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. Neurodevelopmental therapy is limited to children age 17 and under.
- Home health care is limited to 180 visits per calendar year.
- 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.
- Ground ambulance is limited to 300 miles per calendar year and air ambulance is limited to \$5,000 per calendar year.
- Dental care is limited to treatment of an accidental injury to natural teeth or fractured jaw. Diagnosis must be made within 6 months and treatment within 12 months of injury.
- The following will be covered only after six months of enrollment: preexisting conditions, allergies, otitis media (ear infections), removal of tonsils and adenoids, elective and sterilization procedures. You may receive credit from prior medical coverage. See your benefits booklet or employer for details.

Chemotherapy Prescription Medication Information

Covered services include medically necessary self-administered chemotherapy medications, including oral medications. Please refer to your benefits booklet for how prescription medications are covered.

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	Severe pain

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.
- Acupuncture, naturopathy, faith healing services, and homeopathy, even when provided by plan participants.
- Services related to or supporting infertility, reversal of sterilization procedures, and impotence medications.
- 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, medications, 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).
- 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, instructional programs, and physical exercise programs (except where specifically listed).



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

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

www.or.regence.com