

# Preferred Provider Plan



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

Regence BlueCross BlueShield of Oregon

## City of Vancouver - Uniformed Active

Effective January 1, 2009

Your Preferred Provider Plan provides coverage for services rendered by Preferred or Non-Preferred physicians and providers as listed below. For assistance in locating a Preferred physician or provider near you, please refer to your provider directory or visit our Web site at [www.myRegence.com](http://www.myRegence.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	Preferred Provider Benefit	Non-Preferred Provider Benefit
Lifetime maximum benefit	\$2,000,000	
Individual deductible per calendar year	\$100	\$200
Maximum family deductible per calendar year	\$300	\$600
We pay covered expenses up to this amount per calendar year	\$10,000 Individual / \$30,000 Family	
Your maximum coinsurance per person plus deductible	\$1,100	\$3,200
After your maximum coinsurance is met each calendar year, we pay	100%	
<b>Please note:</b> Covered expenses paid at 100% and copayments do not accumulate towards your maximum coinsurance. Copayments will continue to be collected after your maximum coinsurance has been met.		
Preventive Care Services	Deductible Waived We Pay	After Deductible We Pay
Immunizations all ages (deductible waived)	100% after \$5 copay	
Well-baby care (deductible waived)	100% after \$15 copay	70%
Annual women's exams, including Pap and mammogram	100% after \$10 copay	70%
Routine Physicals (up to a \$200 calendar year maximum)	100% after \$15 copay	70%
Professional Services	After Deductible - We Pay	
Office visits including in-office surgery	100% after \$15 copay (no deductible)	70%
Therapeutic injections including allergy shots	90%	70%
Diagnostic radiology and lab	90%	70%
Surgery	90%	70%
Maternity care	90%	70%
Hospital Services	After Deductible - We Pay	
Inpatient hospital stay including inpatient rehabilitation	90%	70%
Maternity hospital stay including newborn care	90%	70%
Outpatient day surgery	90%	70%
Emergency room care (copay waived if admitted to hospital or other facility on an inpatient basis)	90% after \$25 copay	90% after \$25 copay
Emergency room care for non-emergency	90% after \$25 copay	70% after \$25 copay
Other Services	After Deductible - We Pay	
Ambulance (up to 500 miles per calendar year)	80%	
Outpatient rehabilitation (occupational, speech and physical therapy)	80%	
Chemical dependency	90%	70%
Outpatient durable medical equipment and supplies	90%	70%
Additional Accident (deductible waived for treatment within 90 days)	90%	70%
Alternative Services	Deductible Waived - We Pay	
Chiropractic Care with any licensed chiropractor (up to a \$400 calendar year maximum)	100% after \$15 copay	
Chiropractic Care (after \$400 calendar year maximum exhausted)*	100% after \$15 copay	
Complementary and Alternative Medicine*	100% after \$15 copay	

\*Benefit available for Complementary & Alternative Providers only. See Complementary & Alternative Directory for providers.

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.myRegence.com](http://www.myRegence.com).

Preventive Care Schedule	
<b>Well-baby Care</b>	
Newborn	Nursery care, including initial exam
First two years	7 well-baby exams
<b>Women's Exams</b>	
Annual breast & pelvic	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year

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.	

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

- 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.
- 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 30 inpatient days 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. Physical exercise programs are not included. Neurodevelopmental therapy is limited to 30 sessions per calendar year.
- Skilled Nursing Facility care is limited to 100 days per stay.
- Home health care is limited to 180 visits 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.
- Nutritional counseling is covered for the initial visit and two (2) follow up visits per condition.

Mental Illness and Chemical Dependency Schedule*	
<b>Mental Illness Treatment Setting</b>	
Inpatient Care and Residential/partial-hospitalization	30 days per calendar year
Outpatient Care	20 visits per calendar year
<b>Chemical Dependency Treatment Setting</b>	
Inpatient, Residential/partial-hospitalization, and Outpatient Care	\$14,500 per 24 consecutive months
*Subject to limitations designated under state and federal law.	

### Services And Supplies Not Covered

- Services provided by a member of the patient's immediate family.
- Services or supplies that are not medically necessary.
- 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.
- Chronic or long-term psychotherapy (defined as services provided in excess of crisis intervention or short-term therapy).
- Services or supplies for the treatment of personality disorders, paraphilia, or other 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 (except where specifically listed).



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

Regence BlueCross BlueShield of Oregon

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

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

[www.myRegence.com](http://www.myRegence.com)