

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

## Regence BlueCross BlueShield of Oregon Full-time [Discontinues Jan. 1, 2010]

Type of care or supplies*	Preferred provider coverage (amount you pay based on eligible charges)	Nonpreferred provider coverage (amount you pay based on eligible charges)
Hospital inpatient care	15% of semi-private room rate for unlimited days	30% of semi-private room rate for unlimited days
Medical care in skilled nursing facility in lieu of hospital	15% of semi-private room rate for up to 180 days per calendar year	30% of semi-private room rate for up to 180 days per calendar year
Hospital intensive care or isolation unit	15%	30%
Other hospital charges	15%	30%
Hospitalization for rehabilitation	30 days per calendar year at 15%	30 days per calendar year at 30%
Hospital outpatient care	15%	30%
Care in outpatient birthing center	15%	30%
Hospital emergency room**	15%	30%
Outpatient rehabilitation (refer to limitations on this benefit)	15% (60 visits maximum per calendar year)	30% (60 visits maximum per calendar year)
Surgeon	15%	30%
Assistant surgeon	15%	30%
Anesthesiologist	15%	30%

\* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

\*\* Emergency benefits will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition.

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**Benefits for PPO Plan (continued from previous page)**

Type of care or supplies*	Preferred provider coverage (amount you pay based on eligible charges)	Nonpreferred provider coverage (amount you pay based on eligible charges)
Surgical supplies	15%	30%
Preadmission testing	15%	30%
Physician visits in hospital, home, or office for illness or injury	15%	30%
Maternity care professional services	15%	30%
Contraceptive services	15%	30%
Well-baby care	0%	30%
Immunizations	0%	0%
Durable medical equipment (we cover medically necessary durable medical equipment and supplies)	15%	30%
Therapeutic injections	15%	30%
Chemotherapy	15%	30%
Annual women's examinations	\$0 per visit	30%
Routine periodic health appraisals**	0%	30%

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\*\* Routine periodic health appraisals may not be eligible annually.

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**Benefits for PPO Plan (continued from previous page)**

<b>Type of care or supplies*</b>	<b>Preferred provider coverage (amount you pay based on eligible charges)</b>	<b>Nonpreferred provider coverage (amount you pay based on eligible charges)</b>
Diagnostic x-ray and laboratory tests related to routine periodic health appraisals**	0%	30%
Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)	15%	30%
Breast, cervical, prostate, and colorectal cancer screenings	0%	30%
Scan and interpretation fee for Magnetic Resonance Imaging Services	15%	30%
X-ray, radioisotopic, and radium therapy	15%	30%
Infertility services: artificial insemination (includes related or supporting x-ray and laboratory services)	50%	50%
Outpatient diabetic instruction	0%	0%
Outpatient diabetic supplies	0%	0%
Home health care (maximum 180 visits per calendar year)	15%	30%

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\*\* Routine periodic health appraisals may not be eligible annually.

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**Benefits for PPO Plan *(continued from previous page)***

Type of care or supplies*	Preferred provider coverage (amount you pay based on eligible charges)	Nonpreferred provider coverage (amount you pay based on eligible charges)
Palliative hospice care	0%	0%
Home infusion therapy	15%	30%
Treatment of mental illness - Inpatient - Residential - Outpatient	15% 15% 15%	30% 30% 30%
Treatment of alcohol and medication abuse - Inpatient - Residential - Outpatient	15% 15% 15%	30% 30% 30%
Hearing examination	15% every 12 months	30% every 12 months
Hearing aid	10% up to \$4,000 maximum allowance every 4th year	10% up to \$4,000 maximum allowance every 4th year
Ambulance service to the nearest hospital (up to 500 miles per calendar year) **	15%	15%
Blood or blood plasma	15%	30%

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\*\*Your coverage pays eligible charges based on community standards for local ground transportation as determined by Regence BlueCross BlueShield of Oregon.

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**Benefits for PPO Plan *(continued from previous page)***

Other Covered Expenses	Amount You Pay Based On Eligible Charges												
Vision care Vision services are provided through Vision Service Plan (VSP).	Not Covered												
Chiropractic care* Naturopathic care* Acupuncturist care*	30% 30% 30%												
Prescription medications  NOTE: There is no copayment for covered diabetic supplies obtained either at the pharmacy or through a mail order supplier.	<table style="width: 100%; border: none;"> <tr> <td style="width: 15%;"><u>Pharmacy</u></td> <td>\$5 generic</td> </tr> <tr> <td>(34-day supply)</td> <td>\$15 preferred</td> </tr> <tr> <td></td> <td>Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multisource brands)</td> </tr> <tr> <td> <u>Mail Order</u></td> <td> \$12.50 generic</td> </tr> <tr> <td>(90-day supply)</td> <td>\$37.50 preferred</td> </tr> <tr> <td></td> <td>Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)</td> </tr> </table>	<u>Pharmacy</u>	\$5 generic	(34-day supply)	\$15 preferred		Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multisource brands)	 <u>Mail Order</u>	 \$12.50 generic	(90-day supply)	\$37.50 preferred		Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)
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	Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)												
Surgical treatment of morbid obesity	Subject to plan limitations												

\* Alternative care providers may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance. The patient is responsible for those balances.