

SCHEDULE OF BENEFITS

PPO Medical Plan

This is a summary of the Preferred Provider Plan coverage for services provided by Preferred Provider Plan Network and Non-Preferred physicians and other professional providers as listed below. For assistance in locating a Preferred Provider Plan Network physician or provider please refer to your provider directory or visit the claims administrator's 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 plan booklet for a complete list of benefits and the limitations and exclusions that apply.

PPO Plan Benefit Features	Preferred Provider Benefit	Non-Preferred Provider Benefit
Lifetime maximum benefit		\$2,000,000
Individual deductible per calendar year	\$250	\$500
Aggregate deductible per calendar year (family maximum)	\$750	\$1,500
Individual out-of-pocket maximum per calendar year for covered services	\$2,000	\$6,000
Aggregate out-of-pocket maximum per calendar year (family maximum)	\$6,000	\$18,000
Important note: Covered expenses paid at 100% and copayments do not accumulate toward your deductible or out-of-pocket maximum. Also, deductibles do not accumulate toward your out-of-pocket maximum. Copayments will continue to be collected after your out-of-pocket maximum has been met.		
Common Accident: If two or more members of a family are injured in the same accident, only one individual deductible amount will be deducted from all medical services related to the accident for all family members involved in the accident for the remainder of the calendar year.		
Preventive Care Services	After Deductible - The Plan Pays	
Immunizations all ages	100% (deductible waived)	
Well-baby care including related lab and X-ray	100% after \$20 copay (deductible waived)	60%
Annual women's exam including Pap test and mammogram	100% after \$15 copay (deductible waived)	
Routine physical exam including related lab and X-ray	100% after \$20 copay (deductible waived)	60%
Professional Services	After Deductible - The Plan Pays	
Office visits, allergy shots, therapeutic injections and in-office surgery	100% after \$20 copay (deductible waived)	60%
Diagnostic radiology and lab	100%	60%
Maternity care (after initial office visit for diagnosis and through delivery)	80%	60%
Infertility (diagnosis only)	50%	50%
Temporomandibular Joint Disorder Treatment	50%	50%
Hospital Services	After Deductible - The Plan Pays	
Inpatient stay (including maternity, mental health and chemical dependency)	80%	60%
Inpatient rehabilitation	80%	60%
Outpatient surgery	80%	60%
Skilled nursing facility	80%	60%
Women's Health & Cancer Rights: Mastectomy related benefits including reconstruction, surgery, prostheses, treatment of physical complications	80%	60%
Emergency room care for medical emergency (copay waived if admitted to hospital or other facility on an inpatient basis)	80% after \$100 copay (deductible waived)	
Other Services	After Deductible - The Plan Pays	
Ambulance	80%	
Urgent facility care	100% after \$20 copay (deductible waived)	60%
Rehabilitation including occupational, speech, and physical therapy	80%	60%
Skilled nursing, home health, and hospice care	80%	60%
Durable medical equipment and supplies	80%	60%

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.

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 plan booklet for a complete list of benefits and the limitations and exclusions that apply. Once enrolled, your plan booklet can be viewed online at the claims administrator's Web site, www.or.regence.com.

Preventive Services Schedule

Immunizations (Not covered for travel or passport purposes)	
All ages	As indicated by provider
Well-baby care	
Newborn	Nursery care including initial exam
First two years	8 well-baby exams
Women's exam	
Annual breast & pelvic	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year
Routine physical exam including related lab and X-ray	
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 plan booklet for how cancer screenings are covered.

These Benefits Are Limited

- Nutritional counseling services are limited to one nutritional counseling session per enrollee lifetime.
- Infertility services are limited to diagnosis only.
- Residential care treatment for mental health conditions is limited to 45 days per calendar year per enrollee.
- For employees who are hired on or after May 1, 2008, transplant coverage for those employees and their enrolled dependents is subject to a 24-month exclusion period.
- 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.
- 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 7 and under.
- 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 7 and under.
- 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.

These Services Are Not Covered

- Services provided by a member of the patient's immediate family.
- Charges in excess of the amount allowed according to the terms of the plan booklet.
- Services or supplies that are not medically necessary.
- Services related to or supporting infertility (except where specifically listed) 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.
- 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 or investigational treatment, procedures, equipment, 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 plan 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).