Regence Preferred Plan A

$25/$25 Copay
$250 Deductible
80%/60%/60% Coinsurance
Medical, Prescription, Dental & Vision Essentials

VIGILANT GROUP BENEFITS TRUST

Effective Date: January 1, 2011

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

Medical benefits underwritten by Regence BlueCross BlueShield of Oregon

VIGILANT℠ benefits for employers

Benefit Summary	
Annual Maximum Benefit	$2,000,000
Deductible per calendar year	$250 Per Member $750 Per Family (3 times the member amount)
Maximum coinsurance per calendar year	$2,000 Per Member $6,000 Per Family (3 times the member amount)
After the maximum coinsurance is met, the plan pays	100% for the remainder of the calendar year except where noted

Understanding Your Benefits

- Your plan features **Upfront Benefits**. Each office visit is not subject to the deductible for Category 1 and 2 only. In addition, the first $750 of outpatient laboratory and radiology services per calendar year are not subject to the deductible.
- We will begin to pay benefits for covered services in any calendar year only after your deductible is satisfied. Your deductible applies for all services unless otherwise specified. Copayments do not count toward the deductible.
- Once you have satisfied any applicable deductible and any applicable copayment, we pay a percentage of the allowed amount for covered services. When our payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Member Responsibility).
- You can meet the maximum coinsurance by payments of coinsurance for all categories. Any amounts you pay for non-covered services, deductible, copayments or amounts in excess of the allowed amount do not apply toward the maximum coinsurance.

Important Information Regarding Preventive Care: Benefits will be covered under the preventive care benefit if services or supplies are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) or Health Resources and Services Administration (HRSA). Covered services that do not meet this criteria will be covered the same as any other illness or injury.

You Select Your Provider and Control Your Out-of-Pocket Expenses

- **Category 1.** You choose to see a preferred provider and save the most in your out-of-pocket expenses. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. You can find a list of providers at our Website or by calling Customer Service.
- **Category 2.** You choose to see a participating provider and your out-of-pocket expenses will generally be higher than if you choose Category 1 because we may negotiate larger discounts with preferred providers that will result in lower out-of-pocket amounts for you. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services.
- **Category 3.** You choose to see a provider that does not have a participating contract with us and your out-of-pocket expenses will generally be higher than Category 1. **Also, choosing this category means you may be billed for balances beyond any deductible, copayment, and/or coinsurance.** This is sometimes referred to as balance billing.

Covered Medical Services (Per Member)	*Member Responsibility Category 1*	*Member Responsibility Category 2*	*Member Responsibility Category 3*
Preventive Care ▪ Routine office visits including well-baby care, routine physical exams and annual women's examinations ▪ Routine laboratory, radiology and diagnostic procedures including mammography and prostate screenings ▪ Routine procedures including routine colonoscopies ▪ Immunizations for adults and children	0% (deductible waived)	0% (deductible waived)	0% (deductible waived)
Office Visits (Upfront Benefit) ▪ For illness or injury	$25 copayment per visit (deductible waived)	$25 copayment per visit (deductible waived)	40%
Outpatient Laboratory and Radiology Services (Upfront Benefit) ▪ The first $750 per calendar year	20% (deductible waived)	40% (deductible waived)	40% (deductible waived)
Other Professional Services ▪ Surgery, inpatient visits and therapeutic injections ▪ Laboratory, radiology and diagnostic procedures after Upfront Benefit is exhausted	20%	40%	40%
Ambulance Services	20%	20%	20%
Blood Bank	20%	20%	20%
Complementary Care ▪ Acupuncturists, Chiropractors and Naturopaths ▪ 24 visit limit per calendar year ▪ Does not apply toward maximum coinsurance	20% (deductible waived)	20% (deductible waived)	20% (deductible waived)
Dental Hospitalization	20%	40%	40%
Durable Medical Equipment	20%	40%	40%
Emergency Room (Including Professional Charges) ▪ Copay waived if admitted directly to a hospital or facility on an inpatient basis	$100 copayment per visit and 20%	$100 copayment per visit and 20%	$100 copayment per visit and 20%
Genetic Testing	20%	40%	40%
Hearing Aids ▪ Hearing evaluations and hearing aids ▪ Covered for members under age 18 or enrolled children over age 18 and enrolled in an accredited educational institution	20%	40%	40%
Home Health Care ▪ 130 visit limit per calendar year	20%	40%	40%
Hospice Care ▪ 14 respite care day limit per member lifetime	20%	40%	40%
Hospital Care ▪ Inpatient, Outpatient and Ambulatory Service Facility	20%	40%	40%
Maternity Care	20%	40%	40%
Maternity Care for Routine Newborn Nursery Care	20% (deductible waived)	40% (deductible waived)	40% (deductible waived)
Mental Health/Chemical Dependency Services	20% (deductible waived for outpatient services)	40% (deductible waived for outpatient services)	40% (deductible waived for outpatient services)

Covered Medical Services (Per Member)	*Member Responsibility Category 1*	*Member Responsibility Category 2*	*Member Responsibility Category 3*
Neurodevelopmental Therapy ▪ Covered for children age 17 and under ▪ Inpatient: No limit ▪ Outpatient: 25 visit limit per calendar year	20%	40%	40%
Nutritional Counseling ▪ 3 visit limit per member lifetime	20%	40%	40%
Orthotic Devices	20%	40%	40%
Prosthetic Devices	20%	40%	40%
Rehabilitation Services ▪ Inpatient: 30 day limit per calendar year ▪ Outpatient: 25 visit limit per calendar year	20%	40%	40%
Skilled Nursing Facility (SNF) Care ▪ 60 inpatient day limit per calendar year	20%	40%	40%
Temporomandibular Joint (TMJ) Disorders	20%	40%	40%
Tobacco Use Cessation Programs	20%	40%	40%
Transplants ▪ 24 month waiting period (you may receive credit from your prior medical coverage)	20%	40%	40%
Vision Services ▪ $100 maximum per calendar year for one routine eye exam and hardware	0% (deductible waived)	0% (deductible waived)	0% (deductible waived)

Prescription Medication Benefits	
A nationwide network of Participating Pharmacies is available to you. Pharmacies that participate in this network submit claims electronically. You can find a list of Participating Pharmacies at our Website, **www.RegenceRx.com**.	
Individual deductible per calendar year	N/A
Individual maximum coinsurance per calendar year	N/A
Important note: You are not responsible for any applicable deductible, copayment and/or coinsurance when you fill prescriptions at a Participating Pharmacy, for specific strengths or quantities of medications that are specifically designated as preventive medications (including, but not limited to, aspirin, fluoride and iron) or for immunizations. The applicable deductible, copayment and/or coinsurance will apply when you fill these preventive medications and immunizations at a Nonparticipating Pharmacy. The Website above includes a complete list of such medications. Tobacco use cessation medications are covered when obtained with a prescription order.	

Covered Prescription Medication Services (Per Member)	*Member Responsibility Generic*	*Member Responsibility Formulary Brands*	*Member Responsibility Non-Formulary Brands*
Prescription Medications From a Pharmacy ▪ 30-day supply for each prescription	$15	$35	$75
Self-Administrable Cancer Chemotherapy Medication ▪ 30-day supply for each prescription	$10	$50	$100
Injectable Medications From a Pharmacy or Mail-Order Supplier ▪ 30-day supply for each injectable medication	$15	$35	$75
Maintenance Medications From a Mail-Order Supplier ▪ 90-day supply for each prescription	$30	$70	$150
Please note: You will pay $0 for a Generic Medication that is specifically designated as frequently used in the treatment of: asthma, diabetes, high blood pressure, high cholesterol or tobacco addiction for pharmacy and mail order.			

Dental Benefit	
Deductible per calendar year	N/A
Maximum benefit per calendar year	Up to $300 Per Member

Understanding Your Dental Benefits

- We do not reimburse Dentists for charges above the allowed amount. A **Participating Dentist** will not charge you for any balances for covered services beyond your deductible and/or coinsurance amount. **Nonparticipating Dentists**, however, may bill you for any balances over our payment level in addition to any deductible and/or coinsurance amount. You can find a list of providers at our Website or by calling Customer Service.

Covered Dental Services (Per Member)	*Member Responsibility*
Preventive Dental Services ▪ Bitewing x-rays: 2 per calendar year ▪ Complete intra-oral mouth x-rays: Once in a 3-year period ▪ Cleanings: 2 per calendar year (in lieu of periodontal maintenance) ▪ Oral examinations: 2 per calendar year ▪ Panoramic mouth x-rays: Once in a 3-year period ▪ Sealants (bicuspids and molars only): Under 18 years of age ▪ Space Maintainers: Under 12 years of age ▪ Topical fluoride application: Under 18 years of age, 2 treatments per calendar year	0%
Basic Dental Services ▪ Endodontic services including root canal treatment, pulpotomy and apicoectomy ▪ Emergency treatment for pain relief ▪ Fillings consisting of composite and amalgam restorations ▪ General dental anesthesia or intravenous sedation (subject to necessity) ▪ Uncomplicated and complex oral surgery procedures ▪ Periodontal maintenance: 2 per calendar year (in lieu of preventive cleanings) ▪ Periodontal debridement: Once in a 3-year period ▪ Periodontal scaling and root planning: Once per quadrant in a 2-year period	0%
Major Dental Services ▪ Bridges: Except no benefits are provided for replacement made fewer than 7-years after placement ▪ Crowns, inlays and onlays: Except no benefits are provided for replacement made fewer than 7-years after placement ▪ Dentures (full and partial): Except no benefits are provided for replacement made fewer than 7-years after placement ▪ Implants (endosteal): 4 per member lifetime	0%

BlueCard® Program (Out of Area Services)

The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at **www.bcbs.com** or call **1 (800) 810-BLUE (2583)**.

General Exclusions

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service for: 1) an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury, as required by federal law; 2) a preventive service as specified under the preventive care benefit; or 3) services and supplies furnished in an emergency room.

Preexisting Condition Exclusion	
Exclusion Period for Preexisting Conditions	6 months (you may receive credit from your prior medical coverage)

Important note: By preexisting condition, we mean a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period before the enrollment date. If you enrolled during your initial period of eligibility, enrollment date means your effective date of coverage or, if earlier, the first day of any waiting period for coverage applied to you. If you enrolled during a special enrollment, the enrollment date is the effective date of coverage. Pregnancy and phenylketonuria (PKU) are not considered preexisting conditions. Genetic information will not be considered a preexisting condition in the absence of a diagnosis related to such information. In addition, exclusion periods for preexisting conditions are not imposed on a member who is enrolled prior to reaching 19 years of age.

Medical Exclusions
Condition Caused By Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.
Condition Incurred in or Aggravated During Performances in the Uniformed Services: The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.
Cosmetic/Reconstructive Services and Supplies except to treat a congenital anomaly for members up to age 18, to restore a physical bodily function lost as result of injury or illness or related to breast reconstruction following a medically necessary mastectomy, to the extent required by law.
Counseling in the Absence of Illness
Custodial Care: Non-skilled care and helping with activities of daily living.
Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.
Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before your effective date under the contract or after your termination under the contract, except as may be provided under the other continuation options of the contract.
Fees, Taxes, Interest: Charges for shipping and handling, postage, interest or finance charges that a provider might bill.
Foot Care (Routine): Routine foot care including treatment of corns and calluses and trimming of nails, except when indicated for diabetic patients.
Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.
Growth Hormone Therapy (coverage for these services may be provided under the prescription medication benefit).
Hearing Care except as specifically provided under the hearing aids benefit of the contract, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.
Infertility: Treatment of infertility, except to the extent covered services are required to diagnose such condition, including all assisted reproductive technologies and fertility drugs and medications.
Investigational Services: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures.
Mental Health Treatment For Certain Conditions including diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages. Additionally, we will not cover any "V code" diagnoses except the following when medically necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger.
Motor Vehicle Coverage and Other Insurance Liability
Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms and visits or consultations that are not in person, including telephone consultations and email exchanges.
Non-Duplication of Medicare: When, by law, this coverage would not be primary to Medicare had you properly enrolled in Medicare when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare, regardless of whether or not you choose to accept those benefits.
Obesity or Weight Reduction/Control: Medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.
Orthognathic Surgery: By orthognathic surgery, we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to a temporomandibular joint disorder, injury, sleep apnea or congenital anomaly.

Medical Exclusions
Over the Counter Contraceptives including supplies and oral contraceptives (coverage for these services may be provided under the prescription medication benefit).
Personal Comfort Items: Items that are primarily for comfort, convenience, cosmetics, environmental control or education.
Physical Exercise Programs and Equipment including hot tubs or membership fees at spas, health clubs or other such facilities; applies even if the program, equipment or membership is recommended by the member's provider.
Private Duty Nursing including ongoing shift care in the home.
Reversals of Sterilizations including services and supplies related to reversals of sterilization.
Riot, Rebellion and Illegal Acts: Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.
Self-Help, Self-Care, Training or Instructional Programs including diet and weight monitoring services, childbirth-related classes including infant care and breast feeding classes, instruction programs including those to learn how to stop smoking and programs that teach a person how to use durable medical equipment or how to care for a family member.
Services and Supplies Provided by a Member of Your Family
Services and Supplies That Are Not Medically Necessary
Sexual Dysfunction: 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 when mental health services are covered benefits under the contract.
Sexual Reassignment Treatment and Surgery: Treatment, surgery or counseling services for sexual reassignment.
Third-Party Liability: Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
Tobacco Addiction Treatment including supportive items for addiction to tobacco, tobacco products or nicotine substitutes, except as specifically provided under the tobacco use cessation programs benefit in the contract.
Travel and Transportation Expenses other than covered ambulance services.
Vision Care: Routine eye exam and vision hardware, except as specifically provided under the vision benefits section of the contract. Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversal or revisions of surgical procedures which alter the refractive character of the eye.
Work-Related Conditions: Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

Prescription Medication Exclusions
Acne Medication for the treatment of acne in members over age 39.
Biological Sera, Blood or Blood Plasma
Certain Contraceptives: Prescription contraceptives that cannot be self-administered, including Norplant, surgically inserted contraceptive devices, IUDs and Depo-Provera (coverage for these contraceptives may otherwise be provided under the medical benefit).
Cosmetic Purposes: Prescription medications used for cosmetic purposes including, removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin.
Devices or Appliances (coverage for devices and appliances may otherwise be provided under the medical benefit).
Foreign Prescription Medications except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States.
Growth Hormones unless we preauthorize them.
Inhibition and/or Suppression of Sleepiness: Prescription medications used to inhibit and/or suppress drowsiness, sleepiness, tiredness or exhaustion, unless we preauthorize them.
Insulin Pumps and Pump Administration Supplies (coverage for insulin pumps and supplies is provided under the medical benefit).
Medications We Don't Consider Self-Administrable (coverage for these medications may otherwise be provided under the medical benefit).
Nonprescription Medications: Medications that by law do not require a prescription order.
Off-Label Use Prescription Medications: Prescription medications that have not yet received FDA approval for the purpose and in the manner they are being prescribed.
Onychomycosis: Prescription medications for the treatment of onychomycosis (nail fungus), unless we preauthorize them.
Prescription Medications Dispensed in a Facility: Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution.
Prescription Medications Dispensed in Connection with Participation in a Clinical Trial
Prescription Medications For Treatment of Infertility

Prescription Medication Exclusions

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not within a Provider's License: Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications With No FDA Proven Therapeutic Indication

Prescription Medications Without Examination: Prescriptions made by a provider without recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means.

Professional Charges for Administration of Any Medication

Dental Exclusions

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service for an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury, as required by federal law.

Aesthetic Dental Procedures: Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Antimicrobial Agents: Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Collection of Cultures and Specimens

Condition Caused By Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.

Condition Incurred in or Aggravated During Performances in the Uniformed Services: The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies except for dentally appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as result of injury or illness.

Desensitizing: Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic Casts or Study Models

Duplicate X-Rays

Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before your effective date under the contract or after your termination under the contract, except as may be provided under the other continuation options of the contract.

Facility Charges: Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

Fees, Taxes, Interest: Charges for shipping and handling, postage, interest or finance charges that a dentist might bill.

Fractures of the Mandible: Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program.

Home Visits

Implants: Services and supplies provided in connection with implants, whether or not the implant itself is covered.

Investigational Services: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures (health interventions).

Medications and Supplies including take home drugs, pre-medications, therapeutic drug injections and supplies.

Motor Vehicle Coverage and Other Insurance Liability

Nitrous Oxide

Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person (including telephone consultations and email exchanges).

Non-Duplication of Medicare: When by law, this coverage would not be primary to Medicare had you properly enrolled in Medicare when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare, regardless of whether or not you choose to accept those benefits.

Occlusal Treatment: Services and supplies provided in connection with dental occlusion, including occlusal analysis, adjustments and occlusal guards.

Oral Hygiene Instructions

Dental Exclusions
Oral Surgery treating any fractured jaw and orthognathic surgery. By orthognathic surgery, we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.
Orthodontic Dental Services including correction of malocclusion, craniomandibular orthopedic treatment, other orthodontic treatment, preventive orthodontic procedures and procedures for tooth movement, regardless of purpose.
Personal Comfort Items: Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.
Photographic Images
Pin Retention in Addition to Restoration
Precision Attachments
Prosthesis including maxillofacial prosthetic procedures and modification of removable prosthesis following implant surgery.
Provisional Splinting
Replacements: Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.
Riot, Rebellion and Illegal Acts: Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.
Self-Help, Self-Care, Training or Instructional Programs
Separate Charges: Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including any supplies, local anesthesia and sterilization.
Services and Supplies Provided by a Member of Your Family
Services Performed in a Laboratory
Surgical Procedures: Services and supplies provided in connection with the following surgical procedures: exfoliative cytology sample collection or brush biopsy; incision and drainage of abscess extraoral soft tissue, complicated or non-complicated; radical resection of maxilla or mandible; removal of nonodontogenic cyst, tumor or lesion; surgical stent; or surgical procedures for isolation of a tooth with rubber dam.
Temporomandibular Joint (TMJ) Dysfunction Treatment
Third-Party Liability: Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
Tooth Transplantation: Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.
Travel and Transportation Expenses
Work-Related Conditions: Expenses for services and supplies incurred as a result of any work related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

Please note: This benefit summary provides a brief description of your health care plan benefits, limitations and exclusions under your health care plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our Website, **www.myRegence.com**. Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply, and a definition of medical necessity.

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

Contact Customer Service at 1 (888) 367-2116

www.regence.com