

Limitations and Exclusions

Benefits	Regence Breakthru SM		Blue Selections PPO	Regence HSA Healthplan	
	70	50	All Deductibles	Comprehensive	\$2,500/\$3,500 single \$5,000/\$7,000 family
Acupuncture	12 treatments per calendar year		Not Limited	12 treatments per calendar year	
Alcoholism	Not Covered		Limited to \$4,500 in any 24-month period	Not Covered	
Ambulance (ground and air combined)	No limit for emergencies See your contract for other limits		No limit for emergencies See your contract for other limits	No limit for emergencies See your contract for other limits	
Cosmetic / Reconstructive Surgery	Not Covered		Not Covered	Not Covered	
Custodial Care and Rest Cures	Not Covered		Not Covered	Not Covered	
Drug Abuse / Addiction Treatment	Not Covered		Not Covered	Not Covered	
Durable Medical Equipment	\$2,500 per calendar year		Not Limited	\$2,500 per calendar year	
Family Planning (except sterilization & oral contraceptives)	Not Covered		Not Covered	Not Covered	
Growth Hormones	\$25,000 per calendar year		Not Covered	\$20,000 per calendar year	
Hearing Aids	Not Covered		Not Covered	Not Covered	
Home Health Care	130 days per calendar year		180 days per calendar year	130 days per calendar year	
Maternity (Hospital facility, inpatient & outpatient)	9-month waiting period, except prenatal care	Not Covered	9-month waiting period, except prenatal care	9-month waiting period, except prenatal care	Not Covered
Mental Health Treatment	8 inpatient days per calendar year 12 visits per calendar year		30 inpatient days per calendar year 7 visits per calendar year	8 inpatient days per calendar year 12 visits per calendar year	
Obesity or Weight Control	Not Covered		Not Covered	Not Covered	
Orthognathic Surgery	Not Covered		Not Covered	Not Covered	
Rehabilitative Care (Inpatient)	\$4,000 per calendar year		30 inpatient days per calendar year	\$15,000 per calendar year	
Rehabilitative Care (Outpatient)	\$2,000 per calendar year		30 sessions per calendar year	\$1,500 per calendar year	
Skilled Nursing Facility Care	30 days per calendar year		100 days per stay	100 days per stay	
Spinal Manipulation	10 treatments per calendar year		Not Limited	10 treatments per calendar year	
Temporo-Mandibular Joint Disorder	Not Covered		Not Limited	Not Covered	
Tobacco Addiction Treatment	Not Covered		Not Covered	Not Covered	
Transplants	12-month waiting period \$350,000 lifetime maximum		12-month waiting period \$350,000 lifetime maximum	12-month waiting period \$350,000 lifetime maximum	
Vision	Limited to one eye exam per calendar year	Not Covered	One eye exam every 24 months	Not Covered	
You must be covered for at least 9 months before we pay for any of the following (duration reduced by creditable coverage)					
Alcoholism	Not Covered		9-month waiting period	Not Covered	
Allergies	9-month waiting period		9-month waiting period	9-month waiting period	
Ear Infections (otitis media)	9-month waiting period		9-month waiting period	9-month waiting period	
Removal of Tonsils and Adenoids	9-month waiting period		9-month waiting period	9-month waiting period	
Sterilization	9-month waiting period		9-month waiting period	9-month waiting period	
Pre-existing Conditions	9-month waiting period		9-month waiting period	9-month waiting period	

This chart does not contain all limitations and exclusions. Refer to your contract for a complete list of the limitations and exclusions that apply.

Regence BlueCross BlueShield of Oregon
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Find us at: www.regence.com

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Compare

Individual and Family Plans

Effective January 1, 2010	Regence Breakthru SM 70		Regence Breakthru SM 50		Blue Selections PPO		Regence HSA Comprehensive Healthplan		Regence HSA Healthplan	
	Per Member	Per Family	Per Member	Per Family	Per Member	Per Family	Per Single	Per Family	Per Single	Per Family
Annual Deductibles Deductible does not apply to certain benefits	\$1,000; \$3,000	Three deductibles meet the family deductible	\$2,500; \$5,000	Three deductibles meet the family deductible	\$1,000; \$2,500; \$5,000	Three deductibles meet the family deductible	\$1,500	\$3,000	\$2,500; \$3,500	\$5,000; \$7,000
Lifetime Maximum	\$2 million per member		\$2 million per member		\$2 million per member		\$2 million per member		\$2 million per member	
Provider Networks *	Preferred Provider Network (PPP)	Non-Preferred Network	Preferred Provider Network (PPP)	Non-Preferred Network	Preferred Provider Network (PPP)	Non-Preferred Network	Participating Network	Non-Participating Network	Participating Network	Non-Participating Network
Coinsurance Percentage you pay after the deductible	You pay 30%	You pay 50%	You pay 50%	You pay 50%	You pay 20%	You pay 40%	You pay 20%	You pay 40%	You pay 20%	You pay 40%
Annual Coinsurance Maximum Once you reach this amount, Regence pays 100%	\$5,000 (member) \$15,000 (family)	No maximum	\$10,000 (member) \$30,000 (family)	No maximum	\$4,000 (member) no family max.	\$8,000 (member) no family max.	\$5,000 (single) \$10,000 (family)	No maximum	\$5,000 (single) \$10,000 (family)	No maximum
Everyday Needs	PPP	Non-PPP	PPP	Non-PPP	PPP	Non-PPP	Participating	Non-Participating	Participating	Non-Participating
Office Visits	You pay \$30 copay no deductible	You pay \$40 copay no deductible	Deductible and coinsurance		You pay \$20 copay no deductible		Deductible and coinsurance		Deductible and coinsurance	
Prescription Medications RegenceRx Discounts available after limits are reached on Regence Breakthru	Generic: You pay \$10 copay Formulary: You pay 30% Non-Formulary: You pay 50% mail order available no deductible Limited to \$3,000 per calendar year		RegenceRx Discount Program only mail order not available		You pay 50% no deductible mail order not available not limited		You pay deductible and 50% coinsurance mail order not available not limited		You pay deductible and 50% coinsurance mail order not available not limited	
Preventive Care Applies to all ages Includes routine exams and immunizations	Coinsurance only Limited to \$200 per calendar year		Not covered		You pay \$20 copay Limited to women's exam, well-baby to age 2, & immunizations (\$10 copay)		Coinsurance only no deductible not limited		Coinsurance only no deductible not limited	
Preventive Screenings Required by law: PSA tests, Mammograms, Pap Smears	Coinsurance; see additional details below*		Deductible and coinsurance, except routine Pap smears not covered		We pay 100%, you pay 0% no deductible		Coinsurance only no deductible		Coinsurance only no deductible	
Surgeries & Procedures	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Vision Exam Eye exam (refractions)	You pay \$30 copay no deductible	You pay 50% no deductible	Not covered		You pay \$20 copay no deductible	You pay 40% no deductible	Not covered		Not covered	
Vision Hardware Frames Lenses Contacts	We pay 100%, you pay 0% no deductible Limited to \$150 per calendar year		Not covered		Frames: We pay up to \$85 Lenses: We pay up to \$96 Contacts: We pay up to \$181 no deductible Limited to once every 24 months		Not covered		Not covered	
Other Services										
Diagnostic Laboratory & Radiology Services	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance (deductible waived for preventive)		Deductible and coinsurance (deductible waived for preventive)	
Emergency Room Copay waived if admitted	You pay \$100 copay then deductible and coinsurance		You pay \$100 copay then deductible and coinsurance		You pay \$100 copay then deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Hospitalizations Inpatient & outpatient services	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Individual Dentacare Dental Services (optional)	Through Willamette Dental only		Through Willamette Dental only		Through Willamette Dental only		Through Willamette Dental only		Through Willamette Dental only	
Maternity Care Diagnosis, Pre-natal care, Labor and Delivery	Deductible and coinsurance		Not covered		Deductible and coinsurance		Deductible and coinsurance		Not covered	

***Note:** For Regence Breakthru and Blue Selections PPO, expenses are covered at a higher percentage on the Preferred Provider Plan (PPP) network. For alternative care (chiropractic, etc.), Washington Supplemental Providers are preferred. For vision, the Participating (PAR) Vision network is preferred. On the Regence HSA Healthplan, expenses are covered at a higher percentage on the Participating network. On the other plans, the Participating network is non-preferred. For Regence Breakthru 70, mammograms: no deductible; Pap smears: no deductible, subject to preventive care \$200 benefit limit; PSA tests: subject to deductible.