

Limitations and Exclusions

Benefits	Regence Breakthru (All Plans)	Preferred Plan	Selections Plan	Regence HSA Healthplan (Both Plans)
Acupuncture	12 visits per calendar year	12 visits per calendar year	12 visits per calendar year	12 visits per calendar year
Alcoholism	Not covered	Not covered	Not covered	Not covered
Ambulance (ground only)	\$2,000 per calendar year	\$2,000 per calendar year	\$2,000 per calendar year	\$2,000 per calendar year
Cosmetic Surgery	Not covered	Not covered	Not covered	Not covered
Custodial Care and Rest Cures	Not covered	Not covered	Not covered	Not covered
Drug abuse/Addiction Treatment	Not covered	Not covered	Not covered	Not covered
Growth Hormone Therapy	\$25,000 per calendar year	\$25,000 per calendar year	\$25,000 per calendar year	\$20,000 per calendar year
Hearing Aids or Exams	Not covered	Not covered	Not covered	Not covered
Home Health Care	130 visits per calendar year	130 visits per calendar year	130 visits per calendar year	130 visits per calendar year
Home Medical Equipment	\$2,500 per calendar year	\$2,500 per calendar year	\$5,000 per calendar year	\$2,500 per calendar year
Hospice	6 months maximum	6 months maximum	6 months maximum	6 months maximum
Marital and family counseling	Not covered; family counseling covered as specified in the Mental Disorders benefit	Not covered; family counseling covered as specified in the Mental Disorders benefit	Not covered; family counseling covered as specified in the Mental Disorders benefit	Not covered; family counseling covered as specified in the Mental Disorders benefit
Mental Health Treatment	Inpatient: 8 days per calendar year Outpatient: 12 visits per calendar year	Inpatient: 8 days per calendar year Outpatient: 12 visits per calendar year	Selections Network: 8 inpatient days, 12 outpatient visits Extended Network: 6 inpatient days, 10 outpatient visits	Inpatient: 8 days per calendar year Outpatient: 12 visits per calendar year
Occupational Injury	Provided for subscriber only	Not covered	Not covered	Provided for subscriber only
Rehabilitative Care (inpatient)	\$4,000 per calendar year	\$4,000 per calendar year	Not covered	\$4,000 per calendar year
Rehabilitative Care (outpatient)	\$2,000 per calendar year	\$2,000 per calendar year	\$1,500 per calendar year	\$2,000 per calendar year
Skilled Nursing Facility	30 days per calendar year	30 days per calendar year	30 days per calendar year	30 days per calendar year
Smoking Cessation	Not covered	\$500 lifetime maximum	\$500 lifetime maximum	Not covered
Spinal Manipulation	10 manipulations per calendar year	10 manipulations per calendar year	10 manipulations per calendar year	10 manipulations per calendar year
Sterilization	Not covered	Not covered	Not covered	Not covered
Temporo-Mandibular Joint Disorder	Not covered	Not covered	Not covered	Not covered
Transplants	12-month waiting period \$250,000 lifetime maximum	12-month waiting period \$250,000 lifetime maximum	12-month waiting period \$250,000 lifetime maximum	12-month waiting period \$250,000 lifetime maximum
You must be covered for at least 9 months before we pay for any of the following				
Pre-existing conditions	9-month waiting period	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.



Effective October 1, 2008	Regence Breakthru SM 80		Regence Breakthru SM 70		Regence Breakthru SM 50		Preferred Plan		Selections Plan		Regence HSA Healthplan		Regence HSA Healthplan	
	Comprehensive		Comprehensive		Catastrophic		Catastrophic		Catastrophic		Comprehensive		Catastrophic	
Cost-Sharing	Per Member	Family	Per Member	Family	Per Member	Family	Per Member	Family	Per Member	Family	Single	Family	Single	Family
Annual Deductibles Deductible does not apply to certain benefits	\$1,500	Three deductibles meet the family deductible	\$1,000; \$3,000	Three deductibles meet the family deductible	\$2,500; \$5,000	Three deductibles meet the family deductible	\$1,750	Three deductibles meet the family deductible	\$1,750	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		\$1 million per member		\$1 million per member		\$2 million per member		\$2 million per member	
Provider Networks *	Preferred	Participating	Preferred	Participating	Preferred	Participating	Preferred	Participating	Selections	Extended	Preferred	Participating	Preferred	Participating
Coinsurance Percentage you pay after the deductible	You pay 20%	You pay 50%	You pay 30%	You pay 50%	You pay 50%	You pay 50%	You pay 20%	You pay 50%	You pay 20%	You pay 50%	You pay 20%	You pay 40%	You pay 20%	You pay 40%
Annual Coinsurance Maximum Once you reach this amount, Regence pays 100%	\$2,500 per member \$7,500 per family	No maximum	\$5,000 per member \$15,000 per family	No maximum	\$10,000 per member \$30,000 per family	No maximum	\$3,500 per member \$10,500 per family	No maximum	\$3,500 per member \$10,500 per family	No maximum	\$5,000 single \$10,000 per family	No maximum	\$5,000 single \$10,000 per family	No maximum
Everyday Needs	Preferred	Participating	Preferred	Participating	Preferred	Participating	Preferred	Participating	Selections	Extended	Preferred	Participating	Preferred	Participating
Professional Services	You pay \$20 copay no deductible	You pay \$40 copay no deductible	You pay \$30 copay no deductible	You pay \$40 copay no deductible	Deductible and coinsurance		Deductible and coinsurance		You pay \$15 copay then deductible and coinsurance		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 year		Generic: You pay \$10 copay Formulary: You pay 30% Non-Formulary: You pay 50% mail order available no deductible Limited to \$3,000 per year		RegenceRx Discount Program only mail order not available		Not covered		Not covered		You pay deductible and 50% Limited to \$2,000 per calendar year		RegenceRx Discount only mail order available	
Preventive Care Applies to all ages. Includes routine exams, immunizations, and Pap Smears	We pay 100% you pay 0%	Coinsurance only no deductible	Coinsurance only no deductible		Not covered		Not covered		Not covered		Coinsurance only no deductible no annual limit		Coinsurance only no deductible no annual limit	
Preventive screenings Screenings required by law: Mammograms, PSA tests, Colorectal	Coinsurance only no deductible no annual limit		Coinsurance only no deductible no annual limit		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Coinsurance only no deductible no annual limit		Coinsurance only no deductible no annual limit	
Vision Exam Eye exam (refractions)	You pay \$20 copay no deductible	You pay \$40 copay no deductible	You pay \$30 copay no deductible	You pay \$40 copay no deductible	Not covered		Not covered		Not covered		Not covered		Not covered	
Vision Hardware Frames Lenses Contacts	We pay 100%, you pay 0% no deductible Limited to \$400 per calendar year		We pay 100%, you pay 0% no deductible Limited to \$200 per calendar year		Not covered		Not covered		Not covered		Not covered		Not covered	
Other Services														
Diagnostic Laboratory & Radiology Services	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
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		You pay \$100 copay then deductible and coinsurance		You pay \$100 copay then deductible and coinsurance		You pay \$75 copay then deductible and coinsurance		Deductible and coinsurance	
Hospitalizations Inpatient & outpatient including mental health	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Maternity Care Diagnosis, Pre-natal, Labor and Delivery	Deductible and coinsurance		Deductible and coinsurance		Not covered		Not covered		Not covered		Deductible and coinsurance		Not covered	

***Note:** For most plans, you pay a lower coinsurance percentage on the Preferred network and a higher percentage on the Participating provider network. For the Selections Plan, you pay a lower coinsurance percentage on the Selections network and a higher percentage on the Extended provider network. For the Regence HSA Healthplan, the annual coinsurance maximum includes the deductible. For all other plans, the coinsurance maximum does not include the deductible.