Limitations and Exclusions

Benefits	Regence NowSelect	Regence Breakthru (All Plans)	Regence HSA Healthplan (Both Plans)
Acupuncture	12 visits per calendar year	12 visits per calendar year	12 visits per calendar year
Alcoholism	Not covered	Not covered	Not covered
Ambulance (ground only)	$2,000 per calendar year	$2,000 per calendar year	$2,000 per calendar year
Cosmetic 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
Growth Hormone Therapy	$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
Home Health Care	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	$2,500 per calendar year
Hospice	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
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	**Inpatient:** 8 days per calendar year **Outpatient:** 12 visits per calendar year
Occupational Injury	Provided for subscriber only	Provided for subscriber only	Provided for subscriber only
Rehabilitative Care (inpatient)	$4,000 per calendar year	$4,000 per calendar year	$4,000 per calendar year
Rehabilitative Care (outpatient)	$2,000 per calendar year	$2,000 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
Smoking Cessation	Not covered	Not covered	Not covered
Spinal Manipulation	10 manipulations per calendar year	10 manipulations per calendar year	10 manipulations per calendar year
Sterilization	Not covered	Not covered	Not covered
Temporo-Mandibular Joint Disorder	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
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

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 BlueShield
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Effective January 1, 2009	**Regence NowSelect℠**		**Regence Breakthru℠ 70**		**Regence Breakthru℠ 50**		**Regence HSA Healthplan**		**Regence HSA Healthplan**	
	Catastrophic		Comprehensive		Catastrophic		Comprehensive		Catastrophic	
Cost-Sharing	**Regence**	**Family**	**Per Member**	**Family**	**Per Member**	**Family**	**Single**	**Family**	**Single**	**Family**
Annual Deductibles Deductible does not apply to certain benefits	$2,500 $5,000 $7,500 $10,000	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	$1,500	$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**	**Participating**	**Preferred**	**Participating**	**Preferred**	**Participating**	**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 40%	You pay 20%	You pay 40%
Annual Coinsurance Maximum Once you reach this amount, Regence pays 100%	$5,000 per member $15,000 per family	No maximum	$5,000 per member $15,000 per family	No maximum	$10,000 per member $30,000 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**	**Preferred**	**Participating**
Professional Services	Four visits: $35 copay; After four visits: deductible, coinsurance and $35 copay		You pay $30 copay no deductible	You pay $40 copay no deductible	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Prescription Medications RegenceRx Discounts available after limits are reached on Regence Breakthru	RegenceRx Discount Program only mail order not available		**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		You pay deductible and 50% **Limited** to $2,000 per calendar year mail order available		RegenceRx Discount only mail order available	
Preventive Care Applies to all ages. Includes routine exams, immunizations and Pap Smears (Colorectal does not accrue to limit)	Coinsurance only no deductible **Limited** to $200 per calendar year		Coinsurance only no deductible **Limited** to $200 per calendar year		Not covered		Coinsurance only no deductible no annual limit		Coinsurance only no deductible no annual limit	
Mandated Preventive Screenings Mammograms and PSA tests	You pay 0% up to the $400 annual limit, then the deductible and coinsurance *		Coinsurance only no deductible no annual limit		Deductible and coinsurance		Coinsurance only no deductible no annual limit		Coinsurance only no deductible no annual limit	
Diagnostic Laboratory & Radiology Services	You pay 0% up to the $400 annual limit, then the deductible and coinsurance *		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Vision Exam Eye exam (refractions)	Not covered		You pay $30 copay no deductible	You pay $40 copay no deductible	Not covered		Not covered		Not covered	
Vision Hardware Frames Lenses Contacts	Not covered		We pay 100%, you pay 0% no deductible **Limited** to $200 per calendar year		Not covered		Not covered		Not covered	
Other Services										
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 including mental health	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Maternity Care Diagnosis, Pre-natal, Labor and Delivery	Not covered		Deductible and coinsurance		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.

On Regence NowSelect, the Mandated Preventive Screenings benefit and the Diagnostic Laboratory and Radiology Services benefit share a combined $400 annual maximum.

For the Regence HSA Healthplan, the annual coinsurance maximum includes the deductible. For all other plans, the coinsurance maximum does not include the deductible.