

	Limitations and Exclusions			Regence HSA Healthplan
	Blue Selections SM			
	Premier	Plus	Basic	
Acupuncture	Not covered			Not covered
Alcoholism	Limited to \$4,500 in any 24-month period			Limited to \$4,500 in any 24-month period
Ambulance	Not limited			\$5,000 annual limit
Cosmetic / Reconstructive Surgery	Not covered			Not covered
Custodial Care and Rest Cures	Not covered			Not covered
Dental Injury	Not covered			\$1,000 annual limit
Drug Abuse / Addiction Treatment	Not covered			Not covered
Durable Medical Equipment	Not limited			\$2,500 per calendar year. No limit for prosthetics and orthotic devices
Family Planning	Not covered			Not covered
Growth Hormones	Must be preauthorized			\$20,000 per calendar year; must be preauthorized
Hearing Aids (cochlear implants are covered)	Not covered			Not covered
Home Health Care	130 visits per calendar year			130 visits per calendar year
Mental Health Treatment	30 inpatient days per calendar year			Not covered
Obesity or Weight Control	Not covered			Not covered
Orthognathic Surgery (covered when medically necessary)	Not covered			Not covered
Outpatient Counseling	Not covered			Not covered
Preventive Care	Well-Baby-Care up to 2 years Well-Child one exam per calendar year Adult Routine Physical one exam per calendar year			Not limited
Rehabilitative Care (Inpatient)	30 days per calendar year			\$15,000 per calendar year
Rehabilitative Care (Outpatient)	30 sessions per calendar year			\$1,500 per calendar year
Skilled Nursing Facility Care	100 days per stay			100 days per stay
Spinal Manipulation	Not covered			Not covered
Temporo-Mandibular Joint Disorder	\$1,000 per calendar year			\$1,000 per calendar year
Tobacco Addiction Treatment	Not covered			Not covered
Transplants	24-month waiting period \$250,000 lifetime maximum			24-month waiting period \$250,000 lifetime maximum
You must be covered for at least 12 months before we pay for any of the following				
Allergies	12-month waiting period			12-month waiting period
Sterilization	12-month waiting period			12-month waiting period
Elective Procedures	12-month waiting period			12-month waiting period

This chart does not contain all limitations and exclusions. Please refer to your contract for a complete list of benefits, limitations, and exclusions that apply.

- **Eligibility:** You, your legal spouse, or qualified domestic partner are eligible to apply if a resident of Oregon and not eligible for Medicare. Your unmarried, dependent children under the age of 23 are also eligible to apply.
- **Waiting Period:** These plans have a 6-month waiting period for pre-existing conditions, and a 12-month exclusionary period for specific benefits, as listed above.
- **Credit for Prior Coverage:** You may be able to reduce these waiting and exclusionary periods by providing information about prior and/or current creditable medical coverage.

Regence BlueCross BlueShield of Oregon

Compare Individual and Family Plans



	Blue Selections SM Premier		Blue Selections SM Plus		Blue Selections SM Basic		Regence HSA Healthplan	
Benefits	Per Member	Per Family	Per Member	Per Family	Per Member	Per Family	Per Single	Per Family
Annual Deductibles Deductible does not apply to certain benefits	You pay \$1,000	You pay \$3,000	You pay \$1,000	You pay \$3,000	You pay \$1,000	You pay \$3,000	You pay \$1,500	You pay \$3,000
	You pay \$2,500	You pay \$7,500	You pay \$2,500	You pay \$7,500	You pay \$2,500	You pay \$7,500	You pay \$2,500	You pay \$5,000
	You pay \$5,000	You pay \$15,000	You pay \$5,000	You pay \$15,000	You pay \$5,000	You pay \$15,000	You pay \$3,500	You pay \$7,000
	You pay \$7,500	You pay \$22,500			You pay \$10,000	You pay \$30,000		
Lifetime Maximum	\$2 million per member		\$2 million per member		\$2 million per member		\$2 million per member	
Provider Networks	Preferred Provider Plan Network	Non-Preferred Network	Preferred Provider Plan Network	Non-Preferred Network	Preferred Provider Plan Network	Non-Preferred Network	Participating Network	Non-Participating Network
Coinsurance Percentage you pay after the deductible	You pay 20%	You pay 40%	You pay 30%	You pay 50%	You pay 50%	You pay 50%	You pay 20%	You pay 40%
Annual Coinsurance Maximum* Once you reach this amount, Regence pays 100%	\$4,000 (member) \$12,000 (family)	\$8,000 (member) \$24,000 (family)	\$6,000 (member) \$18,000 (family)	\$10,000 (member) \$30,000 (family)	\$10,000 (member) \$30,000 (family)	\$10,000 (member) \$30,000 (family)	\$5,000 (single) \$10,000 (family)	No maximum
Everyday Needs	PPP	Non-PPP	PPP	Non-PPP	PPP	Non-PPP	Participating	Non-Participating
Office Visits	You pay \$20 copay	You pay \$40 copay	You pay \$30 copay	You pay \$40 copay	Deductible and coinsurance		Deductible and coinsurance	
	No deductible		No deductible					
Prescription Medications RegenceRx Discounts available after limits are reached on Blue Selections Plus & Basic	Generic: You pay \$10 copay Not limited Other Charges: You pay 50% No deductible No annual limit		Generic: You pay \$10 copay Not limited Other Charges: You pay 50% No deductible \$5,000 annual limit		Generic: You pay \$10 copay Not limited Other Charges: You pay 50% No deductible \$2,000 limit		You pay deductible and 50% coinsurance No annual limit	
Preventive Care Adult and Child Immunizations Annual Women’s Exams (includes PAP smear and routine mammogram) Annual Men’s Exams (includes PSA test) Routine Care Well-Baby/Child	You pay 0% after \$20 copay	You pay 0% after \$40 copay	You pay 0% after \$30 copay	You pay 0% after \$40 copay	You pay 50%	You pay 50%	You pay 20%	You pay 40%
	No deductible Some limits apply		No deductible Some limits apply		No deductible Some limits apply		No deductible No annual or age limits	
Surgeries & Procedures	Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance		Deductible and coinsurance	
Vision Exam Eye exam (refractions)	You pay 0% after \$20 copay	You pay 40%	You pay 0% after \$30 copay	You pay 50%	Not covered		Not covered	
	Limited to one exam per calendar year No deductible		Limited to one exam per calendar year No deductible					
Vision Hardware Frames Lenses Contacts	You pay 0% No deductible Limited to \$250 per calendar year		You pay 0% No deductible Limited to \$150 per calendar year		Not covered		Not covered	
Other Services	PPP	Non-PPP	PPP	Non-PPP	PPP	Non-PPP	Participating	Non-Participating
Diagnostic Laboratory & Radiology Services	You pay 20%	You pay 40%	You pay 30%	You pay 50%	You pay 50%	You pay 50%	You pay 20%	You pay 40%
	Deductible applies		Deductible applies		Deductible applies		Deductible applies	
Emergency Room Copay waived if admitted	You pay 20% after \$100 copay Deductible applies		You pay 30% after \$100 copay Deductible applies		You pay 50% after \$100 copay Deductible applies		You pay 20% Deductible applies	
Hospitalizations Inpatient & outpatient services	You pay 20%	You pay 40%	You pay 30%	You pay 50%	You pay 50%	You pay 50%	You pay 20%	You pay 40%
	Deductible applies		Deductible applies		Deductible applies		Deductible applies	
Maternity Care Diagnosis, Pre-natal care, Labor and Delivery	You pay 20%	You pay 40%	You pay 30%	You pay 50%	You pay 50%	You pay 50%	You pay 20%	You pay 40%
	Deductible applies		Deductible applies		Deductible applies		Deductible applies	
Individual Dentacare Dental Services (optional with medical plan)	Through Willamette Dental only		Through Willamette Dental only		Through Willamette Dental only		Through Willamette Dental only	
Accidental Death	We pay \$25,000 per subscriber, enrolled domestic partner, or enrolled spouse. \$5,000 per dependent or child subscriber		We pay \$15,000 per subscriber, enrolled domestic partner, or enrolled spouse. \$4,000 per dependent or child subscriber		We pay \$10,000 per subscriber, enrolled domestic partner, or enrolled spouse. \$2,000 per dependent or child subscriber		We pay \$25,000 per subscriber, enrolled domestic partner or enrolled spouse. \$5,000 per dependent or child subscriber	
Additional Accident Coverage	Deductible waived for accidental injuries treated within 90 days of injury date		Paid as any other illness or injury		Paid as any other illness or injury		Paid as any other illness or injury	

***Note:** The Participating Network Annual Out-of Pocket Maximum on the Regence HSA Healthplan includes the deductible. For all other plans, the coinsurance maximum does not include the deductible.