

Regence BlueShield	Regence Evolve Core SM		Regence Evolve Plus SM		Regence Evolve HSA Plan SM				Regence Evolve HSA 100 Plan SM		What you should know
Cost Sharing	Per Individual	Per Family	Per Individual	Per Family	Single		Family		Single	Family	
Annual Deductible (choose one; based on calendar year)	\$2,500, \$5,000, \$7,500 or \$10,000	Family deductible is three times the individual deductible	\$1,000, \$2,500, \$5,000 or \$7,500	Family deductible is three times the individual deductible	\$2,000 or \$3,500		\$4,000 or \$7,000; no one family member is eligible for benefits until the entire family deductible is met.		\$5,000	\$10,000; no one family member is eligible for benefits until the entire family deductible is met.	Your deductible is the dollar amount you pay in a calendar year before the plan pays covered benefits. Not all benefits apply toward the deductible. Some benefits require a copay or other cost-sharing amount.
Annual Maximums	\$7,500 coinsurance maximum	Family coinsurance maximum is three times the individual maximum	\$5,500 coinsurance maximum	Family coinsurance maximum is three times the individual maximum	\$5,000 out-of-pocket maximum		\$10,000 out-of-pocket maximum		\$5,000 out-of-pocket maximum	\$10,000 out-of-pocket maximum	On Regence Evolve Core and Plus, this is the total amount you pay for coinsurance, in addition to the deductible, in a calendar year before the plan covers the full cost (100%) of eligible expenses. For the Regence Evolve HSA Plans, the out-of-pocket maximum includes the deductible.
Lifetime Maximum	\$2,000,000 per individual member		\$2,000,000 per individual member		\$2,000,000 per individual member				\$2,000,000 per individual member		This is the highest dollar amount we will pay toward all health care services during your lifetime under this plan.
Percentages and copays shown are what you pay for each covered event. The percentages shown are what you pay after you have met your deductible, unless otherwise noted.	Provider Type		Provider Type		Provider Type				Provider Type		
	Category 1	Categories 2 & 3	Category 1	Categories 2 & 3	50/50/50 coinsurance option		80/60/60 coinsurance option		Category 1	Categories 2 & 3	Category 1: With Preferred providers, you'll generally have lower out-of-pocket costs. Category 2: With Participating providers, you'll generally pay more out of pocket than with providers in Category 1. Category 3: With non-contracted providers, you'll have the highest out-of-pocket costs and they may bill you for the balance over our payment of the claim.
Office Visits	\$35 per visit, deductible is waived and 0% coinsurance for first four visits per person. After four, then subject to deductible and coinsurance.		\$25 per visit, deductible is waived and 0% coinsurance for first four visits per person. After four, then subject to deductible and coinsurance.		50%	50%	20%	40%	0%	0%	Copay applies only to the office exam. All other services provided during the visit are subject to the applicable deductible and coinsurance.
Prescription Medication	You receive a discount on prescriptions (generic and brand formulary) through the RegenceRx discount program.		\$10 copay for generics, \$500 deductible, 50% coinsurance for brand formulary only. \$2,500 per-year maximum on drugs. No limit for generic and brand formulary diabetic drugs and supplies.		Generics only; 50% after deductible is met. Brand formulary diabetic drugs and supplies covered.		Generics only; 20% after deductible is met. Brand formulary diabetic drugs and supplies covered.		Generics only; 0% after deductible is met; \$2,000 per year maximum. No limit for generic or brand formulary diabetic drugs and supplies.		After you reach the annual maximum, you continue to receive discounts off the full retail price of medications through the RegenceRx discount program. Just show your member card at your pharmacy.
Preventive Care (excludes complex imaging); no benefit limit	30%; not subject to deductible	50%; not subject to deductible	20%; not subject to deductible	50%; not subject to deductible	50%; not subject to deductible	50%; not subject to deductible	20%; not subject to deductible	40%; not subject to deductible	0% after deductible is met	0% after deductible is met	Includes but not limited to routine physical exams, lab and X-ray (includes Pap and PSA screening), and well-baby care.
Immunizations (adult and child); no benefit limit	30%; not subject to deductible	50%; not subject to deductible	0%; not subject to deductible	0%; not subject to deductible	50%; not subject to deductible	50%; not subject to deductible	20%; not subject to deductible	40%; not subject to deductible	0% after deductible is met	0% after deductible is met	
Outpatient Radiology and Laboratory (limit does not apply to preventive care or complex outpatient imaging)	Deductible is waived and 0% coinsurance for first \$200 per year; then subject to deductible and coinsurance.		Deductible is waived and 0% coinsurance for first \$400 per year; then subject to deductible and coinsurance.		50%; subject to deductible	50%; subject to deductible	20%; subject to deductible	40%; subject to deductible	0% after deductible is met	0% after deductible is met	
Vision Care	Excluded	Excluded	20%; routine eye exam and hardware covered to a combined \$150 per-calendar-year maximum. Not subject to deductible or coinsurance maximum		Excluded	Excluded	Excluded	Excluded	Excluded	Excluded	
Spinal Manipulations	30%	50%	20%	50%	50%	50%	20%	40%	0%	0%	10 spinal manipulations per calendar year
Acupuncture	30%	50%	20%	50%	50%	50%	20%	40%	0%	0%	6 visits per calendar year
Ambulance	30%	30%	20%	20%	50%	50%	20%	20%	0% after deductible is met	0% after deductible is met	
Emergency Room	\$150 copay per ER visit (waived if admitted), then 30%		\$100 copay per ER visit (waived if admitted), then 20%		50%	50%	20%	20%			
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	50%; \$1,500 per year maximum.		50%	50%	50%	50%	50%	50%			
Maternity Care	Excluded	Excluded	20%	50%	Excluded	Excluded	Excluded	Excluded	Excluded	Excluded	
Durable Medical Equipment	30%	50%	20%	50%	50%	50%	20%	40%	0% after deductible is met	0% after deductible is met	Limited to \$2,500 per calendar year (limit does not apply to insulin pumps/supplies and lifesaving equipment such as oxygen and ventilators).
Hospitalization	30%	50%	20%	50%	50%	50%	20%	40%	0% after deductible is met	0% after deductible is met	
Mental Health Treatment	30%	50%	20%	50%	50%	50%	20%	40%	0%	0%	

Other Considerations

Waiting Periods There is a nine-month waiting period that must be met before benefits are available for pre-existing conditions. By pre-existing condition, we mean a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received or for which a prudent layperson would have sought medical advice, diagnosis, care or treatment, within the six-month period before the effective date of coverage. The exclusion period will end nine months following your effective date of coverage.

Outside the Service Area

Members have the security of knowing they can access Blue Cross and/or Blue Shield (Blue Plan) providers across the country and worldwide through the BlueCard® Program. Policy benefits apply as described above, and members may receive discounts on their services.

Optional Benefits: You may add one of these dental plan options to any medical plan for an additional cost. (Optional benefits that are not elected are excluded from coverage.)

Dental Option I: Incentive Dental Plan Coverage is limited to \$750 per calendar year. When you incur services that are at least \$250 less than your calendar-year maximum (\$500 with the \$750 year 1 maximum benefit for example), your calendar-year maximum may be increased by \$250 for the following year. Waiting Periods: Six months for Basic and 12 months for Major Services.	No deductible and 0% for Preventive Services \$50 deductible per calendar year for Basic and Major Services 20% for Basic Services 50% for Major Services
Dental Option II: Dollar-Based Dental Plan Waiting Period: Six months for all covered services. Coverage is limited to \$750 per calendar-year maximum benefit (Preventive, Basic and Major Services combined). No age limits or frequency limits.	No deductible 0% for the first \$200 of covered services, then 50% up to the annual maximum

Limitations and Exclusions

	Evolve Core	Evolve Plus	Evolve HSA Plans
Breast Reduction, Eye Lid Surgery and Varicose Vein Surgery	Excluded	\$2,500 per-lifetime maximum benefit	Excluded
Home Health Care	130 visits per calendar year	130 visits per calendar year	130 visits per calendar year
Rehabilitative Services	Inpatient: \$8,000 per calendar year Outpatient: \$1,500 per calendar year	Inpatient: \$8,000 per calendar year Outpatient: \$1,500 per calendar year	Inpatient: \$8,000 per calendar year Outpatient: \$1,500 per calendar year
Respite Care	14 days inpatient/outpatient per lifetime	14 days inpatient/outpatient per lifetime	14 days inpatient/outpatient per lifetime
Skilled Nursing Facility Care	30 inpatient days per calendar year	30 inpatient days per calendar year	30 inpatient days per calendar year
Temporomandibular Joint Disorder	Excluded	Excluded	Excluded
Tobacco Addiction Treatment	Excluded	Excluded	Excluded
Transplants	\$350,000 lifetime maximum including donor cost	\$350,000 lifetime maximum including donor cost	\$350,000 lifetime maximum including donor cost

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

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. Please refer to the policy for a complete list of benefits, limitations and exclusions.

