

COMPARE INDIVIDUAL HEALTH PLANS
that offer more of
what you need,
less of what you don't.

Regence EvolveSM Individual and Family Health Benefit Plans

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the Blue Cross and Blue Shield Association



Regence BlueCross BlueShield of Oregon	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)	\$1,000, \$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	\$1,500 or \$3,500		\$3,000 or \$7,000; family deductible can be met by one, a combination of or all family members.		\$5,000	\$10,000; family deductible can be met by one, a combination of or all family members.	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	\$4,000 (for \$1,000 deductible plan only)/\$5,500 (for all other deductibles) coinsurance maximum	\$12,000 (for \$1,000 deductible plan only); family coinsurance maximum is three times the individual maximum for all other deductibles	\$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 below are what you pay for each covered service. 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	Category 2 & 3	
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	\$10 copay for generics. \$500 deductible, 50% coinsurance for brand formulary only. \$1,000 per-year maximum for all drugs. Self-administered oral chemotherapy medication \$10 generic/\$50 brand-name formulary/\$100 brand-name nonformulary (not subject to prescription medication deductible or annual benefit maximum). \$500 lifetime maximum on tobacco-cessation prescription drugs (includes generic/brand/nonformulary).		\$10 copay for generics. \$500 deductible, 50% coinsurance for brand formulary only. \$4,500 per-year maximum on all drugs. Self-administered oral chemotherapy medication \$10 generic/\$50 brand-name formulary/\$100 brand-name nonformulary (not subject to prescription medication deductible or annual benefit maximum). \$500 lifetime maximum on tobacco-cessation prescription drugs (includes generic/brand/nonformulary).		Generics only; 50% after deductible is met. Self-administered oral chemotherapy (includes generic/brand/non-formulary). \$500 lifetime maximum on tobacco-cessation prescription drugs (includes generic/brand/nonformulary).		Generics only; 20% after deductible is met. Self-administered oral chemotherapy (includes generic/brand/non-formulary). \$500 lifetime maximum on tobacco-cessation prescription drugs (includes generic/brand/nonformulary).		Generics only; 0% after deductible is met; \$2,000 per-year maximum. Self-administered oral chemotherapy (includes generic/brand/non-formulary); not subject to the annual maximum. \$500 lifetime maximum on tobacco-cessation prescription drugs (includes generic/brand/nonformulary).		After you reach the annual limit, 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)	0%, deductible is waived for first \$200 per year; then subject to deductible and coinsurance		0%, deductible is waived 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	
Complementary Care	Excluded	Excluded	20%; limited to \$500 per calendar year maximum; Not subject to deductible or coinsurance.		Excluded	Excluded	Excluded	Excluded	Excluded	Excluded	Complementary care includes naturopathic, chiropractic and acupuncture services and supplies.
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%	0% after deductible is met	0% after deductible is met	
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	50%; \$1,500 per-year maximum.		50%	50%	50%	50%	50%	50%	0% after deductible is met	0% after deductible is met	
Maternity Care	30%	50%	20%	50%	50%	50%	20%	40%	0% after deductible is met	0% after deductible is met	
Hospitalization	30%	50%	20%	50%	50%	50%	20%	40%	0% after deductible is met	0% after deductible is met	

Other Considerations

Waiting Periods No benefits are provided for treatment relating to a transplant until the member has been covered under this or a prior plan for 24 consecutive months. There is a six-month waiting period that must be met prior to benefits being available for pre-existing conditions. Members may receive credit from prior medical 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.

To learn more, please visit www.regence.com or call 1 (888) REGENCE.

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.

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
Complementary Care	Excluded	\$500 per-calendar-year limit; not subject to deductible or co-insurance maximum.	Excluded
Breast Reduction, Eye Lid Surgery and Varicose Vein Surgery	Excluded	\$2,500 per-lifetime maximum benefit	Excluded
Hearing Aids and Evaluations (for dependents who meet criteria)	\$4,000 every four calendar years maximum	\$4,000 every four calendar years maximum	\$4,000 every four calendar years maximum
Home Health Care	130 visits per calendar year	130 visits per calendar year	130 visits per calendar year
Hospice Care	Not limited	Not limited	Not limited
Mental Health Treatment	Excluded	Inpatient: 6 days per calendar year Outpatient: 12 visits per calendar year	Inpatient: 6 days per calendar year Outpatient: 12 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 Use Cessation Programs	\$500 per-lifetime maximum	\$500 per-lifetime maximum	\$500 per-lifetime maximum
Transplants	\$250,000 lifetime maximum including donor cost	\$250,000 lifetime maximum including donor cost	\$250,000 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.

