

# Regence Evolve Plus

**\$1,000, \$2,500, \$5,000, \$7,500 Deductible Options**

Family deductible maximum is 3x individual deductible.

Benefits shown below are when you use a preferred provider.



**Regence  
BlueShield**

An Independent Licensee of the Blue Cross  
and Blue Shield Association

**Before the deductible is met:**

These benefits are not subject to the deductible.

**1. \$25 co-pay for office visits – first four per calendar year**

Deductible, then 20% co-insurance applies for additional visits  
(Includes office, urgent care and naturopathy visits)

**2. Preventive care – covered at 100%** (no annual benefit maximum)

Includes the following when billed as preventive: Routine physical exam, well child care, adult and child immunizations, routine laboratory, radiology and diagnostic procedures including mammography, pap smear, PSA and colonoscopy. (See contract for complete list of preventive care benefits)

**3. Outpatient radiology and laboratory - First \$400 per calendar year paid at 100%**

Deductible and 20% co-insurance applies after upfront benefit limit of \$400 is met.

**4. Vision care – \$150 benefit maximum per calendar year.**

Routine Exam and vision hardware - you pay 20% co-insurance. Use participating provider.

**5. Prescription drugs – \$2,500 maximum per person per calendar year – includes contraceptives**

- Tier 1 (Generic) = \$10 retail or mail order co-pay per 30 day supply
- Tier 2 (Brand Name Formulary) = \$500 Rx deductible, then 50% co-pay for retail or mail order
- Tier 3 (Non-Formulary) = **Not covered**

**After the deductible has been met,** all other covered benefits are provided.

- **\$100 Emergency room co-pay** (waived if admitted), plus 20% co-insurance.
- **20% co-insurance for hospital and physician services** (preferred provider network)
- **50% co-insurance for complex outpatient imaging** (CT Scan, MRI, PET, SPECT, Bone Density)
- **50% co-insurance for discretionary surgery, \$2,500 lifetime max**
- **\$5,500 annual co-insurance maximum, plus deductible and co-pays**  
(After you have met your deductible, you pay up to \$5,500 in co-insurance, then Regence covers 100% of allowable charges up to 2 million)

- **Inpatient rehabilitation - \$8,000 PCY**
- **Outpatient rehabilitation – \$1,500 PCY**
- **Inpatient and outpatient mental health**
- **Includes 24 hour “on the job” coverage** for subscriber/spouse who are exempt from L&I
- **Includes maternity coverage**
- Spinal manipulations, 10 PCY
- Acupuncture, 6 PCY
- No fourth quarter deductible carry-over

**Partial list of Exclusions:**  
chemical dependency, TMJ,  
non-formulary brand name drugs.

AGE	\$1000 DEDUCTIBLE		\$2500 DEDUCTIBLE		\$5000 DEDUCTIBLE		\$7500 DEDUCTIBLE	
	NS	SMOKER	NS	SMOKER	NS	SMOKER	NS	SMOKER
<25	\$215	\$247	\$163	\$187	\$135	\$155	\$122	\$140
25-29	\$247	\$284	\$187	\$215	\$155	\$178	\$140	\$161
30-34	\$287	\$330	\$217	\$249	\$180	\$207	\$163	\$187
35-39	\$339	\$390	\$256	\$295	\$212	\$244	\$192	\$221
40-44	\$399	\$458	\$301	\$347	\$250	\$287	\$226	\$260
45-49	\$482	\$555	\$365	\$419	\$302	\$348	\$273	\$314
50-54	\$574	\$660	\$434	\$499	\$360	\$414	\$325	\$374
55-59	\$673	\$775	\$509	\$586	\$422	\$485	\$382	\$439
60-64	\$789	\$907	\$597	\$686	\$495	\$569	\$447	\$515
65>	\$789	\$907	\$597	\$686	\$495	\$569	\$447	\$515
Child	\$215		\$163		\$135		\$122	

\*This flyer was prepared by the Health Insurance Connection, Inc. This is a brief summary of benefits and is not a certificate of coverage. For full coverage provisions, including a description of waiting periods and limitations, refer to a benefit brochure and contract. This summary is not a contract. Rates are scheduled to increase October 1, 2011. However, due to health care reform mandated coverage there could be a slight increase before that date.

# Regence Evolve Plus<sup>SM</sup>

- Category 1:** Preferred providers. You'll generally have lower out-of-pocket costs when you see providers in this category.
- Category 2:** Participating providers. When you see providers in this category, you'll generally pay more out of pocket than you would with providers in Category 1.
- Category 3:** Non-contracted providers. You'll have the highest out-of-pocket costs when you see these providers. Also, they may bill you for the balance of their charge after we pay the claim.

Benefits	Per individual		Per family
<b>Annual deductible</b> Deductible does not apply to certain benefits	\$1,000, \$2,500, \$5,000, \$7,500		Family deductible is three times the single amount
<b>Annual coinsurance maximum</b> Once you reach this amount, Regence pays 100%	\$5,500 per member		\$16,500 per family
<b>Lifetime maximum</b>	No overall lifetime maximum		
<b>Provider networks</b>	<b>Category 1 (Preferred)</b>	<b>Category 2 (Participating)</b>	<b>Category 3 (Non-contracted)</b>
<b>Coinsurance</b> Percentage you pay after the deductible	You pay 20%	You pay 50%	You pay 50%
<b>Preventive care and immunizations</b> Preventive services and immunizations are covered according to guidelines set by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA). Standard plan benefits apply for any service that does not meet these guidelines.	Categories 1 and 2: You pay 0%, no deductible		Category 3: Standard plan benefits apply
<b>Up-front office visits (injury and illness)</b> First four per calendar year Not subject to deductible	\$25 office-visit copay; no deductible		
<b>Prescription medications</b> \$2,500-per-calendar-year maximum for all drugs (including contraceptives); RegenceRx discount available	Generics - \$10 copay Brand formulary - \$500 deductible, 50% coinsurance. We follow USPSTF guidelines for certain preventive medications covered with no deductible, no copay at participating pharmacies only. Member must have a prescription.		
<b>Up-front outpatient radiology and laboratory</b> Limit does not apply to complex outpatient imaging	First \$400 per calendar year, not subject to deductible		
<b>Vision care - refraction and hardware</b>	20% coinsurance; routine eye exam and hardware covered to a combined \$150-per-calendar-year maximum; not subject to deductible or coinsurance maximum		
<b>Emergency room</b>	\$100 copay per ER visit (waived if directly admitted); deductible and 20% coinsurance		
<b>Hospitalizations</b> Inpatient and outpatient services	Deductible and coinsurance		
<b>Maternity</b> Diagnosis, prenatal care, labor and delivery	Deductible and coinsurance		
<b>Individual dental options</b> Optional with medical plan	Dental Option 1 or Dental Option 2		
<b>Complex outpatient imaging</b> CT Scan, MRI, PET, MRA, SPECT, bone density	Deductible and 50% coinsurance		
<b>After the up-front benefits are exhausted</b> Office visits, laboratory and radiology services	Deductible and coinsurance		

## Other Considerations

**Waiting Periods** There is a nine-month waiting period that must be met before benefits are available for pre-existing conditions. (The pre-existing conditions waiting period does not apply to members up to age 19.) 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.

**To learn more, please visit [www.regence.com](http://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
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.

