Regence BlueCross BlueShield of Oregon

Evolve Plus[SM] Highlights

Evolve Plus features:

• Provider choice: Members have direct access to their choice of providers. Coinsurance levels are lower for Category 1 services; coinsurance levels are higher for Category 2 and 3 services; members may be responsible for provider costs above the Category 3 allowed amount.

• Upfront benefits: The first four office visits and the first $400 of outpatient radiology and laboratory services per calendar year are not subject to the deductible (Category 1, 2 and 3).

• Additional benefits: Subsequent office visits, outpatient radiology and laboratory beyond the first $400 per calendar year, and all other professional services are subject to the deductible and coinsurance levels as specified below.
• Preventive care: Preventive care is included in the plan with no separate limits and not subject to the deductible. That's immediate access to commonly-needed care, including annual exams, well-child exams, mammograms, and prostate screenings, billed as preventive by your provider.
• This plan offers optional dental packages. For details see the Optional Benefits Available section.

Lifetime Maximum Benefit	**$2,000,000**
Calendar Year Deductible Applies to all covered expenses except where noted	Individual deductible options per calendar year for each member: **$1,000, $2,500, $5,000, $7,500** Family deductible is three times the individual amount
Calendar Year Coinsurance Maximum Applies to all covered expenses except where noted When the coinsurance maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year	Individual coinsurance maximum per calendar year for each member: **$5,500** Family coinsurance maximum is three times the individual amount

Covered Services	Evolve Plus Member Responsibility		
	Category 1 (Preferred)	**Category 2 (Participating)**	**Category 3 (Non-contracted)** (Member may be responsible for any provider costs above the Category 3 allowed amount)
Upfront Office Visits (Injury and Illness) Upfront office visits: first four per calendar year Not subject to deductible	**$25 copay**	**$25 copay**	**$25 copay**

Coinsurance applies after deductible is met and until coinsurance maximum is reached.

Covered Services	Evolve Plus		
	Category 1 (Preferred)	**Category 2 (Participating)**	**Category 3 (Non-contracted)** (Member may be responsible for any provider costs above the Category 3 allowed amount)
	Member Responsibility **Coinsurance applies after deductible is met and until coinsurance maximum is reached.**		
Upfront Outpatient Radiology and Laboratory First $400 per calendar year (limit does not apply to preventive care or complex outpatient imaging). Not subject to deductible	**0%**	**0%**	**0%**
Other Professional Services Deductible applies after upfront benefit limits are met. Office and inpatient services and supplies	**20%**	**50%**	**50%**
Other Outpatient Radiology and Laboratory Deductible applies after upfront benefit limits are met			
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	**50%**	**50%**	**50%**
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies	**20%**	**50%**	**50%**
Maternity			
Emergency Room Services $100 copay per ER visit (waived if directly admitted)	**20%**	**20%**	**20%**
Ambulance Services Air and ground ambulance to nearest facility			
Preventive Care (excludes complex imaging) Not subject to the deductible; no benefit limit	**20%**	**50%**	**50%**
Immunizations - Adult and Childhood Not subject to the deductible; no benefit limit	**0%**	**0%**	**0%**
Genetic Testing $5,000 per lifetime maximum benefit (this limit does not apply to prenatal testing). Deductible applies after upfront benefit limits are met	**20%**	**50%**	**50%**
Home Health 130 visits per calendar year			
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime			
Mental Health Treatment			
Acupuncture Six visits per calendar year maximum benefit			
Spinal Manipulations 10 spinal manipulations per calendar year maximum benefit			
Durable Medical Equipment $2,500 per calendar year maximum benefit (this limit does not apply to insulin pumps/supplies and lifesaving equipment such as oxygen and ventilators)			
Orthotics $500 per calendar year maximum benefit (this limit does not apply to diabetic orthotics)			
Prostheses $2,500 per calendar year maximum benefit (this limit does not apply to surgically implanted and external breast prostheses)			

Covered Services	Evolve Plus Member Responsibility		
	Category 1 (Preferred)	**Category 2 (Participating)**	**Category 3 (Non-contracted)** (Member may be responsible for any provider costs above the Category 3 allowed amount)
Rehabilitation Services Inpatient: $8,000 per calendar year maximum benefit Outpatient: $1,500 per calendar year maximum benefit	**20%**	**50%**	**50%**
Skilled Nursing Facility 30 inpatient days per calendar year			
Transplants $350,000 lifetime maximum benefit; includes donor costs			
Vision Routine eye exam and hardware covered to a combined $150 per calendar year maximum; not subject to deductible or coinsurance maximum	**20%**	**20%**	**20%**
Breast Reduction, Eye Lid Surgery, Varicose Vein Surgery $2,500 per lifetime maximum benefit	**50%**	**50%**	**50%**

Prescription Medication Coverage
$10 copay for generics $500 deductible, 50% coinsurance for brand formulary only. $2,500 per calendar year maximum for all drugs (including contraceptives) (No benefit limit for diabetic drugs and supplies).

Optional Benefits Available (Optional benefits that are not elected are excluded from coverage)	
Covered Services	**Evolve Plus Member Responsibility**
Dental Option I Incentive Dental Plan $750 per calendar year maximum benefit. When you incur services less than $500, your calendar year maximum may be increased by $250 for the following year. Waiting Periods: 6 months for Basic Services and 12 months for Major	No deductible and 0% for Preventive dental care $50 deductible per calendar year for Basic and Major Care 20% for Basic care 50% for Major care
Dental Option II Dollar-Based Dental Plan Waiting Periods: 6 months for all covered services $750 per calendar year maximum benefit (Preventive, Basic and Major services combined)	No deductible 0% for the first $200 of covered services then 50% up to the annual maximum

Coinsurance applies after deductible is met and until coinsurance maximum is reached.

Additional Information	
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 12 consecutive months. There is a nine 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. Plan benefits apply as described above, and members may receive discounts on their services.

General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **Chemical Dependency Treatment.**
- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly, and for breast reconstruction following a medically necessary mastectomy to the extent required by law.
- **Counseling** in the absence of illness.
- **Custodial Care:** Non-skilled care and helping with activities of daily living.
- **Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest, or finance charges that a provider might bill.
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.
- **Hospitalization for Dentistry.**
- **Infertility** except to the extent covered services are required to diagnose such condition.
- **Investigational Services:** Treatment or procedures (health interventions) and services, supplies, and accommodations provided in connection with investigational treatments or procedures.
- **Medications without a Prescription Order.**
- **Military Service Related Conditions:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection or conditions incurred in or aggravated during performance in the Uniformed Services.
- **Motor Vehicle Coverage and Other Insurance Liability.**
- **Neurodevelopmental Therapy Services.**
- **Non-Direct Patient Care** including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges.
- **Obesity or Weight Reduction/Control:** Medical treatment, medication, surgical treatment (including reversals), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis.
- **Orthognathic Surgery** except for congenital conditions, injury, and sleep apnea.
- **Personal Comfort Items:** Items that are primarily for comfort, convenience, cosmetics, environmental control, or education.
- **Physical Exercise Programs and Equipment** including hot tubs or membership fees at spas, health clubs, or other facilities; applies even if the program, equipment, or membership is recommended by the member's provider.
- **Private Duty Nursing** including ongoing shift care in the home.
- **Riot, Rebellion and Illegal Acts:** Services and supplies for treatment of an illness, injury, or condition caused by a member's voluntary participation in a riot, armed invasion, or aggression, insurrection, or rebellion or sustained by a member while committing an illegal act or felony.
- **Routine Foot Care** including treatment of corns and calluses and trimming of nails.
- **Routine Hearing Care:** Routine hearing examinations, programs, or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them, except for cochlear implants.
- **Self-Help, Self-Care, Training, or Instructional Programs** including childbirth classes, diet and weight monitoring services and instruction programs, including those to learn how to stop smoking and programs that teach a person how to use durable medical equipment or how to care for a family member.
- **Services and Supplies Provided by a Member of Your Family.**
- **Services and Supplies That Are Not Medically Necessary.**
- **Services to Alter Refractive Character of the Eye.**
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, and counseling services for sexual reassignment.
- **Sexual Dysfunction:** Regardless of cause, except for counseling provided by covered, licensed mental health practitioners.
- **Temporomandibular Joint Disorders (TMJ) Treatment.**
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
- **Tobacco Addiction Treatment** including supportive items for addiction to tobacco, tobacco products, or nicotine substitutes, including prescription medications
- **Travel and Transportation Expenses** other than covered ambulance services.
- **Work-Related Conditions** except for subscribers and spouses who are owners, partners, or corporate officers and are exempt from state or federal workers' compensation law.

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage provisions, refer to the contract.