Regence Evolve Dental Option 1
Summary of benefits

Dental benefits	
Deductible per calendar year	$50 per insured $150 per family (3 times the insured amount)
Maximum benefit per calendar year	$750 per insured
Important note: The dental deductible is calculated separately from any other deductible of the policy.	

Understanding your dental benefits
We will begin to pay benefits for covered services in any calendar year only after your deductible is satisfied unless otherwise specified.
Once you have satisfied any applicable deductible, we pay a percentage of the allowed amount for covered services up to the maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your coinsurance (insured responsibility).
Under the policy, you have the opportunity to qualify for a reward increase and add certain unused portions of the maximum benefit for the current calendar year to the maximum benefit for the following calendar year. For more information please refer to the policy.
We do not reimburse dentists for charges above the allowed amount. A participating dentist will not charge you for any balances for covered services beyond your deductible and/or coinsurance amount. Nonparticipating dentists, however, may bill you for any balances over our payment level in addition to any deductible and/or coinsurance amount. You can find a list of providers at our Web site or by calling Customer Service.

Covered dental services (per insured)	Insured responsibility
Preventive dental services Bitewing X-rays: 2 per calendar year Complete intra-oral mouth X-rays: Once in a 3-year period Cleanings: 2 per calendar year (including of periodontal maintenance) Oral examinations: 2 per calendar year Panoramic mouth X-rays: Once in a 3-year period Sealants (permanent bicuspids and molars only): Under 18 years of age Space maintainers: Under 12 years of age Topical fluoride application: Under 18 years of age, 2 treatments per calendar year	0% deductible waived
Basic dental services (six-month waiting period) Endodontic services including root canal treatment, pulpotomy and apicoectomy Emergency treatment for pain relief Fillings consisting of composite and amalgam restorations General dental anesthesia) Uncomplicated and complex oral surgery procedures Periodontal maintenance: 2 per calendar year (including prophylaxis) Periodontal debridement: Once in a 3-year period Periodontal scaling and root planing: Once per quadrant in a 2-year period	20%
Major dental services (12-month waiting period) Bridges: Except no benefits are provided for replacement made fewer than seven-years after placement Crowns, inlays and onlays: Except no benefits are provided for replacement made fewer than seven-years after placement Dentures (full and partial): Except no benefits are provided for replacement made fewer than seven-years after placement Implants (endosteal): 4 per insured lifetime	50%

COMPARE INDIVIDUAL HEALTH PLANS

that offer more of **what you need,** less of what you don't.

Regence Evolve℠ Individual and Family Health Benefit Plans

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Regence BlueCross BlueShield of Utah	Regence Evolve Core℠			Regence Evolve Plus℠			Regence Evolve HSA Plan℠ (80% or 50% coinsurance options)			Regence Evolve HSA 100 Plan℠			What you should know
Cost Sharing	**Per Indivdual**	**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 two times the individual amount and is met by a combination of all family members		$500, $1,000, $1,500, $2,500, $4,000 or $7,500	Family deductible is two times the individual amount and is met by a combination of all family members		$1,200, $2,000 or $3,500	$2,400, $4,000 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	$5,000 coinsurance maximum	Family coinsurance maximum is two times the individual maximum		$5,000 coinsurance maximum	Family coinsurance maximum is two times the individual maximum		$5,000 out-of-pocket maximum; $3,600 for $1,200-deductible plan	$10,000 out-of-pocket maximum; $7,200 for $2,400-deductible plan		$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.
Provider Network Choice: (Percentages and copays shown are what you pay for each covered event after you have met your deductible, unless otherwise noted)	**Provider Type**			**Provider Type**			**Provider Type** Choose both network and coinsurance options for Evolve HSA Plan			**Provider Type**			**Preferred Network (ValueCare)** **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. **Participating Network (Traditional)** **Categories 1 & 2:** Participating providers. You'll generally have lower out-of-pocket costs when you see providers in these categories. **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.
Preferred (ValueCare) Network option	**Category 1 (Preferred) 30%**	**Category 2 (Participating) 45%**	**CCategory 3 (Non-contracted) 45%**	**Category 1 (Preferred) 20%**	**Category 2 (Participating) 40%**	**Category 3 (Non-contracted) 40%**	**Category 1 (Preferred) 20% or 50%**	**Category 2 (Participating) 40% or 50%**	**Category 3 (Non-contracted) 40% or 50%**	**Category 1 (Preferred) 0%**	**Category 2 (Participating) 0%**	**Category 3 (Non-contracted) 0%**	
Participating (Traditional) Network option	**Category 1 (Participating) 30%**	**Category 2 (Participating) 30%**	**Category 3 (Non-contracted) 45%**	**Category 1 (Participating) 20%**	**Category 2 (Participating) 20%**	**Category 3 (Non-contracted) 40%**	**Category 1 (Participating) 20% or 50%**	**Category 2 (Participating) 20% or 50%**	**Category 3 (Non-contracted) 40% or 50%**	**Category 1 (Participating) 0%**	**Category 2 (Participating) 0%**	**Category 3 (Non-contracted) 0%**	
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.			Deductible and coinsurance			0% after the deductible is met			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. Generic and formulary brand diabetic drugs and supplies not subject to the calendar-year maximum.			$10 copay for generics. $500 deductible, 50% coinsurance for brand formulary only. $5,000 per-year maximum for all drugs. Generic and formulary brand diabetic drugs and supplies not subject to the calendar-year maximum.			Generics only*; 20% after medical deductible is met. Brand formulary diabetic drugs and supplies covered.			Generics only*; 0% after medical deductible is met. Brand formulary diabetic drugs and supplies covered. $2,000 annual limit.			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. *Exception: In addition to generics, Formulary Brand name drugs and supplies used in the treatment of diabetes covered with no annual limit on all HSA plans.
Preventive Care (excludes complex imaging); no benefit limit	Coinsurance only; no deductible, or age or annual limits			Coinsurance only; no deductible, or age or annual limits			Coinsurance only; no deductible, or age or annual limits			0% after deductible is met			Includes but not limited to routine office visits including well-baby care and routine physical exams. Routine laboratory, radiology and diagnostic procedures including mammography and prostate screenings. Routine procedures including routine colonoscopies.
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.			Deductible and coinsurance			0% after deductible is met			
Vision Care	Excluded			20% coinsurance; routine eye exam and hardware covered to a combined $150 per-calendar-year maximum; not subject to deductible or coinsurance maximum.			Excluded			Excluded			
Ambulance	Deductible and 30% coinsurance			Deductible and 20% coinsruance			Deductible and 20% coinsurance			0% after the deductible is met			
Emergency Room	$150 copay per ER visit (waived if admitted); deductible and 30% coinsurance			$100 copay per ER visit (waived if admitted); deductible and 20% coinsurance			Deductible and 20% coinsurance			0% after the deductible is met			
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	Deductible and 50% coinsurance; $1,500 annual benefit maximum			Deductible and 50% coinsurance			Deductible and 50% coinsurance			0% after the deductible is met			
Maternity Care	Separate $7,500 routine maternity deductible per pregnancy, then coinsurance			Separate $5,000 routine maternity deductible per pregnancy, then coinsurance			Excluded, except complications			Excluded, except complications			The maternity deductible for Regence Evolve Core and Evolve Plus is separate from the medical deductible.
Durable Medical Equipment	Deductible and coinsurance			Deductible and coinsurance			Deductible and coinsurance			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	Deductible and coinsurance			Deductible and coinsurance			Deductible and coinsurance			0% after deductible is met			

Other Considerations

Waiting Periods There is a 12-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 within the six-month period before the enrollment date of coverage. The exclusion period will end 12 months following your enrollment date of coverage.

If your enrollment date is within 63 days after similar coverage with another insurance carrier ends, we'll credit the time you were covered by the other company to the 12-month pre-existing condition waiting period. We need to receive a copy of your Certificate of Creditable Coverage from your previous insurance carrier in order to apply credits.

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 Coverage is limited to $750 per calendar-year maximum benefit (Preventive, Basic and Major Services combined). No age limits or frequency limits. **Waiting Period:** Six months for all covered services.	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	$500,000 Centers of Excellence life-time limit; $250,000 non-Centers of Excellence lifetime limit. Includes donor costs.	$500,000 Centers of Excellence life-time limit; $250,000 non-Centers of Excellence lifetime limit. Includes donor costs.	$500,000 Centers of Excellence life-time limit; $250,000 non-Centers of Excellence lifetime limit. Includes donor costs.

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.

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

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