

Regence Evolve Plus Highlights



Regence BlueCross BlueShield of Oregon is an independent licensee of the Blue Cross and Blue Shield Association

Evolve Plus features:

- **Provider choice:** Members have direct access to their choice of providers. Coinsurance levels are lowest for Category 1 providers; coinsurance levels are higher for Category 2 and 3 providers; members may be responsible for provider costs above the Category 3 allowed amount.
- **Preventive care:** Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).
- **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.
- This plan offers optional dental packages. For details see the Optional Benefits Available section.

Annual Maximum	\$2,000,000 Annual Maximum		
Calendar Year Deductible Applies to all covered expenses except where noted	Individual deductible options per calendar year for each member: \$1,000, \$5,000 or \$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		
	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 Office Visits (Injury and Illness) Upfront office visits: first four per calendar year Not subject to deductible	\$25 copay	\$25 copay	\$25 copay

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. Not subject to deductible.	0%	0%	0%
Professional Services / Outpatient Radiology and Laboratory Deductible applies after upfront benefit limits are met. Office and inpatient services and supplies	20%	50%	50%
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%
Preventive Care and Immunizations Not subject to the deductible	0%	0%	Category 3 Benefits Apply
Home Health 130 visits per calendar year	20%	50%	50%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime			
Mental Health Treatment			
Acupuncture Six visits per calendar year			
Spinal Manipulations 10 spinal manipulations per calendar year			
Rehabilitation Services Inpatient: 10 days per calendar year Outpatient: 25 visits per calendar year	20%	50%	50%
Skilled Nursing Facility 30 inpatient days per calendar year			
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%
Discretionary Surgery (includes medically necessary breast reduction, eye lid surgery, varicose vein surgery)	50%	50%	50%

Prescription Medication Coverage
<p>\$10 copay for generics \$500 deductible, 50% coinsurance for brand formulary only Insulin and diabetic supplies not subject to deductible</p> <p>Brand tobacco cessation medications not covered</p> <p>Retail: 30-day supply per copay Mail order: 90-day supply (one copay per 30-day supply) Up to 30-day supply for covered self-administrable injectable medications at retail and mail order.</p> <p>We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription.</p>

Optional Benefits Available	
Covered Services	Evolve Plus Member Responsibility
Dental Rewards Option When you incur services less than \$750, you may be rewarded with an additional benefit of \$250 the following year, not to exceed a total benefit of \$1,500. Waiting Periods: 6 months for Basic Services and 12 months for Major Services.	<p>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</p>
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)	<p>No deductible 0% for the first \$200 of covered services then 50% up to the annual maximum</p>

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. Pre-existing condition waiting periods do not apply to Members up to age 19. Separate waiting periods apply for dental services when you select a dental product. See Optional Benefits for more information.
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; except sales taxes for durable medical equipment and mobility enhancing equipment.
- **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.
- **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.