COMPARE INDIVIDUAL HEALTH PLANS

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

Regence Evolve Individual and Family Plans

II0110PCORI, II0110PPLUI, II0110PHSAI, II0110P100I

share the well℠

Regence

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Regence Blue Shield of Idaho℠	Regence Evolve Core℠		Regence Evolve Plus℠		Regence Evolve HSA Plan℠ (50%)		Regence Evolve HSA Plan℠ (80%)		Regence Evolve HSA 100 Plan℠		What you should know
Cost-sharing	**Per Indivdual**	**Per Family**	**Per Individual**	**Per Family**	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**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 deductible	$2,500, $5,000, $7,500, or $10,000	Family deductible is two times the individual deductible	$1,500 or $3,500	$3,000 or $7,000	$1,500 or $3,500	$3,000 or $7,000	$5,000	$10,000	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	$4,000 coinsurance maximum	Family coinsurance maximum is two times the individual maximum	$3,000 coinsurance maximum	Family coinsurance maximum is two times the individual maximum	$5,000 Out of Pocket Maximum	$10,000 Out of Pocket Maximum	$5,000 Out of Pocket Maximum	$10,000 Out of Pocket Maximum	$5,000	$5,000	On Regence Evlove 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 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		$2,000,000 per individual member		This is the largest dollar amount we will pay toward all health care services during your lifetime under this plan.
Percentages and copays shown are what you pay for each covered event. The percentages shown are what you pay after you have met your deductible, unless otherwise noted.	**Provider Type**		**Provider Type**		**Provider Type**		**Provider Type**		**Provider Type**		**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.
	Category 1	**Category 2 & 3**	**Category 1**	**Category 2 & 3**	**Category 1 (50% coverage)**	**Category 2 & 3 (50% coverage)**	**Category 1 (80% coverage)**	**Category 2 & 3 (80% coverage)**	**Category 1**	**Category 2 & 3**	
Office Visits	$35 copay per visit for first four visits per person. After four, then subject to deductible and coinsurance		$25 copay per visit 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, then 50% coinsurance for brand formulary only $1,000 per calendar year maximum for all drugs Prescriptions not subject to medical deductible		$10 copay for generics $500 deductible, then 50% coinsurance for brand formulary only $2,000 per calendar year maximum for all drugs Prescriptions not subject to medical deductible		Generics only (including generic contraceptives and generic diabetic drugs and supplies); 50% after deductible is met		Generics only (including generic contraceptives and generic diabetic drugs and supplies); 20% after deductible is met		Generics only (including generic contraceptives and generic diabetic drugs and supplies); $2,000 per calendar year maximum benefit; 0% after deductible is met.		After you reach the annual limit, you can receive discounts off the full retail price of medications through the Regence Rx discount program. Just show your member ID 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 routine physical exams, lab and X-ray, and well-baby care.
Immunizations (adult and child)	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	
Upfront Outpatient Radiology and Laboratory (limit does not apply to preventive care or complex outpatient imaging).	0% for first $200 per year; then subject to deductible and coinsurance		0% 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%; not subject to deductible or coinsurance maximum $500 per calendar year combined maximum benefit		Excluded	Excluded	Excluded	Excluded	Excluded	Excluded	Complementary care includes chiropractic care, acupuncture, and naturopathic care.
Emergency Room	$150 copay per ER visit (waived if admitted), then deductible and 30%		$100 copay per ER visit (waived if admitted), then deductible and 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)	30%	50%	20%	50%	50%	50%	20%	40%			
Maternity Care	Separate $7,500 deductible per pregnancy		Separate $5,000 deductible per pregnancy		Excluded, except for complications	Excluded, except for complications	Excluded, except for complications	Excluded, except for complications	Excluded, except for complications	Excluded, except for complications	The maternity deductible is separate from the medical deductible.
	30%	50%	20%	50%							

Please note: If you are declined coverage or are HIPAA eligible with 12 months of creditable coverage, you may be eligible for your choice of the following High Risk Pool Plans: Basic, Standard, Catastrophic A, Catastrophic B, or an HSA compatible plan. You may also be eligible for any High Risk plan if your insurance carrier refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool Plan. Please contact us for more information.

Other Considerations
Qualifying coverage means with respect to an individual, health benefits or coverage provided under any of the following: Group health benefit plan; Health insurance coverage without regard to whether the coverage is offered in the group market, individual market or otherwise; Medicare; Medicaid; medical and dental care for members and certain former members of the uniformed services and their dependents ("uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service); a medical care program of the Indian Health Services or of a tribal organization; a state high-risk pool coverage; Federal Employees Health Benefits Program (FEHBP); a public health plan (a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan); or a health plan issued under the Peace Corps Act. A state Children's Health Insurance Program (CHIP), is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

Waiting Periods
There is a 12 month waiting period that must be met prior to benefits being available for pre-existing conditions. By pre-existing, we mean a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six months immediately preceding the effective date of coverage; a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or a pregnancy existing on the effective date of coverage. Members may receive credit from prior medical coverage.

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage

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 $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 Restorative and 12 months for Major Services	No deductible; 0% for Preventive dental care $50 deductible per calendar year for Restorative and Major Care 20% for Restorative 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 (Basic, Restorative and Major services combined) No age limits or frequency limts	No deductible 0% for the first $200 of covered services then 50% up to the annual maximum

Limitations and Exclusions

	Regence Core	Regence Plus	Regence HSA Plans
Complementary Care (accupuncture, chiropractic, naturopathic)	Excluded	$500 per calendar year combined maximum benefit, not subject to deductible or coinsurance maximum	Excluded
Custodial Care	Excluded	Excluded	Excluded
Foot Care (routine)	Excluded	Excluded	Excluded
Hearing Care (including hearing aids)	Excluded	Excluded	Excluded
Home Health	$5,000 per calendar year maximum benefit	$5,000 per calendar year maximum benefit	$5,000 per calendar year maximum benefit
Hospice	$5,000 per lifetime maximum	$5,000 per lifetime maximum	$5,000 per lifetime maximum
Mental Health and Chemical Dependency	Excluded	Limited to 8 days inpatient/20 visits outpatient per year	Limited to 8 days inpatient/20 visits outpatient per year
Medically Unnecessary Services	Excluded	Excluded	Excluded
Obesity or Weight Control	Excluded	Excluded	Excluded
Rehabilitation Services *inpatient*	$15,000 per calendar year maximum benefit	$15,000 per calendar year maximum benefit	$15,000 per calendar year maximum benefit
Rehabilitation Services *outpatient*	$800 per calendar year maximum benefit for each type of therapy (physical, speech and occupational)	$800 per calendar year maximum benefit for each type of therapy (physical, speech and occupational)	$800 per calendar year maximum benefit for each type of therapy (physical, speech and occupational)
Skilled Nursing Facility	30 inpatient days per calendar year	30 inpatient days per calendar year	30 inpatient days per calendar year
TMJ Disorder	$2,000 per lifetime maximum benefit	$2,000 per lifetime maximum benefit	$2,000 per lifetime maximum benefit
Transplants	$250,000 lifetime maximum; including donor costs	$250,000 lifetime maximum; including donor costs	$250,000 lifetime maximum; including donor costs

This chart does not contain all limitations and exclusions. Please refer to your policy for a complete list of benefits and the limitations and exclusions that apply.

To learn more, please visit www.regence.com or call1 (888) REGENCE

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