Regence

Regence Evolve HSA Plan (80/60/60) Highlights

The Regence Evolve HSA Plan is a simple way to pay for life's medical expenses.
It's a comprehensive health plan and a tax-free savings account all rolled into one.
You get broad medical coverage, support and guidance from a Regence HSA specialist plus additional valuable services that compliment the policy, but are not insurance.
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	Deductible per calendar year **$1,500 or $3,500** for single coverage **$3,000 or $7,000** for family coverage Family coverage: no one family member is eligible for benefits until the entire family deductible is met.		
Calendar Year Out-of-Pocket Maximum Out-of-pocket maximum amount per calendar year, including deductible, applies to all covered expenses. When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year	Out-of-Pocket maximum per calendar year **$5,000** for single coverage **$10,000** for family coverage Family coverage: no one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.		
Covered Services	**Evolve HSA Plan**		
	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 out-of-pocket maximum is reached.**		
Professional Services Office and inpatient services and supplies	**20%**	**40%**	**40%**
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies			
Emergency Room Services	**20%**	**20%**	**20%**
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	**50%**	**50%**	**50%**

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

Covered Services	Evolve HSA Plan 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)
Preventive Care and Immunizations Not subject to the deductible	**0%**	**0%**	**40%**
Mental Health Treatment Inpatient: 6 days per calendar year Outpatient: 12 visits per calendar year	**20%**	**40%**	**40%**
Home Health 130 visits per calendar year			
Maternity			
Hospice Respite care limited to 14 days inpatient/ outpatient per lifetime			
Rehabilitation Services Inpatient: 5 days per calendar year Outpatient: 25 visits per calendar year			
Skilled Nursing Facility 30 inpatient days per calendar year			
Prescription Drugs: Generics only; subject to medical deductible. Brand and non-formulary self administered chemotherapy medications and tobacco cessation medications covered. We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible at participating pharmacies only. Member must have a prescription.	**20%**		

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

Optional Benefits Available	
Covered Services	**Evolve HSA Plan Member Responsibility**
Dental Option I Incentive Dental Plan 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.	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
Additional Information	
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).
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 24 consecutive months. There is a six 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.
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.

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

General Medical Exclusions

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

- **Breast Reduction, Eye Lid Surgery and Varicose Vein Surgery.**
- **Complementary Care:** Acupuncture, chiropractic care, massage or massage therapy and the services of an acupuncturist, a chiropractor, a massage therapist and a naturopath.
- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly for members up to age 18, 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.
- **Drug Abuse Treatment.**
- **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.**
- **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.
- **Non-Duplication of Medicare:** Services and supplies to the extent payable under Medicare, when by law, the plan would not be primary to Medicare had the member properly enrolled in Medicare when first eligible regardless of whether or not the member actually enrolled.
- **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 Exams.**
- **Routine Vision Exam and Hardware.**
- **Self-Help, Self-Care, Training, or Instructional Programs** including childbirth classes, diet and weight monitoring services and instruction programs, including 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 services 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. Please refer to the policy for a complete list of benefits, limitations and exclusions.