

# Medical plan

## Limitations and exclusions

A pre-existing condition is 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 effective date of coverage and terminates nine months following the effective date of coverage.

Medical limitations and exclusions	Regence Evolve Core	Regence Evolve Plus	Regence Evolve HSA Plans
Breast Reduction, Eye Lid Surgery, Varicose Vein Surgery	Excluded	\$2,500 per lifetime maximum benefit	Excluded
Chemical Dependency Treatment	Excluded	Excluded	Excluded
Cosmetic/Reconstructive Services and Supplies	Excluded	Excluded	Excluded
Counseling in the Absence of Illness	Excluded	Excluded	Excluded
Custodial Care	Excluded	Excluded	Excluded
Fees, Taxes, Interest	Excluded	Excluded	Excluded
Government Programs	Excluded	Excluded	Excluded
Hospitalization for Dentistry	Excluded	Excluded	Excluded
Infertility Treatment	Excluded	Excluded	Excluded
Investigational Services	Excluded	Excluded	Excluded
Medications without a Prescription Order	Excluded	Excluded	Excluded
Military Service Related Conditions	Excluded	Excluded	Excluded
Motor Vehicle Coverage and Other Insurance Liability	Excluded	Excluded	Excluded
Neurodevelopmental Therapy Services	Excluded	Excluded	Excluded
Non-Direct Patient Care	Excluded	Excluded	Excluded
Nutritional Counseling (except as provided for diabetic education)	Excluded	Excluded	Excluded
Obesity or Weight Reduction/Control	Excluded	Excluded	Excluded
Orthognathic Surgery (except for congenital conditions, injury, and sleep apnea)	Excluded	Excluded	Excluded
Orthotics (except diabetic orthotics)	Excluded	\$500 per-calendar-year maximum benefit	Excluded
Personal Comfort Items	Excluded	Excluded	Excluded
Physical Exercise Programs and Equipment	Excluded	Excluded	Excluded
Private Duty Nursing	Excluded	Excluded	Excluded
Riot, Rebellion and Illegal Acts	Excluded	Excluded	Excluded
Routine Foot Care	Excluded	Excluded	Excluded
Routine Hearing Exams	Excluded	Excluded	Excluded

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Self-Help, Self-Care, Training or Instructional Programs	Excluded	Excluded	Excluded
Services and Supplies Provided by a Member of Your Family	Excluded	Excluded	Excluded
Services and Supplies That Are Not Medically Necessary	Excluded	Excluded	Excluded
Services to Alter Refractive Character of the Eye	Excluded	Excluded	Excluded
Sexual Reassignment Treatment and Surgery	Excluded	Excluded	Excluded
Sexual Dysfunction	Excluded	Excluded	Excluded
Temporomandibular Joint (TMJ) Disorder Treatment	Excluded	Excluded	Excluded
Third-Party Liability	Excluded	Excluded	Excluded
Tobacco Addiction Treatment	Excluded	Excluded	Excluded
Travel and Transportation Expenses (other than covered ambulance services)	Excluded	Excluded	Excluded
Routine Vision Exam and Hardware	Excluded	Combined \$150 per calendar year maximum; not subject to deductible or coinsurance maximum	Excluded
Work-Related Conditions	Excluded	Excluded	Excluded

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