



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield Individual Health Plans

2012 Benefit Summary*

Benefits	Evolve Plus	Evolve Core	Evolve HSA	Evolve HSA 100
Annual Deductible PCY; per individual with a family max of three (choose one)	\$1,000 / \$2,500 / \$5,000 or \$7,500	\$2,500 / \$5,000 or \$7,500 / \$10,000	Single: \$2,000 or \$3,500 Family: \$4,000 or \$7,000	Single: \$5,000 Family: \$10,000
Coinsurance (what you pay)	20%	30%	Choose either: 20% or 50%	0%
Annual Coinsurance Maximum (PCY, family max of three; once met, preferred providers covered in full; deductible not included)	\$5,500 per person \$16,500 per family	\$7,500 per person \$22,500 per family	Single: \$5,000 Family: \$10,000 (includes deductible)	Single: \$5,000 Family: \$10,000 (includes deductible)
Annual Maximum	2 Million	2 Million	2 Million	2 Million
Preventive Care and Immunizations	Deductible Waived; Covered 100%	Deductible Waived; Covered 100%	Deductible Waived; Covered 100%	Deductible Waived; Covered 100%
Office Visits (Injury and Illness) First four visits per calendar year; not subject to deductible.	Deductible Waived on 1st 4 Visits, \$25 Copay; (additional visits subject to deductible, then 20%)	Deductible Waived on 1st 4 Visits, \$35 Copay; (additional visits subject to deductible, then 30%)	Deductible and Coinsurance	Deductible and 0% Coinsurance
Outpatient Radiology & Lab Services preventive care or complex outpatient imaging)	First \$400 PCY, not subject to deductible	First \$200 PCY, not subject to deductible	Deductible and Coinsurance	Deductible and 0% Coinsurance
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	Deductible, then 50%	Deductible, then 50% \$1500 PCY maximum	Deductible, then 50%	Deductible and 0% Coinsurance
After the up-front benefits are exhausted (Office visits, lab & radiology)	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance
Hospital Inpatient/Outpatient	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance
Maternity Care (including prenatal care)	Deductible, then 20%	Not Covered	Not Covered	Not Covered
Emergency Services (Worldwide coverage)	\$100 copay, then subject to deductible, then 20%. (copay waived if admitted)	\$150 copay, then subject to deductible, then 30%. (copay waived if admitted)	Deductible and Coinsurance	Deductible and 0% Coinsurance
Rehabilitation Inpatient: 10 days PCY Outpatient: 25 days PCY	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance
Skilled Nursing Facility 30 Inpatient days PCY	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance

Home Health & Hospice Home Health - 130 visits PCY Hospice - Respite care limited to 14 days in/outpatient per lifetime	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance
Acupuncture Services 6 visits PCY	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance
Spinal Manipulations 10 visits PCY	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance%
Vision Care Routine eye exam & hardware covered to a combined \$150 PCY max.	Deductible Waived, then 20%	Not Covered	Not Covered	Not Covered
Mental Health Treatment	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance
Prescription Drugs	Generics: \$10 copay Brand-Formulary: \$500 Deductible, then 50%	Not Covered (**Pharmacy discount program available)	Generics Only: Deductible and Coinsurance (**Pharmacy discount program available)	Generics Only: Deductible and 0% Coinsurance (**Pharmacy discount program available)
Transplants \$350,000 lifetime benefit; includes donor costs (12 month waiting period)	Deductible, then 20%	Deductible, then 30%	Deductible and Coinsurance	Deductible and 0% Coinsurance
24 Hour Coverage (when enrollee is not entitled to receive Worker's Compensation)	Yes	Yes	Yes	Yes

***This is an overview of Preferred Plan Provider Network deductible, coinsurance and copay levels only. Participating or recognized provider deductible, coinsurance and copay levels are not shown and are higher in most instances. Preferred Plan Provider Directory.**

****Pharmacy discount program. Instantly save on qualifying drugs at select retail pharmacies. Simply show your Regence ID card at any participating network pharmacy. Compare prescription medication costs.**

This is only a summary of the major benefits provided by Regence BlueShield. This is not a contract. See Benefit Booklet/Contract for specific coverage information.

Questions? 800-877-8019

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