



## Online Application Instructions

- 1) To start *click "Begin Shopping"*
- 2) Choose the plan that fits your needs. If you would like advice on selecting a plan please call 253-848-7653 to speak to us.
- 3) Follow the steps to create an account by entering all required information.
- 4) Under "*Who is applying for coverage?*" Click through the 3 steps and enter all information.
- 5) On "application info" under step 3, do not forget to enter in your prior coverage if you have been covered within the last 2 months.
- 6) Under the Health Questionnaire exemptions, MOST people are NOT exempt from the questionnaire. You will most likely answer "no" to all the questions and proceed to complete the Health Questionnaire.
- 7) Choose your payment preference.
- 8) Sign (by typing in your name) all required signature sections.
- 9) Your application is complete!
- 10) You will receive an email from Regence within 15 business days informing you of your Acceptance or Denial.

# Regence Evolve Core

**\$2,500, \$5,000, \$7,500, \$10,000 Deductible Options**

Family deductible maximum is 3x individual deductible.

Benefits shown below are when you use a preferred provider.



**Regence  
BlueShield**

An Independent Licensee of the Blue Cross  
and Blue Shield Association

**Before the deductible is met:**

These benefits are not subject to the deductible.

- 1. \$35 co-pay for office visits – first four per calendar year**  
Deductible and 30% co-insurance applies for additional visits  
(Includes office, urgent care and naturopathy visits)
- 2. Preventive care – covered @ 100%** (no annual benefit maximum)  
Includes the following when billed as preventive: Routine physical exam, well child care; routine laboratory, radiology and diagnostic procedures including mammography, pap smear, PSA and colonoscopy (excludes complex imaging). Adult and child immunizations.
- 3. Outpatient radiology and Laboratory - First \$200 per calendar year covered at 100%**  
Deductible and co-insurance applies after upfront benefit limit of \$200 is met.
- 4. Prescription Drug Discount Program is included**  
(Discount applies to generic and brand name formulary drugs)

**After the deductible has been met,** all other covered benefits are provided.

- **\$150 Emergency room co-pay** (waived if admitted), plus 30% co-insurance.
- **30% co-insurance for hospital and physician services** (preferred provider network)
- **50% co-insurance for complex outpatient imaging**, \$1,500 calendar year maximum benefit (CT Scan, MRI, PET, SPECT, Bone Density)
- **\$7,500 annual co-insurance maximum**, plus deductible and co-pays  
(After you have met your deductible, you pay up to \$7,500 in co-insurance, then Regence covers 100% of allowable charges up to 2 million)
- **2 million lifetime maximum**
- **Inpatient rehabilitation - \$8,000 PCY**
- **Outpatient rehabilitation – \$1,500 PCY**
- **Inpatient and outpatient mental health**
- **Includes 24 hour “on the job” coverage**
- for subscriber/spouse who are exempt from L&I
- Spinal manipulations, 10 PCY
- Acupuncture, 6 PCY
- No 4th quarter deductible carry-over

**Partial list of Exclusions:**

maternity, chemical dependency, TMJ, prescription drugs, vision exam and hardware, discretionary surgery

AGE	\$2500 DEDUCTIBLE		\$5000 DEDUCTIBLE		\$7500 DEDUCTIBLE		\$10000 DEDUCTIBLE	
	NS	SMOKER	NS	SMOKER	NS	SMOKER	NS	SMOKER
<25	\$97	\$112	\$80	\$92	\$69	\$80	\$62	\$71
25-29	\$112	\$129	\$92	\$106	\$79	\$91	\$71	\$82
30-34	\$130	\$149	\$107	\$123	\$92	\$106	\$83	\$95
35-39	\$153	\$176	\$126	\$145	\$109	\$125	\$98	\$113
40-44	\$180	\$207	\$148	\$170	\$128	\$147	\$115	\$132
45-49	\$218	\$251	\$179	\$206	\$155	\$178	\$139	\$160
50-54	\$260	\$298	\$213	\$245	\$185	\$212	\$166	\$191
55-59	\$305	\$350	\$250	\$288	\$217	\$249	\$195	\$224
60-64	\$357	\$410	\$293	\$337	\$254	\$292	\$228	\$262
65>	\$357	\$410	\$293	\$337	\$254	\$292	\$228	\$262
Child	\$97		\$80		\$69		\$62	

\*This flyer was prepared by the Health Insurance Connection, Inc. This is a brief summary of benefits and is not a certificate of coverage. For full coverage provisions, including a description of waiting periods and limitations, refer to a benefit brochure and contract. This summary is not a contract. Rates are scheduled to increase October 1, 2011. However, due to health care reform mandated coverage there could be a slight increase before that date.



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

## Regence Evolve Core<sup>SM</sup> Highlights

Evolve Core's features:

- **Provider choice:** Members have direct access to their choice of providers. Member coinsurance levels are lower for Category 1 services; coinsurance levels are higher for Category 2 and 3 services; 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). Standard plan benefits apply for any service that does not meet these guidelines.
- **Upfront benefits:** The first four office visits and the first \$200 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 \$200 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.

<b>Lifetime Maximum Benefit</b>	<b>No Overall Lifetime Maximum</b>
<b>Calendar Year Deductible</b> Applies to all covered expenses except where noted	Individual deductible options per calendar year for each member: <b>\$2,500, \$5,000, \$7,500, \$10,000</b> Family deductible is three times the individual amount
<b>Calendar Year Coinsurance Maximum</b> 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: <b>\$7,500</b> Family coinsurance maximum is three times the individual amount

Covered Services	Evolve Core 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)
<b>Upfront Office Visits (Injury and Illness)</b> Upfront office visits: first four per calendar year Not subject to deductible	<b>\$35 copay</b>	<b>\$35 copay</b>	<b>\$35 copay</b>

Covered Services	Evolve Core		
	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.		
<b>Upfront Outpatient Radiology and Laboratory</b> First \$200 per calendar year. Not subject to deductible.	0%	0%	0%
<b>Other Professional Services</b> Deductible applies after upfront benefit limits are met. Office and inpatient services and supplies	30%	50%	50%
<b>Other Outpatient Radiology and Laboratory</b> Deductible applies after upfront benefit limits are met			
<b>Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)</b> \$1,500 per calendar year maximum benefit	50%	50%	50%
<b>Hospital Services/Ambulatory Surgical Center</b> Inpatient and outpatient services and supplies	30%	50%	50%
<b>Emergency Room Services</b> \$150 copay per ER visit (waived if directly admitted)			
<b>Ambulance Services</b> Air and ground ambulance to nearest facility	30%	30%	30%
<b>Preventive Care and Immunizations</b> Not subject to the deductible	0%	0%	50%
<b>Genetic Testing</b> \$5,000 per lifetime maximum benefit (this limit does not apply to prenatal testing). Deductible applies after upfront benefit limits are met			
<b>Home Health</b> 130 visits per calendar year			
<b>Hospice</b> Respite care limited to 14 days inpatient/outpatient per lifetime	30%	50%	50%
<b>Mental Health Treatment</b>			
<b>Acupuncture</b> Six visits per calendar year maximum benefit			
<b>Spinal Manipulations</b> 10 spinal manipulations per calendar year maximum benefit			

Covered Services	Evolve Core		
	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.		
<b>Durable Medical Equipment</b> \$2,500 per calendar year maximum benefit (limit does not apply to insulin pumps/supplies and lifesaving equipment such as oxygen and ventilators)	<b>30%</b>	<b>50%</b>	<b>50%</b>
<b>Prostheses</b> \$2,500 per calendar year maximum benefit (this limit does not apply to surgically implanted and external breast prostheses)			
<b>Rehabilitation Services</b> Inpatient: \$8,000 per calendar year maximum benefit Outpatient: \$1,500 per calendar year maximum benefit			
<b>Skilled Nursing Facility</b> 30 inpatient days per calendar year			
<b>Transplants</b> \$350,000 lifetime maximum benefit; includes donor costs			

Prescription Medication Coverage
Rx discount program only (includes generic & brand formulary drugs).  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.

Optional Benefits Available (Optional benefits that are not elected are excluded from coverage)	
Covered Services	Evolve Core Member Responsibility
<b>Dental Option I</b> 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 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
<b>Dental Option II</b> 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	
<b>Waiting Periods</b>	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.
<b>Outside the Service Area</b>	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.

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.
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:	
<ul style="list-style-type: none"> <li>• <b>Chemical Dependency Treatment.</b></li> <li>• <b>Cosmetic/Reconstructive Services and Supplies</b> 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.</li> <li>• <b>Counseling</b> in the absence of illness.</li> <li>• <b>Custodial Care:</b> Non-skilled care and helping with activities of daily living.</li> <li>• <b>Fees, Taxes, Interest:</b> Charges for shipping and handling, postage, interest, or finance charges that a provider might bill.</li> <li>• <b>Government Programs:</b> Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.</li> <li>• <b>Hospitalization for Dentistry.</b></li> <li>• <b>Infertility</b> except to the extent covered services are required to diagnose such condition.</li> <li>• <b>Investigational Services:</b> Treatment or procedures (health interventions) and services, supplies, and accommodations provided in connection with investigational treatments or procedures.</li> <li>• <b>Medications without a Prescription Order.</b></li> <li>• <b>Military Service Related Conditions:</b> 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.</li> <li>• <b>Motor Vehicle Coverage and Other Insurance Liability.</b></li> <li>• <b>Neurodevelopmental Therapy Services.</b></li> <li>• <b>Non-Direct Patient Care</b> 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.</li> <li>• <b>Obesity or Weight Reduction/Control:</b> Medical treatment, medication, surgical treatment (including reversals), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis.</li> <li>• <b>Orthognathic Surgery</b> except for congenital conditions, injury, and sleep apnea.</li> <li>• <b>Personal Comfort Items:</b> Items that are primarily for comfort, convenience, cosmetics, environmental control, or education.</li> <li>• <b>Physical Exercise Programs and Equipment</b> 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.</li> <li>• <b>Private Duty Nursing</b> including ongoing shift care in the home.</li> <li>• <b>Riot, Rebellion and Illegal Acts:</b> 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.</li> <li>• <b>Routine Foot Care</b> including treatment of corns and calluses and trimming of nails.</li> <li>• <b>Routine Hearing Care:</b> 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.</li> <li>• <b>Self-Help, Self-Care, Training, or Instructional Programs</b> 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.</li> <li>• <b>Services and Supplies Provided by a Member of Your Family.</b></li> <li>• <b>Services and Supplies That Are Not Medically Necessary.</b></li> <li>• <b>Services to Alter Refractive Character of the Eye.</b></li> <li>• <b>Sexual Reassignment Treatment and Surgery:</b> Treatment, surgery, and counseling services for sexual reassignment.</li> <li>• <b>Sexual Dysfunction:</b> Regardless of cause, except for counseling provided by covered, licensed mental health practitioners.</li> <li>• <b>Temporomandibular Joint Disorders (TMJ) Treatment.</b></li> <li>• <b>Third-Party Liability:</b> Services and supplies for treatment of illness or injury for which a third party is or may be responsible.</li> <li>• <b>Tobacco Addiction Treatment</b> including supportive items for addiction to tobacco, tobacco products, or nicotine substitutes, including prescription medications</li> <li>• <b>Travel and Transportation Expenses</b> other than covered ambulance services.</li> <li>• <b>Work-Related Conditions</b> except for subscribers and spouses who are owners, partners, or corporate officers and are exempt from state or federal workers' compensation law.</li> </ul>	

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.