



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

## Evolve HSA Plan 2.0<sup>SM</sup> (80/60) Benefit Highlights

Evolve HSA Plan 2.0 features:

- Members can choose from one of three networks for In-Network benefits: Preferred BlueOption Network, Preferred ValueCare Network or Preferred FocalPoint Network.
- Comprehensive health plan combined with a separate tax-free savings account provides a simple way to pay for life's medical expenses.
- Broad medical coverage, support and guidance from an HSA specialist plus rewards for healthy living.
- This plan offers optional dental packages. For details see the Optional Benefits Available section.

<b>Annual Maximum</b>	<b>\$2,000,000 Annual Maximum</b>	
<b>Calendar Year Deductible</b> Applies to all covered expenses except where noted	Deductible per calendar year <b>\$1,200, \$2,000 or \$3,500</b> for single coverage <b>\$2,400, \$4,000 or \$7,000</b> for family coverage  Family coverage: no one family member is eligible for benefits until the entire family deductible is met.	
<b>Calendar Year Out-of-Pocket Maximum</b> 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 <b>\$3,600</b> for single coverage on \$1,200 deductible plan <b>\$5,000</b> for single coverage on \$2,000 and \$3,500 deductible plans <b>\$7,200</b> for family coverage on \$2,400 deductible plan <b>\$10,000</b> for family coverage on \$4,000 and \$7,000 deductible plans  Family coverage: no one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.	
<b>Covered Services</b>	<b>Evolve HSA Plan 2.0</b>	
	<b>Member Responsibility</b> Coinsurance applies after deductible is met and until out-of-pocket maximum is reached.	
	<b>In-Network</b>	<b>Out-of-Network</b> (Member may be responsible for any provider costs above the allowed amount)
<b>Preventive Care and Immunizations</b>	<b>0%</b> (Deductible waived)	<b>25%</b> (Deductible applies)

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<b>Professional Services</b> Office and inpatient services and supplies	20%	40%
<b>Hospital Services/Ambulatory Surgical Center</b> Inpatient and outpatient services and supplies	20%	40%
<b>Home Health</b> 130 visits per calendar year	20%	40%
<b>Hospice</b> Respite care limited to 14 days inpatient/outpatient per lifetime	20%	40%
<b>Mental Health and Chemical Dependency Treatment (combined)</b> Inpatient: 6 days per calendar year Outpatient: 12 visits per calendar year	20%	40%
<b>Rehabilitation Services</b> Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year	20%	40%
<b>Skilled Nursing Facility</b> 30 days per calendar year	20%	40%
<b>Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)</b>	50%	50%
<b>Emergency Room Services</b>	20%	20%

<b>Prescription Medications</b> Subject to medical deductible. Retail or Mail Order: Up to 90 day supply for covered prescription medications.	<p><b>20% coinsurance for generics.</b></p> <p><b>50% coinsurance for brand formulary only. Brand formulary tobacco cessation medications not covered.</b></p> <p>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</p>
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Optional Benefits Available	
Covered Services	Evolve HSA Plan 2.0 Member Responsibility
<b>Dental Option I</b>  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.	<p>No deductible and 0% for Preventive dental care</p> <p>\$50 deductible per calendar year for Basic and Major Care</p> <p>20% for Basic care</p> <p>50% for Major care</p>
<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)	<p>No deductible</p> <p>0% for the first \$200 of covered services then 50% up to the annual maximum</p>

Additional Information	
<b>Preventive Care</b>	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).
<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 12 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.

### General Medical Exclusions

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

- **Acupuncture**
- **Breast Reduction, Eye Lid Surgery and Varicose Vein Surgery.**
- **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.
- **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.**
- **Immunizations** if the Insured receives them only for purposes of travel, occupation or residency in a foreign country.
- **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.
- **Maternity Care:** Maternity benefits, except complications of pregnancy are covered as any illness condition; adoption services
- **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.**
- **Neurodevelopmental Therapy Services.**
- **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.
- **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.
- **Orthotics** except for diabetic orthotics
- **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 such 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 Care:** 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.
- **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 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.
- **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 provided by covered, licensed mental health practitioners.
- **Spinal Manipulations.**
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
- **Temporomandibular Joint Disorders (TMJ) Treatment.**
- **Termination of Pregnancy** except under certain circumstances.
- **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. For full coverage provisions, refer to the contract.