



# EVERGREEN SECURITY TRUST

## SUMMARY of BENEFITS – PREFERRED PLAN

### PPO 350



**Regence  
BlueShield**

An Independent Licensee of the Blue Cross  
and Blue Shield Association

For medically necessary services rendered by a Preferred Plan or participating provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below. All benefits are subject to the annual deductible, any copays and/or coinsurance. When you have reached the annual out-of-pocket coinsurance maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year. Any balances of charges not covered by this plan will be your responsibility to pay. The annual deductible, copays, outpatient mental disorders care, neurodevelopmental therapy services, outpatient rehabilitation care, repair of teeth, and smoking cessation programs do not apply to the maximum out-of-pocket coinsurance amount.

Benefit Information	Preferred Plan Provider	Participating Provider
<b>Calendar Year Deductible</b> Deductible waived on office call visits	\$350 Per Person \$700 Per Family	
<b>Stoploss Amount (out-of-pocket maximum)</b> Per calendar year	\$2,500 per person \$5,000 per family	
<b>Lifetime Maximum</b>	\$2,000,000	
<b>Office Calls</b> (Including associated diagnostic x-ray and laboratory)	\$25 Copay then 100%	\$25 Copay then 50%
<b>Preventive Care:</b> Routine exams, immunizations, well child care, cancer screening. (Not subject to annual deductible)	\$25 Copay then 100%	\$25 Copay then 50%
<b>Professional Services</b> (unless otherwise specified)	80%	50%
<b>Hospital Facility***</b> Inpatient and outpatient including diagnostic x-ray and laboratory \$125 copay per emergency room visit (waived if admitted)	80%	50%
<b>Acupuncture</b> 12 visits per calendar year maximum	\$25 Copay then 100%	\$25 Copay then 50%
<b>Ambulance Services**</b>	80%	80%
<b>Blood Bank**</b>	80%	80%
<b>Chemical Dependency</b> \$14,500 every two calendar years maximum	100%	50%
<b>Growth Hormone</b> \$25,000 per calendar year maximum	80%	50%
<b>Home Health and Hospice</b> Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	80%	80%
<b>Home Medical Equipment, Prostheses and Orthotics</b>	80%	50%
<b>Home Phototherapy</b>	80%	80%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges of a dentist	80%	50%
<b>Maternity</b> (provided for the subscriber or spouse)	same as any other condition	
<b>Mental Disorders</b> Inpatient - 8 days per calendar year Outpatient - 12 visits per calendar year	80% 80%	50% 50%
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year	80%	50%

<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	80%	50%
<b>Phenylketonuria (PKU) Formulas</b>	80%	50%
<b>Prescription Drugs</b> Pharmacy- 100 day supply limit / Mail Order- 90 day supply limit	Pharmacy - 80% per prescription or refill	
<b>Rehabilitation</b> Inpatient - \$15,000 per condition Outpatient - \$2,500 per calendar year maximum	80%	50%
<b>Repair of Teeth**</b> \$1,000 per occurrence	80%	80%
<b>Skilled Nursing Facility</b> 90 days per calendar year maximum	*	80%
<b>Smoking Cessation**</b> \$500 lifetime maximum	75%	75%
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b> (10 visit maximum)	\$25 Copay then 100%	\$25 Copay then 50%
<b>Temporomandibular Joint Disorders (TMJ)</b> \$1,000 per calendar year maximum; \$5,000 lifetime maximum	80%	50%
<b>Transplants</b> \$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum	80%	50%
<b>Vision Services (Not Subject to Annual Deductible)</b> One routine eye exam per year. Subject to a \$25 Copay	Eye Exam - 100% after copay Lenses and frames are paid at 80% up to a combined maximum of <b>\$200</b> every two calendar years	

\* At this time, these services are provided only by participating providers.

\*\* At this time, these services are provided only by recognized providers.

\*\*\* Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

**Annual Out-of-Pocket Coinsurance Amount:** The total amount of Coinsurance the Member is responsible to pay during a calendar Year for covered services, after which the Contract will provide Benefits at 100 percent of the Allowed Amount for the remainder of that Year, unless otherwise specified. The maximum annual out-of-pocket coinsurance amount per family is two times the individual out-of-pocket coinsurance amount. Refer to your benefits brochure for your specific annual out-of-pocket amount.

**Emergency Care:** Emergency benefits will be provided at the level specified for a Preferred Plan provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan provider. Benefits will be based on the recognized provider's actual charge for the service.

**Care Outside the Service Area:** All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Call 1-800-810-BLUE for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan.

**Cost Containment Provisions:** All hospital and skilled nursing facility admissions must be medically necessary. When outside the service area, preadmission approval should be obtained to ensure that full plan benefits will be provided.

**Waiting Periods:** No benefits are provided for treatment relating to a transplant until you have been covered under this or a prior plan with the Company (Regence BlueShield) or the Company's HMO subsidiary for six consecutive months. There is a preexisting condition waiting period of three months that must be met prior to benefits being available. Maternity benefits are not subject to the waiting periods of this plan.

**This is a brief summary of benefits; it is not a certificate of coverage.**



# SUMMARY OF BENEFITS

## PRESCRIPTION DRUGS

### 80%



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**Getting Your Prescription Filled:** Prescription drugs and other covered items must be furnished by an approved pharmacy or a participating mail order supplier. There are more than 1,200 approved pharmacies in our Washington State network from which to choose, as listed in our current provider directory. A list of these participating pharmacies, along with a list of participating out-of-state pharmacies is available on our website at [www.regencerox.com](http://www.regencerox.com).

- Present your identification card at an approved pharmacy.
- Prescription drugs furnished by an approved pharmacy will be limited to a 100-day supply, except as otherwise specified.
- **You must pay for your entire prescription at the time you purchase it. Regence will then mail you a check less deductible and/or coinsurance responsibility.**

**Major Medical Prescription Drug Card:** Participants covered by Regence or one of its subsidiaries will have the benefit of automatic claims submission for prescription drugs when using an approved pharmacy. Each employee/subscriber will receive a “Prescription Drug Card.” **You must still pay for your prescription at the time you purchase it**, however, presenting the “Prescription Drug Card” at an approved pharmacy will provide the advantage of automatic claims submission and of the discounted prices available to approved pharmacies. **Prescription drug charges are still subject to the deductible and co-insurance provisions of your contract.**

**Using Our Mail Order Service:**

- Pay the full amount of the prescription.
- Send an order form and the prescription along with the full amount of the prescription to the address listed on the mail order service form.
- The Company will reimburse you at 80% of the allowed amount.
- Prescription drugs furnished by mail order will be limited to a 90-day supply per purchase, except that certain drugs, including but not limited to antidepressants, narcotics, and other select medications may be limited to a lesser supply as indicated on your prescription or as required by the Company.
- Drugs requiring continuous refrigeration may not be available through mail order service.

Prescription drugs (including oral contraceptives) and other covered items will be provided as described below after you have paid the specified copay amount. **Benefits will be subject to any applicable waiting periods, limitations and exclusions.**

<b>FORMULARY</b>	A formulary is a list of selected generic and brand-name preferred drugs, which is established, reviewed, and updated routinely by the Company. You will be required to pay more if the drug does not appear in the formulary. All drugs are reviewed and selected for inclusion in the Company’s formulary by an outside committee of providers, including physicians and pharmacists. Drugs are selected based on published scientific evidence and support proper use and cost-effective medication decisions. If clinical data show several drugs are equally effective, the committee usually chooses the most cost effective ones. For your convenience, the list is available on our website at <a href="http://www.regencerox.com">www.regencerox.com</a> .
<b>DEDUCTIBLE</b>	The \$350 annual deductible must be satisfied before any pharmacy benefits will be paid.
<b>COINSURANCE</b>	You will be responsible for paying the coinsurance amount of <b>20%</b> for each covered prescription or refill.
	<b>Approved Pharmacies .....80% of the allowed amount</b>

**Covered Items:** Prescription drugs will be covered when medically necessary for the treatment of an illness, accidental injury, or disability covered under this plan, subject to all provisions described below. Other items covered under this benefit and requiring a prescription include:

- Legend vitamins for prenatal care.
- Smoking cessation prescription drugs and medications, limited to a 90-day lifetime maximum supply.
- Diabetic supplies, including insulin and insulin syringes.
- For oral contraceptive drugs, a maximum of three prepackaged monthly cycles may be purchased at one time.

**Limitations:** Benefits for prescription drugs and other covered items will be limited as follows:

- Prescription drugs must be prescribed by a provider covered under the plan who is acting within the scope of his or her license.
- Certain prescription drugs require preauthorization from the Company before they are covered. Participating pharmacies have been provided with a list of those drugs along with preauthorization requirements.
- Prescription drugs related to transplants are covered under this Prescription Drugs Benefit; however, claims for such drugs will be applied to and are subject to the Transplants Benefit maximum of the plan.
- Certain drugs may be limited to a lesser supply as indicated on your prescription or as determined by the Company. Participating pharmacies have been provided with a list of those drugs.
- Any drug purchased outside the United States must have an equivalent to a prescription drug approved by the FDA to be a covered benefit under this plan, and must be either:
  - Associated with a medical emergency while you are traveling. When submitting a claim for reimbursement, you will be responsible for notifying the Company that the prescription was required for a medical emergency; or
  - When you are residing outside the United States. When submitting a claim for reimbursement, you will be responsible for notifying the Company that your residence is outside the United States. The medication needs to be purchased in the country in which you are residing, except for a medical emergency.
- The Company may require you to obtain all prescriptions from a single approved pharmacy.

**Exclusions:** The following items are not covered under this Prescription Drugs Benefit due to contract exclusions or, as noted, covered under another benefit of the plan:

- Any items limited or excluded by the medical plan, except where specifically provided.
- Appetite suppressants and drugs for weight loss.
- Drugs or medications used for cosmetic purposes.
- Drugs dispensed by a non-approved pharmacy, except when specifically provided for cases of emergency or outside the service area.
- Inside the United States, any prescription drug that has not been approved by the FDA, including compounded products with active ingredient(s) that have not been approved by the FDA.
- Any drugs or items obtained from a participating pharmacy when you fail to present the identification card.
- Over-the-counter medications (OTC) and any prescription medication with the same active ingredients and in the same strength as an over-the-counter product.
- Replacement prescriptions resulting from loss, theft, or breakage.
- Oral progesterone compounded products.
- Any drugs or items in excess of the specific limits described above.

This is a brief description of a prescription drug option.