



EVERGREEN SECURITY TRUST

SUMMARY of BENEFITS

SELECTIONS 80/50/\$30



**Regence
BlueShield**

An Independent Licensee of the Blue Cross
and Blue Shield Association

The benefits of this plan, for medically necessary services, will be provided at the percentage specified below, after the deductible and any applicable copays have been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any copays and coinsurance. The Selections network offers you the most complete coverage. To be eligible you must choose a Personal Care Provider (PCP) from our list of Selections providers, except for self-referral benefits specified in your benefits brochure. Your PCP will manage your care; however when you need more specialized care, your PCP will refer you to a Selections specialist or extended network provider. The extended network offers you the freedom to choose from many of the providers who participate with the Company (Regence Blue Shield). You may use these providers without a referral if you are willing to pay a greater share of the cost. For chemical dependency and mental disorders benefits contact the Company at 1-800-780-7881 for referrals.

Benefit Information	Selections Network	Extended Network
Annual Deductible Copays do not count toward the deductible	none	\$500 per person \$1,000 per family
Stoploss Amount (out of pocket maximum) Per Calendar year	\$3,500 per person \$7,000 per family	\$10,000 per person \$20,000 per family
Lifetime Maximum	\$2,000,000	
Preventive Care \$30 professional copay* Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries, such as colonoscopies. One routine vision and hearing exam per calendar year maximum	80%	not covered except for mammograms and prostate cancer screening at 50%
Professional Services \$30 professional copay in office, home or hospital outpatient department*	80%	50% (unless otherwise specified)
Hospital Facility (Inpatient & Outpatient)** \$125 copay per emergency room visit (waived if admitted)	80%	50%
Acupuncture \$30 professional copay* 12 visits per calendar year maximum	80%	50%
Ambulance Services Ground services provided to \$2,000 per calendar year	80%	80%
Blood Bank	80%	80%
Chemical Dependency \$14,500 every two calendar year maximum	80%	50%
Growth Hormone \$25,000 per calendar year maximum	80%	50%
Home Health and Hospice Home Health - 130 visits per calendar year maximum Hospice – 6 month maximum	80%	50%
Home Medical Equipment, Protheses and Orthotics	80%	50%
Hospitalization for Dental Services \$1,000 per calendar year maximum No benefits provided for charges of a dentist	80%	50%
Maternity (provided for the subscriber or spouse)	same as any other condition	
Mental Disorders Inpatient Outpatient - \$30 professional copay*	80% 8 days per calendar year 12 visits per calendar year	50% 6 days per calendar year 12 visits per calendar year
Neurodevelopmental Therapy* (for children age 6 and under) \$30 professional copay* \$1,500 per calendar year maximum	80%	50%
Occupational Injury (for the subscriber only) \$250,000 lifetime max	80%	50%
Prescription Drugs Pharmacy -34 day supply limit – Mail Order 90 day Supply Limit	Pharmacy Copays \$15/Generic \$40/Brand \$60/Non-Formulary Mail Order – 3 copays for 90 day supply	
Rehabilitation Inpatient - \$15,000 per condition Outpatient - \$30 professional copay*; \$2,500 per calendar year maximum	80%	50%

Repair of Teeth \$1,000 per occurrence	80%	80%
Skilled Nursing Facility 90 days per calendar year maximum	80%	50%
Smoking Cessation \$500 lifetime maximum	80%	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations \$30 professional copay* 10 Visits per calendar year maximum	80%	50%
Temporomandibular Joint Disorders (TMJ) \$1,000 per calendar year maximum; \$5,000 lifetime maximum	80%	50%
Transplants \$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum	80%	Not Covered
Vision Services One routine eye exam per year. Subject to a \$30 copay.	\$30 then 80%	Not Covered
	Lenses and frames are paid at 80% to a combined maximum of \$200 every two calendar years.	

* Member copays and coinsurance do not apply to the out-of-pocket coinsurance amount.

** Services and supplies required to treat a medical emergency, inside the service area, will be provided at the Selections network payment level of benefits.

Lifetime Maximum: \$2,000,000

Selections Network Benefits: The Selections network offers you the most complete coverage. To be eligible you must choose a Personal Care Provider (PCP) from our list of Selections providers, except for self-referral benefits specified below. Your PCP will manage your care, however when you need more specialized care, your PCP will refer you to a Selections specialist or Extended network provider.

Extended Network Benefits: The extended network offers you the freedom to choose from many of the providers who participate with the Company (Regence BlueShield). You may use these providers without a referral if you are willing to pay a greater share of the cost.

Self-Referral Care: You may refer yourself to a Selections physician, Selections optometrist, or an approved audiologist for routine vision and hearing exams. You may also self-refer to an approved smoking cessation provider. A female subscriber or dependent may refer herself to a Selections physician, Selections midwife, Selections advanced registered nurse practitioner specializing in women's health and midwifery, or Selections physician's assistant for covered women's health care services and receive the Selections network benefit level. You may also self refer to an approved chiropractor for covered chiropractic services and receive the Selections network benefit level. A subscriber or spouse may also refer herself to the specified above Selections or extended network providers for maternity benefits.

Annual Out-of-Pocket Coinsurance: The benefits of this plan will be provided at the percentage specified until the annual out-of-pocket coinsurance maximum has been reached for that network. Thereafter, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year for that network. The annual deductible, per-visit copays, outpatient mental disorder 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. The maximum annual out-of-pocket coinsurance amount per family is three times the individual out-of-pocket coinsurance amount. Refer to your benefits brochure for your specific annual out-of-pocket amount.

Copay: There is a \$30 copay for each outpatient professional service in the office, home, hospital, or other facility. This amount will not apply for diagnostic laboratory and x-ray, outpatient surgery, radiation, chemotherapy, hospice, home health, home phototherapy, chemical dependency, and smoking cessation.

Emergency Care: Inside the service area, your plan will cover treatment by a physician or hospital for a 24-hour period or longer to allow time for you to come under the care of one of our providers. You will receive the higher level of benefits only if you notify us within 24 hours or as soon as is reasonably possible, and you agree to follow our managed care guidelines. Otherwise, you will receive the lower level of benefits.

Care Outside the Service Area: You have the same coverage and limitations for care outside our service area as you do within the extended network. However, any benefit payable at 50% will be paid at 80%. Any additional charges will be your responsibility and you may have to submit your own claims. If you live in the service area and are admitted to a hospital while traveling outside the service area, your inpatient care will be covered at the higher level of benefits provided you notify us within 24 hours of the admission and move under the care of a Selections provider when directed by the Company. Preadmission approval is required for all inpatient admissions outside the service area, except emergency services or maternity admissions.

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 for six consecutive months. There is a preexisting condition waiting period that must be met prior to benefits being available. Refer to your benefits brochure for details regarding this waiting period. Maternity benefits and PKU 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

\$15/\$40/\$60 Copay



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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.regencercx.com

- Present your identification card at an approved pharmacy and pay your applicable copay amount.
- Prescription drugs furnished by an approved pharmacy will be limited to a 34-day supply, except as otherwise specified.

Using Our Mail Order Service:

- Send an order form and the prescription along with your copay amount to the address listed on the mail order service form.
- 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 medications for ulcers and HIV disease 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 in full as described below after you have paid the specified copay amount. **Benefits will be subject to any applicable waiting periods, limitations and exclusions, except that prescription drugs benefits will not be subject to the coordination of benefits provisions or to any deductible or stoploss described in this plan.**

FORMULARY

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 www.regencercx.com.

COPAY

Tier 1 – Generic Formulary Drugs – means drugs included in the current formulary that are equivalent to the brand-name version, are marketed and sold by more than one source, and are listed in widely accepted references as a generic drug based on manufacturer and price. Equivalent means the U.S. Food and Drug Administration (FDA) ensures that the generic must: a) have the same active ingredients found in the brand-name version; b) meet the same manufacturing and testing standards as the brand-name version; and c) be absorbed into the bloodstream at the same rate and same total amount as the brand-name version.

Approved Pharmacies.....\$15.00
Mail Order Service..... \$45.00

Tier 2 - Brand-Name Formulary Drugs – means drugs included in the current formulary that have a patent and are marketed and sold by only one source.

Approved Pharmacies.....\$40.00
Mail Order Service..... \$120.00

Tier 3 - Non-Formulary Drugs – means drugs that do not appear in the current formulary list established by the Company.

Approved Pharmacies.....\$60.00
Mail Order Service.....\$180.00

However, if the allowed amount is less than the appropriate copay you will pay only the allowed amount.

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.
- Oral contraceptive drugs will be provided for a single copay per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one copay per monthly cycle.

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.