



**P P O**  
**750**



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

For medically necessary services rendered by a Preferred Plan, participating, or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below. The deductible must be met for all services except as specified below. 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, unless otherwise specified. Refer to your benefits brochure for your specific deductible and out-of-pocket coinsurance amount. Any balances of charges not covered by this plan will be your responsibility to pay. The annual deductible, copays, neurodevelopmental therapy, outpatient rehabilitation, repair of teeth, and smoking cessation do not apply to the maximum out-of-pocket coinsurance amount.

<b>Benefits</b>	<b>Preferred Plan Provider</b>	<b>Participating/Recognized Provider</b>
<b>Calendar Year Deductible</b>	\$750 Per Person \$2,250 Per Family	
<b>Stoploss Amount (Out-of-Pocket Maximum)</b> Per Calendar Year	\$2,500 Per Person \$7,500 Per Family	
<b>Professional Services</b>		
Not Subject to Deductible - Unlimited visits in the office, home, or outpatient hospital per year after \$25 office-visit copay, and first \$500/year for outpatient x-ray and lab	100%	50%
Subject to Deductible - Outpatient x-ray and lab above the first \$500/year; and all other professional services not billed as an office visit	80%	50%
<b>Hospital Facility***</b> Inpatient and outpatient including diagnostic x-ray and laboratory \$200 copay per emergency room visit (waived if admitted)	80%	50%
<b>Acupuncture</b> 12 visits per calendar year maximum	80%	50%
<b>Ambulance Services**</b>	80%	80%
<b>Blood Bank**</b>	80%	80%
<b>Chemical Dependency</b>	80%	50%
<b>Colorectal Cancer Screening</b>	80%	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, Protheses 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>Mammography</b>	80%	50%
<b>Maternity</b> (provided for the subscriber or spouse)	same as any other condition	
<b>Mental Disorders</b>	80%	50%
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year maximum	80%	50%
<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	same as any other condition	

<b>Prescription Drugs (MAC-A)****</b>	Retail – 34 day supply	\$15/\$45/\$65
	Mail Order – 90 day supply	\$45/\$135/\$195
<b>Preventive Care</b>		
No Annual Maximum	100%	50%
Subject to \$25 Copay; Not Subject to Deductible		
<b>Phenylketonuria (PKU) Formulas</b>	80%	80%
<b>Prostate Cancer Screening</b>	80%	50%
<b>Rehabilitation</b>		
Inpatient - \$30,000 per condition	80%	50%
Outpatient - \$1,500 per calendar year maximum	80%	50%
<b>Repair of Teeth**</b>	80%	80%
\$1,000 per occurrence		
<b>Skilled Nursing Facility</b>	*	80%
90 days per calendar year maximum		
<b>Smoking Cessation</b>	75%	75%
\$500 lifetime maximum		
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b>	80%	50%
10 spinal manipulations per calendar year		
<b>Temporomandibular Joint Disorders (TMJ)</b>	same as any other condition	
\$1,000 per calendar year maximum; \$5,000 lifetime maximum		
<b>Transplants</b>	80%	50%
\$350,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum		

\* At this time, this service is 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.

\*\*\*\* If your provider prescribes or you elect to purchase brand-name drugs when a generic equivalent is available, you will be responsible for paying the difference in price between the brand-name drug and the generic drug in addition to the copay amount.

**Lifetime Maximum:** \$2,000,000

**Annual Deductible:** \$750 per individual / \$2,250 per family. The deductible is waived for professional services billed as office visits in the office, home, or hospital outpatient department and for outpatient diagnostic x-ray and laboratory. Services provided by professionals that are not subject to the per-visit copay are subject to the annual deductible.

**Annual Out-of-Pocket Coinsurance Amount:** \$2,500 per individual / \$7,500 per family. The total amount of coinsurance you are responsible to pay during a calendar year for covered services, after which the plan will provide benefits at 100 percent of the allowed amount for the remainder of that calendar year, unless otherwise specified.

**Copay:** There is a \$25 per-visit copay for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department (waived for surgery, for radiation and chemotherapy, for spinal manipulations, or if you are directly admitted to the hospital as an inpatient). Copays do not apply toward the deductible or to the out-of-pocket coinsurance 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 or participating 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, participating, or recognized provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating or recognized 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. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.

**Cost Containment Provisions:** All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for 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 medical plan 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. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to your benefits brochure and the contract on file with your group. myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.**



# SUMMARY OF BENEFITS

## PRESCRIPTION DRUGS

### \$15/\$45/\$65 Copay (MAC-A)



**Regence  
BlueShield**  
An Independent Licensee of the Blue Cross  
and Blue Shield Association

**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 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.**

<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>COPAY</b>	<p><b>Tier 1 – Generic Formulary Drugs</b> – 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.</p> <p>Approved Pharmacies.....\$15.00 Mail Order Service..... \$45.00</p> <p><b>Tier 2 - Brand-Name Formulary Drugs</b> – means drugs included in the current formulary that have a patent and are marketed and sold by only one source.</p> <p>Approved Pharmacies.....\$45.00 Mail Order Service..... \$135.00</p> <p><b>Tier 3 - Non-Formulary Drugs</b> – means drugs that do not appear in the current formulary list established by the Company.</p> <p>Approved Pharmacies.....\$65.00 Mail Order Service..... \$195.00</p> <p><i>However, if the allowed amount is less than the appropriate copay you will pay only the allowed amount.</i></p> <p>If your provider prescribes or you elect to purchase brand-name drugs for which a less expensive generic equivalent is available, you will be responsible for paying the difference in price between the brand-name drug and the generic drug in addition to the copay amount.</p>

**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.