

**SUMMARY OF BENEFITS
PRESCRIPTION
DRUGS \$10 / \$25 / \$50**



Regence

Regence BlueShield is 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 a participating pharmacy or a participating mail order supplier. There are more than 1,200 participating 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 Web site at www.regencerox.com.

- Present your identification card at a participating pharmacy and pay your applicable copay amount.
- Prescription drugs furnished by a participating 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 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 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 convenience, the list is available on our Web site at www.regencerox.com .
COPAY	<p>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 FDA specifications for quality, purity, and potency; and c) have the same medical effect as the brand-name version.</p> <p>Participating Pharmacies.....\$10.00 Participating Mail Order Service.....\$30.00</p> <p>Tier 2 - Brand-Name Formulary Drugs – means drugs included in the current formulary that are under patent and are generally marketed and sold by only one source.</p> <p>Participating Pharmacies.....\$25.00 Participating Mail Order Service.....\$75.00</p> <p>Tier 3 - Non-Formulary Drugs – means drugs that do not appear in the current formulary list established by the Company.</p> <p>Participating Pharmacies.....\$50.00 Participating Mail Order Service.....\$150.00</p> <p><i>However, if the allowed amount is less than the appropriate copay you will pay only the allowed amount.</i></p>

Covered Items: Prescription drugs will be covered when medically necessary for the treatment of an illness, 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 participating pharmacy when reasonably necessary.

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-participating 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.
- Any drugs or items in excess of the specific limits described above.

This is a brief description of a prescription drug option for Selections, Preferred (except the HSA-Qualified Preferred Plan and the Regence HSA Healthplan), and Traditional plans; it is not a certificate of coverage. A complete statement of benefits, including waiting periods, limitations and exclusions is available through your Marketing Representative. 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.