



EVERGREEN SECURITY TRUST

SUMMARY OF BENEFITS – H S A QUALIFIED PREFERRED PLAN

HSA 1500



**Regence
BlueShield**

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 after the deductible has been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any coinsurance.

Benefits	Preferred Plan Provider	Participating Provider
Annual Deductible <i>Family deductible applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member, the entire family deductible must be met.</i>	\$1,500 Individual \$3,000 Family	
Professional Services Including diagnostic x-ray and laboratory	80%	60%
	(unless otherwise specified)	
Hospital Facility Inpatient and outpatient including diagnostic x-ray and laboratory	80%	60%
Acupuncture 12 visits per calendar year maximum	80%	60%
Ambulance Services**	80%	80%
Blood Bank**	80%	80%
Chemical Dependency \$14,500 every two calendar year maximum	80%	60%
Growth Hormone \$20,000 per calendar year maximum	80%	60%
Home Health and Hospice Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	80%	80%
Home Medical Equipment, Protheses and Orthotics	80%	60%
Home Phototherapy	80%	80%
Hospitalization for Dental Services \$1,000 per calendar year maximum No benefits provided for charges of a dentist	80%	60%
Maternity (provided for the subscriber or spouse)	same as any other condition	
Mental Disorders Inpatient - 8 days per calendar year Outpatient - 12 visits per calendar year	80%	60%
	80%	60%
Neurodevelopmental Therapy (for children age 6 and under) \$1,500 per calendar year maximum	80%	60%
Occupational Injury (provided for the subscriber only) \$250,000 lifetime maximum	80%	60%
Phenylketonuria (PKU) Formulas	80%	80%
Prescription Drugs Pharmacy- 90 day supply limit / Mail Order- 90 day supply limit	*	80%

Preventive Care No calendar year maximum; not subject to deductible	80%	60%
Rehabilitation Inpatient - \$30,000 per condition Outpatient - \$1,500 per calendar year maximum	80%	60%
Repair of Teeth** \$1,000 per occurrence	80%	80%
Skilled Nursing Facility 90 days per calendar year maximum	*	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations (10 visit maximum)	80%	60%
Temporomandibular Joint Disorders (TMJ) \$1,000 per calendar year maximum; \$5,000 lifetime maximum	80%	60%
Transplants \$250,000 lifetime maximum	80%	60%
Vision Services One routine eye exam per year provided in full. This benefit is not subject to any deductible or copay requirements.	Eye Exam – 100% Lenses & Frames are paid at 80% up to a combined maximum of \$200 every two calendar years	

* At this time, this service is provided only by participating providers.

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

Lifetime Maximum: \$2,000,000

Annual Deductible: \$1,500 annual deductible. \$3,000 Family deductible applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member, the entire family deductible must be met.

Annual Out-of-Pocket Amount: \$5,000 Member/\$10,000 Family. The total amount of coinsurance and deductible amount you or you and your family 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. Any balances of charges not covered by this plan will be you or your and your family's responsibility to pay. The family out-of-pocket amount applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member at 100%, the entire family out-of-pocket maximum must be met.

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. 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 prior plan with the Company (Regence BlueShield) 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. Your feedback is important to us. If you have suggestions about the benefits covered under this plan, you may contact us at 1-800-458-3523 or visit our Web site at www.wa.regence.com and complete the Suggestion Box form located on the Contact page.