Preferred HSA Plans

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Washington plans for individuals & families
Beginning January 1, 2015

			PREFERRED SILVER & BRONZE HSA	
	Network = Heritage Signature		**Heritage Signature providers**	**Non-Heritage Signature providers**
	Aggregate Deductible	Per Calendar Year = PCY Family = 2x individual	Individual: Silver $2,500 / Bronze $5,250 Family: Silver $5,000 / Bronze $10,500	2x Individual deductible
	Coinsurance	Amount you pay after your deductible is met	Silver 20% / Bronze 0%	50%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual	Silver $4,100 / Bronze $5,250	Unlimited
	10 Essential Benefits *Covered Services*			
1	**Ambulatory Patient Services** **Office Visits**	Outpatient services Primary care doctor office visit Spinal manipulation (10 visits PCY); Acupuncture (12 visits PCY)	Deductible, then coinsurance	Deductible, then 50%
2	**Emergency Services**	Emergency Care	Deductible, then coinsurance Ambulance: deductible, then coinsurance	
3	**Hospitalization**	Inpatient services Organ and tissue transplants, inpatient	Deductible, then coinsurance	Deductible, then 50% Not covered
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal	Deductible, then coinsurance	Deductible, then 50%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit Inpatient hospital Outpatient services	Deductible, then coinsurance	Deductible, then 50%
6	**Prescription Drugs**	**Retail** 30-day supply **Mail Order** 90-day supply **Specialty Rx** 30-day supply **Drug Formulary** X1	Deductible, then coinsurance	Not covered
7	**Rehabilitative & Habilitative Services & Devices**	Inpatient rehabilitation: 30 days PCY Physical, speech, occupational, massage therapy: 25 visits PCY Durable medical equipment	Deductible, then coinsurance	Deductible, then 50%
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET *(Prior Authorization for certain services)*	Deductible, then coinsurance	Deductible, then 50%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings Exams and immunizations	Covered in full	Deductible, then 50% Not covered
10	**Pediatric Vision** *Under 19 years of age*	**Eye exam:** 1 PCY **Eyewear:** 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Deductible waived, then 20% Covered in full	

Definitions

Aggregate deductible: With an aggregate deductible, there is one deductible for the subscriber (individual) and their family that must be met before benefits are paid for anyone in the family. The family out-of-pockret maximum is also aggregate.

Allowed amount: The negotiated amount for which a contracted provider agrees to provide service or supplies.

Coinsurance: Your share of the cost for a service. If your plan's coinsurance is 20%, you pay 20% of the allowed amount and your plan benefit pays the other 80% of the allowed amount.

Copay: A flat fee you pay for a specific service, such as an office visit, at the time you receive service.

Covered in full: Services your plan pays for in full. Benefits provided at 100% of the allowed amount; not subject to deductible or coinsurance.

Deductible: The amount of money you pay every year before the plan pays for certain services.

Formulary: A list of drugs the plan covers for specific uses. Not all generic, name-brand and specialty drugs are included in the formulary. To find the formulary for your plan, go to premera.com/wa/member and select Pharmacy on the Member Services tab.

HSA - Health Savings Account: A health savings account available to taxpayers who are enrolled in a qualified High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used for qualified medical expenses.

In-network: A group of doctors, dentists, hospitals, and other healthcare providers that contract with Premera Blue Cross to provide service and supplies at negotiated amounts called allowed amounts.

Out-of-pocket maximum: A preset limit after which your plan pays 100% of the allowed amount for services received in-network. All in-network essential benefits apply to the out-of-pocket maximum.

Note that if you see a non-contracted provider, you will be responsible for the difference between the allowed amount and the provider's billed charges, in addition to the coinsurance and any applicable copay. The allowed amount for a non-contracted provider is determined by Premera Blue Cross as described in your forthcoming benefit book.

Contact Us

For information about how a health plan works, visit **premera.com** and click the Health Plan Basics tab. You'll find information there about:

- Help with monthly healthcare rates for low-income members (government subsidies)
- Penalties for people who don't choose a health plan
- Finding an in-network doctor

For information or questions about Premera Blue Cross:

- Visit **premera.com/wa/member**
- Call customer service at **800-722-1471** from 8 a.m. to 5 p.m. Pacific time, Monday – Friday
- Talk to your producer

General exclusions and limitations

Benefits are not provided for treatment, surgery, services, drugs, or supplies for any of the following:

- Cosmetic or reconstructive surgery (except as specifically provided)
- Experimental or investigative services
- Infertility
- Learning disorders
- Obesity/morbid obesity, including surgery, drugs, foods, and exercise programs
- Orthognathic surgery (except when repairing a dependent child's congenital abnormality
- Orthotics, up to $300 PCY; except for treatment of diabetes, unlimited
- Services in excess of specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when you are not covered by this program
- Sexual dysfunction
- Sterilization reversal

For a list of services and procedures that require approval for coverage from your plan before you receive them (prior authorization), visit **premera.com** and select learn about prior authorization.

This is only a summary of the major benefits provided by our plans. This is not a contract. Please see **premera.com/SBC** for the Summary of Benefits and Coverage and Glossary. On our website, you can also find a Supplemental Guide with information about privacy policies, provider organization, key utilization management procedures, and pharmaceutical management procedures.