

Utah BridgeSpan Exchange HSA Plan Highlights

Silver HSA, Bronze HSA+, Bronze HSA

Why Choose BridgeSpan?

When you choose BridgeSpan you're getting a health care partner. One that can help with your needs every step of the way, from quick health information to answers about claims, and from wellness programs to one-on-one help with serious health conditions.

Plan Features

- Provider choice: Members have direct access to their choice of providers. Member coinsurance levels are lowest for In-Network providers. If a member chooses an Out-of-Network provider, the member may be required to pay costs above the allowed amount.
- Members get access to Optimum Value Medication List generics and certain medications for chronic conditions, before satisfying a deductible on the Silver HSA plan.
- Family coverage: no one family member is eligible for benefits until the entire family deductible is met. No one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.

Calendar Year Deductible

- Separate deductible amounts per calendar year for In-Network / Out-of-Network providers.
- Applies to all covered expenses except where noted.

Silver HSA	Bronze HSA+	Bronze HSA
Single \$2,000/\$4,000 Family \$4,000/\$8,000	Single \$3,750/\$7,500 Family \$7,500/\$15,000	Single \$5,000/\$10,000 Family \$10,000/\$20,000

Calendar Year Out-of-Pocket Maximums

- Separate Out-of-Pocket maximum amounts for In-Network / Out-of-Network providers (includes deductible).
- Applies to all covered expenses except where noted.
- When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year.

Silver HSA	Bronze HSA+	Bronze HSA
Single \$5,000/\$10,000 Family \$10,000/\$20,000	Single \$6,000/\$12,000 Family \$12,000/\$24,000	Single \$6,250/\$12,500 Family \$12,500/\$25,000



Covered Services

	Member Responsibilities		
	Silver HSA	Bronze HSA+	Bronze HSA
Preventive Care and Immunizations In-Network not subject to deductible	0%	0%	0%
Office Visits	20%	50%	30%
Cardiac and Pulmonary Rehabilitation (Outpatient) 5 visits combined per calendar year	20%	50%	30%
Chemical Dependency Treatment / Mental Health (Inpatient and Outpatient)	20%	50%	30%
Durable Medical Equipment	20%	50%	30%
Emergency Room Services In-Network deductible, coinsurance and In-Network out-of-pocket maximum apply regardless of provider network.	20%	50%	30%
Hospital Services Inpatient and outpatient services and supplies.	20%	50%	30%
Home Health 30 visits per calendar year	20%	50%	30%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime.	20%	50%	30%
Maternity	20%	50%	30%
Nutritional Counseling	20%	50%	30%
Prostheses Limited to once in 5 years per site for artificial prosthetic eyes.	20%	50%	20%
Radiology and Lab (Inpatient and Outpatient)	20%	50%	30%
Rehabilitation Services and Skilled Nursing Facility (Inpatient) 30 days combined per calendar year	20%	50%	30%
Rehabilitation and Habilitation Services (Outpatient) 20 visits combined per calendar year	20%	50%	30%
Spinal Manipulations 18 spinal manipulations per calendar year	20%	50%	30%

Member responsibility for In-Network services is indicated above, after In-Network deductible is met and until out-of-pocket maximum is met, except where noted. Out-of-Network services are covered 50% on all plans after Out-of-Network deductible is met and until out-of-pocket maximum is met, except where noted.

Prescription Medications

- All out-of-pocket expenses go towards In-Network Medical Out-of-Pocket Maximum.
- Essential Formulary applies to all plans.
- Members can receive a 5% discount for prescription medications at Preferred Pharmacies.
- Retail: Up to 30-day supply and up to 90-day supply at Preferred Pharmacies.
- Mail-Order: Up to 90-day supply.
- Specialty Medications: Covered at participating retail pharmacies for first fill only. After first fill members use specialty pharmacies. Up to 30-day supply per fill.
- Self- Administable Cancer Chemotherapy: Up to 30-day supply per fill.

	Silver HSA	Bronze HSA+	Bronze HSA
Deductible (per calendar year) In-Network medical deductible applies unless otherwise specified	Medical deductible applies	Medical deductible applies	Medical deductible applies
Tier 1: Generics (Category 1)	20% Retail / 15% Mail	50% Retail / 40% Mail	25% Retail / 20% Mail
Tier 2: Generics (Category 2) and Brand Name (Category 1)	35% Retail / 30% Mail	50% Retail / 40% Mail	35% Retail / 30% Mail
Brand Name (Category 2)	50% Retail / 40% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail
Tier 3: Specialty Medications	40%	50%	40%

Pediatric Dental Services

	Silver HSA	Bronze HSA+	Bronze HSA
• Covered for members up to age 19	In-Network / Out-of-Network: • Preventive: 0% • Cleanings; oral exams; routine x-rays: two times per year. • Complete mouth x-rays are allowed once during any three-year period for members age 13 through age 18, in lieu of panorex x-ray. • Full series bitewing x-rays (4) allowed only twice in a plan year. Panorex covered once in a 3 year period in lieu of complete mouth x-ray. • Sealants for permanent molars covered once during a 5 year period through 17 years of age. • Fluoride treatment covered up to two treatments per calendar year. • Restorative and Major services not covered. • Deductible waived on all services.		

Pediatric Vision Services

	Silver HSA	Bronze HSA+	Bronze HSA
• Covered for members up to age 19	In-Network / Out-of-Network: • One routine eye exam per calendar year: 0% • One pair (two lenses) of corrective lenses per calendar year: 0% • Frames and contacts not covered. • Deductible waived for routine eye exam; deductible applies to corrective lenses.		

General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **Acupuncture**
- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly for members up to age 26, and for breast reconstruction following a medically necessary mastectomy to the extent required by law.
- **Counseling in the absence of illness** unless a covered benefit or required by law.
- **Custodial Care:** Non-skilled care and helping with activities of daily living unless member is eligible for Palliative Care benefits.
- **Dental Examinations and Treatments except when covered under the Pediatric Dental benefit or any dental option.**
- **Fees, Taxes, Interest: Charges for shipping and handling, postage, interest, or finance charges that a provider might bill.**
- **Genetic Testing**
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.
- **Hospitalization for Dentistry**
- **Immunizations** if the Member receives them only for purposes of travel, occupation, or residency in a foreign country.
- **Infertility** except to the extent covered services are required to diagnose such condition.
- **Investigational Services:** Treatment or procedures (health interventions) and services, supplies, and accommodations provided in connection with investigational treatments or procedures.
- **Military Service Related Conditions:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection or conditions incurred in or aggravated during performance in the Uniformed Services.
- **Motor Vehicle Coverage and Other Insurance Liability**
- **Neurodevelopmental Therapy Services**
- **Non-Direct Patient Care** including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges.
- **Obesity or Weight Reduction/Control:** Medical treatment, medication, surgical treatment (including reversals), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis.
- **Orthognathic Surgery** except for injury, sleep apnea and congenital anomaly.
- **Personal Comfort Items:** Items that are primarily for comfort, convenience, cosmetics, environmental control, or education.
- **Physical Exercise Programs and Equipment** including hot tubs or membership fees at spas, health clubs, or other such facilities; applies even if the program, equipment, or membership is recommended by the member's provider.
- **Private Duty Nursing including ongoing shift care in the home.**
- **Riot, Rebellion and Illegal Acts:** Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion, or aggression, insurrection, or rebellion or sustained by a member while committing an illegal act or felony.
- **Routine Foot Care**
- **Routine Hearing Care:** routine hearing exam, hearing aids (externally worn or surgically implanted), and other hearing devices.
- **Self-Help, Self-Care, Training, or Instructional Programs** including, but not limited to control weight, or provide general fitness (childbirth classes); Programs that teach a person how to use durable medical equipment or how to care for a family member.
- **Services and Supplies Provided by a Member of Your Family**
- **Services and Supplies That Are Not Medically Necessary**
- **Services to Alter Refractive Character of the Eye**
- **Sexual Dysfunction:** Regardless of cause, except for counseling provided by covered, licensed mental health practitioners.
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, and counseling services for sexual reassignment.
- **Temporomandibular Joint Disorders (TMJ) Treatment**
- **Termination of Pregnancy** except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is responsible.
- **Travel and Transportation Expenses** other than covered ambulance services .
- **Work-Related Conditions** except for subscribers and spouses who are both owners, partners, or corporate officers and are exempt from state or federal worker's compensation law.