

# 4 Plans

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**Description** This chapter is designed to provide information about our health plans.

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- Section 1: Dimensions
- Section 2: Personal Funding Accounts
- Section 3: Plan Types

See the following chapters for more information about:

- **Chapter 6: Member Eligibility and Coverage**
- **Chapter 7: Claims and Payment**



## Section 1: Dimensions

<b>Paradigm of Products</b>	Experience shows that conventional healthcare products don't always fit the needs of our members, physicians, other healthcare providers or employer groups. So Premera developed Dimensions, a paradigm of products that focuses on empowering our customers and shifting our role from middle-man to a facilitator of care.
<b>Flexible Options</b>	<p>Our Dimensions suite of products uncouples the three components that make up a product: the benefits, the network, and integrated health management. This means that our customers can choose from a variety of separate benefit, network, and Integrated Health Management options to develop a plan that suits their needs – it's their choice.</p> <p>Dimensions was developed in response to market demands for a simpler, more flexible and more efficient approach to accessing healthcare. Our flexible network options allow customers to choose coverage and a network based upon what's most important to them like:</p> <ul style="list-style-type: none"> <li>• Widest selection of physicians and providers</li> <li>• Having a specific physician or provider in the network, or</li> <li>• Maximizing the purchasing power of their benefit dollars</li> </ul>
<b>Plans and Networks</b>	<p>For physicians and other providers, Dimensions represents an opportunity to participate in a variety of networks. We offer our members these product/network combinations:</p> <ul style="list-style-type: none"> <li>• Foundation</li> <li>• Heritage</li> <li>• Global</li> </ul>
<b>Improved Functionality</b>	<p>For physicians and other providers participating in Dimensions, doing business with Premera is easy with instant access to:</p> <ul style="list-style-type: none"> <li>• New technology with a state-of-the-art claims processing system</li> <li>• Online functionality (member eligibility, benefits and claims status information), and</li> <li>• Enhanced customer service.</li> </ul>
<b>Ancillary Providers</b>	Ancillary providers participate in all Dimensions networks under the terms of their existing PPO agreements.



## Section 2: Personal Funding Accounts

### Consumer-Directed Health Programs

Customized healthcare options with flexible products and networks is the concept behind Dimensions. Personal Funding Accounts were launched to further expand the options that Dimensions offers. The goal of these accounts is to help members become more involved in managing their healthcare spending.

Personal Funding Accounts include Health Savings Accounts (HSA), Flexible Spending Accounts (FSA) and Health Reimbursement Accounts (HRA). These options combine quality healthcare coverage with a choice of tax-advantaged healthcare spending accounts.

### Personal Funding Accounts

Personal Funding Accounts allow employers the opportunity to combine quality healthcare coverage with a choice of tax-advantaged healthcare spending accounts for use with eligible healthcare expenses.

### Health Savings Account (HSA)

A Health Savings Account (HSA) is an individually-owned, fully portable, tax-advantaged savings account that allows the employee to save and help pay for current and future medical expenses of the employee and eligible dependents. An HSA can provide several tax advantages:

- Contributions are made on a tax-advantaged basis
- Any unused funds carry over from year to year and may grow tax-deferred
- When used to pay for qualified medical expenses, funds may be withdrawn tax-free

### Flexible Spending Account (FSA)

A Flexible Spending Account (FSA) is a tax-advantaged account where pre-tax dollars are withheld from an employee's paycheck and deposited into an FSA account. The employee (and employer) choose how much money to contribute to an FSA, within plan limits, at the beginning of each plan year and can access these funds throughout the year. Unused FSA funds revert back to the employer.

- Once election has been made for the plan year, the employee cannot change the amount unless there is a valid change in status
- Employees pay for eligible healthcare and dependent care expenses incurred by themselves, their spouse and eligible dependents by using the funds in their healthcare and dependent care FSAs, respectively

Available Health FSA Options (as determined by the employer):

- **General Purpose FSA** – covers all approved healthcare expenditures under IRC Section 213(d)
- **Special Purpose FSA** – covers health plan expenses after the medical deductible has been fully satisfied plus covers vision and dental expenses only and is usually paired with a Health Savings Account (HSA)
- **Limited Purpose FSA** – covers vision and dental expenses only and is usually paired with a Health Savings Account (HSA)

### Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA) is a tax-advantaged account funded by an employer to help cover healthcare costs. Only the employer may contribute to this account and also determines what healthcare expenses are reimbursable by the HRA for the employee and eligible dependents.

An optional feature that may be offered alongside one of these funding mechanisms is a healthcare payment card (payment card). Payment cards may be used to pay for qualified health-related expenses and may be used at locations that accept Visa.

**Identifying Members** Members with a Premera health plan (Foundation, Global or Heritage); will present an ID card for their Dimensions health plan. They may also present their payment card to pay for qualified, out-of-pocket healthcare expenses such as copay, coinsurance, and deductible; and dental or orthodontic expenses.

**Claims** Submit the claim for services just like you do now. If a member presents a healthcare payment card to pay a copay, coinsurance or deductible amount, simply process (swipe) the card as you would a credit card (no PIN is needed). If you do not have card swiping capabilities, the member has the option of submitting a claim for reimbursement from their personal funding account (HAS, FSA or HRA). The best time for the member to submit such a claim is after the claim has been fully adjudicated and an Explanation of Benefits (EOB) has been issued.

Payment from some personal funding accounts may occur through direct feeds of the health plan claims. This will coincide with issuance/availability of an EOB as noted above. This setup is determined by the employer. Besides the direct feed of claims activity there may be additional steps the member needs to initiate to complete actual reimbursement. They should check with instructions provided by their employer or they may contact Customer Service.

**Online Support** To view a member's currently-available benefits, or check on the status of a claim, visit our Provider Portal at [premera.com/provider](http://premera.com/provider). Providers cannot access a member's personal funding account. Access and use of funds resides with the member.

**Note:** For information about submitting healthcare claims, refer to **Chapter 7, Claims and Payment**. To learn more about our Provider Portal, refer to **Chapter 2, Online Services**.

**Member Support Tools** To promote a healthy lifestyle for members and help reduce their costs, the following member educational tools support the function of Dimensions and Personal Funding Accounts:

- **Secure Member Portal:** In addition to benefits and claims history, our enhanced member portal features online consumer decision support tools including a medical library, health trackers, health risk assessments, calculators, healthy living program and health and symptom evaluator.
- **Preferred Drug List:** Search our online Preferred Drug List to determine the copay tier for a medication, or to see if there an available generic equivalent.
- **Extras!:** Members receive discounts on weight management, chiropractic services, child safety items, alternative healthcare products, fitness solutions, massage therapy, laser vision correction, eyeglasses, contact lenses, hearing aids, and bicycle helmets.
- **Provider Directory:** [premera.com](http://premera.com) lists our contracted physicians and other providers by product, so members can select a provider within their plan to reduce out-of-pocket healthcare costs.

**Important:** The information in this section is not intended to be tax or legal advice. The reader should consult with his or her own tax advisor to determine the tax implications of purchasing the products discussed herein. Advice, if any, included in this material was not intended or written by Premera to be used, and that it cannot be used by any taxpayer, for the purpose of avoiding penalties that may be imposed on the taxpayer.



## Section 3: Plan Types

**Plans and Service Areas** Premera Blue Cross plans are available throughout Washington state under the “Blue Cross” brand (except Clark county).

In Eastern Washington, Premera Blue Cross is available in the following counties under both the “Blue Cross” and “Blue Shield” brands: Adams, Benton, Chelan, Douglas, Ferry, Franklin, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens and Whitman.

**Group Plans** **Premera Blue Cross (Statewide)**  
Preferred  
Global

**Individual Plans** **Premera Blue Cross** **LifeWise Health Plan of Washington**  
Preferred (PPO) Preferred (PPO)

**Global Plans** Global plans allow members to seek care from a wide variety of physicians, providers and hospitals in our Participating provider network.

We offer a wide range of coverage alternatives featuring varying levels of benefits, deductibles and coinsurance.

- **Freedom of choice** – The choice of physicians and other healthcare providers is up to the member.
- **Easy claims filing**– Members’ healthcare claims are submitted by participating physicians and providers.
- **No balance billing** – This means that providers who have contracted with us agree to accept our allowable charges as payment in full. Members pay only applicable deductibles, coinsurance, and charges for any non-covered services or amounts beyond the program's maximum benefits.
- **Customer care** – The members’ needs are our priority. We are happy to answer any questions they may have, or assist them with concerns.
- **No referrals** – Members may see physicians or specialists, without a referral.
- **We are regional** – Our Global plans are available throughout the state of Washington.
- **Access to nationwide care** – When traveling, if members need care, they have access to the BlueCard program which links a nationwide network of healthcare providers and the independent Blue Cross and Blue Shield Plans across the country.

Coverage is based on a percentage of covered medical expenses after an annual deductible is satisfied.

**Preferred  
Provider  
Organization  
(PPO)**

PPO plans offer a cost-effective approach to healthcare. These plans offer access to a select network of Preferred providers and facilities to help reduce out-of-pocket expenses when seeking care from a Preferred (PPO) provider or facility.

Physicians, specialists, and facilities are chosen from one of the largest physician networks in the Northwest. Benefit designs are flexible, especially for larger employers. Coverage is generally based on a percentage of covered medical expenses after an annual deductible is satisfied, and may also include point-of-service copays for specific services.

- **Extensive provider network** – Members have significant choice and access. Members may select physicians, including specialists, from one of the largest physician networks in Washington.
- **Easy claims filing** – Members' healthcare claims are submitted by preferred providers.
- **No balance billing** – This means that providers who have contracted with us agree to accept our allowable charges as payment in full. Members pay only applicable deductibles and coinsurance, charges for any non-covered services, or amounts beyond their program's maximum benefits.
- **Cost effective** – When members choose physicians and other healthcare providers within our preferred provider network, they receive the highest level of benefits.
- **Flexible benefit designs** – Benefit designs are flexible, especially for larger employers. Coverage is generally based on a percentage of covered medical expenses after an annual deductible is satisfied. Benefits are provided at a lower benefit level if out-of-network providers are used.
- **Customer care** – Members' needs are our priority. We are happy to answer any question they may have, or assist them with concerns.
- **Access to nationwide care** – When traveling, if members need care, they have access to the BlueCard program which links a nationwide network of healthcare providers and the independent Blue Cross and Blue Shield Plans across the country.
- **No referrals** – Members may see physicians, including specialists, and other healthcare providers, without a referral.
- **We are regional** – Our PPO plans are available throughout the state of Washington.

See the following chapters for more information about:

- **Chapter 6: Member Eligibility and Coverage**
- **Chapter 7: Claims and Payment**