

TRH HIGH DEDUCTIBLE HEALTH PLAN

Health Savings Account (HSA) Qualified



HEALTH PLANS

Live better. Save more.



TRH offers High Deductible Health Plans which meet federal requirements for Health Savings Accounts. However, TRH does not administer HSAs or offer tax, investment or legal advice.

What is an HSA?

A Health Savings Account (HSA) is a special account owned by an individual where contributions are made to pay for current and future medical expenses. In order to qualify for an HSA, you must be covered by a High Deductible Health Plan (HDHP). Tennessee Rural Health has developed HDHPs which meet all federal guidelines and are designed specifically to be used in conjunction with HSAs.

How does an HSA-qualified HDHP differ from traditional health care plans?

- For family coverage, all family members' expenses apply to one deductible and out-of-pocket maximum so the full family deductible must be met before benefits are paid on any family member's claim.
- There are no copays. All covered services are subject to deductibles and coinsurance.
- HSA-qualified HDHPs are subject to federal tax regulations, which can change annually. TRH will perform a review every year to ensure the HDHP meets current HSA qualifications.

Who is eligible for an HSA?

In order to qualify for an HSA, an individual or family members must:

- Be covered by an HDHP
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return (dependent children cannot establish their own individual HSAs)
- Not be covered by other health insurance, with the exception of specific disease or illness insurance and accident, disability, dental care, vision care and long-term care insurance. You can also be covered by employee assistance programs, disease management or wellness programs as long as these programs do not provide significant

medical care or treatment benefits.

Individuals eligible for VA benefits can qualify for an HSA unless they have actually received VA health benefits in the previous three months.

Why should I open an HSA?

- HSAs allow you to save money and reduce your taxable income. You will not be penalized or taxed on money withdrawn from an HSA to pay for eligible health care expenses. You can deduct your HSA contributions from your gross income on your tax return.
- The money you contribute to an HSA earns interest, plus you can choose from accounts that have investment options which can increase your savings. Again, these earnings are tax-free.
- An HSA can help you increase your retirement income. When you turn 65, you may no longer contribute to your HSA, but you can use the funds to pay for Medicare premiums (except for Medicare supplement plans) and other expenses not covered by Medicare. After you turn 65, you can also use HSA funds for non-qualified expenses without penalty, although those withdrawals will be subject to income tax.
- In the event of your death, your HSA can be transferred to a surviving spouse who can then begin using the funds in accordance with applicable guidelines and contributing funds if they are under age 65.
- You can use money from your HSA to pay for some health-related expenses not covered by your health plan. Examples include covered expenses applied toward your plan's deductible and coinsurance, and non-covered expenses such as contact lenses, dental care, qualified long term care insurance premiums, and even over-the-counter drugs. However, HDHP health

insurance premiums are generally not an eligible HSA expense.

What are qualified expenses?

HSA funds can be used to pay for several types of medical expenses, including but not limited to:

- Health insurance plan deductibles, copayments, and coinsurance
- Prescription and over-the-counter drugs
- Dental services, including braces, bridges and crowns
- Vision, including eyeglasses and lasik eye surgery
- Psychiatric and certain psychological treatments
- Long-term care services
- Transportation and lodging related to medical treatment

Consult your tax advisor for information about qualified medical expenses.

How much can I contribute?

HSA contribution limits are established annually by the federal government. Unused portions of your HSA contributions roll over each year, which allows you to build up savings. Additional special contributions apply for those currently age 55 and over.

Consult your tax adviser or the IRS/Department of Treasury at: <http://www.treasury.gov/offices/public-affairs/hsa/> for more details.

How much can I withdraw?

Withdrawals from an HSA cannot exceed the balance in the account at the time of withdrawal. However, if your eligible expense exceeds your balance, you can be reimbursed later for the remainder of the expense once the balance reaches that amount.

Where can I set up an HSA?

TRH does not offer HSA administration, only HSA-qualified HDHPs. You can contact your financial advisor or bank to see if they offer HSAs. Enclosed you will find a list of institutions we are aware of that offer HSA administration.

Sample income tax rates and potential HSA tax savings

Sample Table- Married Filing Jointly

* Taxable Income	Tax Rate	HSA Contribution	Tax Savings
\$15,651 to \$63,700	15% X	\$3,000 =	\$450
\$63,701 to \$128,500	25% X	\$3,000 =	\$750
\$128,501 to \$195,850	28% X	\$3,000 =	\$840

*Taxable Income Brackets are subject to change.

Sample Table- Filing Single

*Taxable Income	Tax Rate	HSA Contribution	Tax Savings
\$7,826 to \$31,850	15% X	\$1,500 =	\$225
\$31,851 to \$77,100	25% X	\$1,500 =	\$375
\$77,101 to \$160,850	28% X	\$1,500 =	\$420

*Taxable Income Brackets are subject to change.

Source: Tennessee Farm Bureau Income Tax Service

(TRH does not offer tax, investment or legal advice. If such advice is needed, please consult with a professional in these fields. TRH does not offer HSA administration. For more information, please consult a financial advisor or institution which offers HSA accounts.)

Quality health care coverage at an affordable cost

TRH offers HDHPs which use a large base of providers, hospitals, physicians, ambulatory surgical facilities, home health agencies, pharmacies and suppliers of durable medical equipment in the network called Blue Network P. Blue Network P has over 21,000 participating providers.

The Blue Network P plan offers members a network of doctors and medical facilities that agree to provide health care services to plan members so that members save money using the network. When you join the plan and use network providers, you receive the highest level of benefits. You may also seek medical care outside the network from out-of-network providers, but substantially reduced benefits and higher out-of-pocket expenses may result.

Paying network providers

Network providers have agreed to special pricing arrangements. You are responsible for your deductibles and coinsurance for covered services.

Paying out-of-network providers

There are no limits to your out-of-pocket expenses when you use out-of-network providers.

Your benefits may be substantially reduced and your out-of-pocket expenses may be higher.

Your identification card

When you are accepted for TRH coverage, you will receive a TRH Plan identification card issued in your name for use by you and your eligible dependents. Because TRH has chosen BlueCross BlueShield of Tennessee to administer its claims, the TRH Plan ID card is recognized and accepted by health care providers throughout the United States and many foreign countries. Your TRH Plan ID card does not contain a Social Security number which helps minimize the risk of identity theft.

\$2 million in benefits

You can receive up to \$2 million in benefits during the lifetime of the coverage for eligible expenses.

Covered services

The following services and supplies are eligible expenses when they are medically necessary and are prescribed or performed by a physician for treatment of illness, accidental injury or pregnancy:

- Hospital - inpatient and outpatient services
- Physician services - inpatient and outpatient
- Surgical services
- Emergency services
- Prescription drugs (including Prescription Home Delivery Service)
- Diagnostic services
- Home health care services
- Therapy services
- Behavioral health care services
- Durable medical equipment
- Transplants

Certain limitations may apply to covered services. Please review the Evidence of Coverage for details on limitations and exclusions.

Air and ground ambulance benefits

Ambulance transport benefits are available for up to a maximum allowable charge of \$4,000 for air transport and up to a maximum allowable charge

of \$350 for ground transport. Please see the Evidence of Coverage for details and limitations regarding these services.

Cost-saving features

TRH health plans have several cost-saving features to help hold down health care costs. These cost-saving features are designed to ensure you receive necessary health care services at the most appropriate time and in the most appropriate setting.

• **Prior Authorization**

Prior authorization is required for certain services. Some of those services include: inpatient hospital stays, home health care, skilled nursing facilities, private duty nursing, inpatient behavioral health care, transplants, hospice home care, prosthetic appliances, home infusion therapy and physical therapy when performed at home. *A prior authorization confirmation is not a guarantee of benefits. Please see the Evidence of Coverage for details and limitations.*

• **Care Management**

Provides cost-effective treatment alternatives for patients with complicated, chronic, and/or catastrophic illnesses or injuries. Care Management helps maintain the patient's quality of care without the expenses involved in long-term hospitalization. These features are fully explained in the Evidence of Coverage.

• **Pharmacy Network**

Benefits are available for prescription drugs subject to deductible and coinsurance for use by a member outside of a hospital. By showing your TRH Plan identification card at the time of filling a prescription at a network pharmacy, you will receive the benefit of negotiated pricing for your prescriptions. Using an out-of-network pharmacy can decrease the amount you are reimbursed for prescription drugs, (after your annual plan deductible has been met) from 80 percent to 60 percent. Since prescription purchases are paid by the member up front, the member can file a claim along with their prescription receipts for any eligible reimbursement. A reference number will be

issued for each prescription filled, which should be submitted with a claim form for reimbursement. **Claims are not electronically filed by the pharmacist.**

Look for generic equivalents to brand name prescription drugs. Generic drugs can cost you less -- on the average some may even cost 50 percent less than brand name prescriptions.

Prescription home delivery

A Prescription Home Delivery service is also available to members. By using the service, members can enjoy the convenience of receiving many of their prescription drugs delivered right to their door. This service may also save you money.

No benefits are available for prescription drugs purchased outside the U.S., unless approved by the Plan.

Who is covered?

- **Individual Coverage** - covers only you (**does not include maternity benefits**).
- **Family Coverage** - covers you, your spouse and eligible children up to age 24.

Maternity benefits are available after Family Coverage has been in effect for nine consecutive months.

Waiting period for pre-existing conditions

Benefits will not be provided for any pre-existing condition until you have completed a waiting period of at least 12 months.

There is a waiting period before benefits will be available for treatment of any condition existing before your coverage became effective. A pre-existing condition is defined as: An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under the Evidence of Coverage for which:

1. Medical advice or treatment was recommended by, or received from a provider of health care services; or

2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment. ***Consult your Evidence of Coverage to determine your pre-existing condition waiting period.***

Benefit exclusion rider

Benefit exclusion riders are attachments to coverage which specifically and totally exclude certain conditions. A benefit exclusion rider can remain for the life of the coverage. The pre-existing condition waiting period does not apply to benefit exclusion riders.

Exclusions

To help keep your coverage affordable, there are some services and supplies which are not covered. Some of these include:

- Services provided before the member's coverage begins, services deemed pre-existing during the pre-existing condition waiting period or services after the coverage is terminated;
- Services or supplies which the administrator determines are not medically necessary or medically appropriate;
- A drug, device or medical treatment or procedure which is investigational (as defined in the EOC definitions);
- Services, supplies or prosthetics primarily to change or improve appearance;
- Routine physical examinations, immunizations and screening examinations, except as otherwise specified in the EOC;
- Custodial care, such as help in walking, getting in or out of bed;
- Personal hygiene, (including diapers, disposable underpads and incontinence pads, except as otherwise specified in the EOC) and convenience items (such as air conditioners, breast pumps, humidifiers or physical fitness equipment);
- Any treatment, service or supply including, but not limited to, surgical procedures for the treatment of obesity or morbid obesity;
- Treatment of sexual dysfunction;
- Self-treatment or services provided by any person related to the member by blood or marriage;
- Services or supplies for dental care, except as otherwise specified in the EOC. Dental services include routine, restorative, prosthetic and orthodontic services;

- Eyeglasses, contact lenses and examinations for and the fitting of eyeglasses and contact lenses, except as otherwise specified in the EOC;
- Hydrotherapy, educational therapy, occupational therapy, speech therapy, massage therapy, craniosacral therapy, vision exercise therapy, neuromuscular reeducation, cognitive rehabilitation, nutrition therapy and acupuncture, unless otherwise specified in the EOC;

- Charges in excess of the maximum allowable charge for a service or supply;

This is a partial list of exclusions. Please review the Evidence of Coverage for a complete list of coverage exclusions.

Contact Us Today!

Visit the TRH Representative
in your local
Farm Bureau office
or call our toll-free line
for a no-obligation information
package at:

1-877-874-8323

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