

Benefit Selection Report

Group Number: 1037904

TMS West Coast Inc

Effective Date: 12/01/2011

Product Name: Your Choice (Plus 1 Copay) NGF	Specifications and Benefit Limits	Heritage In-Network	Heritage Out-of-Network
Plan Name: Opt 3 YC HCR \$3000/6000-30/50%-\$5000/25 Union			
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY	Family deductible 3X Individual	\$3,000 PCY	\$6,000 PCY
Fourth Quarter Deductible Carryover	No		
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		30%	50%
Individual Out of Pocket Maximum PCY, Excludes Copay	Family OOP max 3X Individual	\$5,000 PCY	Not Applicable
Office Visit Cost Share		\$25 Copay	Deductible, then 50%
Annual Plan Maximum		Unlimited Lifetime Max; \$2,000,000 Aggregate Annual Max	Shared with in-network
HRA Pricing	Price Standalone		
FACILITY CARE			
Inpatient Facility		Deductible, then 30%	Deductible, then 50%
Outpatient Surgery Facility		Deductible, then 30%	Deductible, then 50%
Skilled Nursing Facility	60 days PCY	Deductible, then 30%	Deductible, then 50%
EMERGENCY CARE			
Emergency Care (Waive copay if admitted to inpatient facility)		Deductible, then 30%	Deductible, then 30%
Ambulance Transportation	Unlimited	Deductible, then 30%	Deductible, then 30%
Air Ambulance	Unlimited	Deductible, then 30%	Deductible, then 30%
DIAGNOSTIC SERVICES			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered In Full	Deductible, then 50%
Preventive Mammography		Covered In Full	Deductible, then 50%
Other Professional Diagnostic Imaging and Laboratory Services		Deductible, then 30%	Deductible, then 50%
Diagnostic Mammography		Deductible, then 30%	Deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit	Unlimited	Covered In Full	Not Covered
Immunizations	Unlimited	Covered In Full	Not covered
Preventive Colon Health		Covered In Full	Deductible, then 50%
Health Education (HE)	Unlimited	Covered In Full	Not Covered
Community Wellness, Prevention & Safety Programs (CW)	Not Covered	Not Covered	Not Covered
Nicotine Dependency Programs (ND)	Unlimited	Covered In Full	Not Covered
Diabetes Health Education (DE)	Unlimited	Covered In Full	Not Covered
PROFESSIONAL CARE			
Professional Office Visit including Urgent Care		\$25 Copay	Deductible, then 50%
Inpatient Professional Services		Deductible, then 30%	Deductible, then 50%
Contraceptive Management	Unlimited	\$25 Copay	Deductible, then 50%
OTHER SERVICES			
Infertility	Not Covered	Not Covered	Not Covered
Mental Health Inpatient Facility Care	Unlimited	Deductible, then 30%	Deductible, then 50%
Mental Health Outpatient Professional Care	Unlimited	\$25 Copay	Deductible, then 50%
Acupuncture	12 visits PCY	\$25 Copay	Deductible, then 50%
Manipulations (Spinal and other)	12 visits PCY	\$25 Copay	Deductible, then 50%
Naturopathy Services	Unlimited	\$25 Copay	Deductible, then 50%
Nutritional Therapy	Unlimited	Covered In Full	Deductible, then 50%
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neurodev & Mental Health)	12 hours PCY	Deductible, then 30%	Deductible, then 50%

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Plan Name: Opt 3 YC HCR \$3000/6000-30/50%- \$5000/25 Union			
Rehab Inpatient Facility	30 days PCY	Deductible, then 30%	Deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab; and Chronic Pain	45 visits PCY	\$25 Copay	Deductible, then 50%
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth)	MS: Unlimited, ME: Unlimited, Pro: Unlimited, Orth: \$300 PCY (Unlimited Diabetes Related)	Deductible, then 30%	Deductible, then 50%
Chemical Dependency Inpatient Facility Care	Unlimited	Deductible, then 30%	Deductible, then 50%
Chemical Dependency Outpatient Professional Care	Unlimited	\$25 Copay	Deductible, then 50%
Home Health Care	130 visits PCY	Deductible, then 30%	Deductible, then 50%
Hospice Care	Inpatient: 10 days; Respite: 240 hours; 6 month limit	Deductible, then 30%	Deductible, then 50%
Transplants	Unlimited up to the member annual maximum; \$75,000 donor and \$7,500 travel and lodging limits	Covered as any other service	Not Covered
TMJ (Temporomandibular Joint Disorders)	\$1,000 PCY/\$5,000 per Lifetime	Covered as any other service	Covered as any other service
Orthognathic/Maxillofacial Care	Included in the \$5,000 lifetime max	Covered as any other service	Covered as any other service
Allergy/Therapeutic Injections		Deductible, then 30%	Deductible, then 50%
SUPPLEMENTAL BENEFITS			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Hardware	Not Covered	Not Covered	Not Covered
ADMINISTRATIVE OPTIONS			
BlueCard/National Coverage Program	BlueCard PPO (ZKR)		
Obstetrical Care for Dependent Daughters	No		

COVERAGE SELECTIONS AGREEMENT

I affirm that the coverage selections and corresponding rates are correct and I am authorized to sign on behalf of the group.

Signature of Group's Representative

Date

Group's Representative (Print Name)

Title

Benefit Selection Report

Group Number: 1037904

TMS West Coast Inc

Effective Date: 12/01/2011

Product Name: Pharmacy WA NGF	Specifications and Benefit Limits
Plan Name: Rx Retail \$15/35 Mail \$37/87	
PHARMACY	
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Retail Cost Shares	\$15/\$35
Mail Cost Shares	\$37/\$87
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty:30 Days
Out of Pocket Max	Unlimited
Non-Participating	Cost Share, then 40% (to allowable)
Annual Benefit Maximum	Unlimited
Generics required when available	Member pays the difference between the brand and the generic plus the brand name cost share (regardless of medical necessity)
Drug List	Preferred
Specialty Pharmacy	Mandatory

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Signature of Group's Representative

Date

Group's Representative (*Print Name*)

Title

Benefit Selection Report

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TMS West Coast Inc

Effective Date: 12/01/2011

Product Name: Dental Optima	Specifications and Benefit Limits	In Network
Plan Name: Dental Optima \$50-150/20-20-50%/\$1500/Ortho\$1000-Age19		
DENTAL COST SHARE		
Individual/Family Deductible PCY	\$50 PCY / \$150 PCY	
Diagnostic/Preventive		20%
Basic		20%
Major		50%
Annual Maximum	\$1,500 PCY	
Dental Waiting Period (Major services)	0 months	
OPTIONAL SERVICES		
Dental Benefit Enhancement		Endodontics & Periodontal Treatment (In Basic)
TMJ	Not Covered	Not Covered
Orthodontia Diagnostics/Banding	\$1,000 Lifetime	100% up to Lifetime Max; 19 years
Reimbursement Level	WA Out of Network Reduced Fee Schedule	

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Group's Representative (*Print Name*)

Title