Benefit Selection Report

Washington Conservation Corps

Group Number: 4002446

Effective Date: 10/01/2014

PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Product Name: Your Choice (Plus 1 Coinsurance) NGF	Specifications and Benefit Limits	Heritage In-Network	Heritage Out-of-Network
Plan Name: $100 - $200 / 20% - 40% / $1,500 Rx-MM, Plan Year			
MEDICAL COST SHARE OPTIONS			
HRA Pricing	Price Standalone		
Individual Deductible PPY	Family deductible 3X Individual	$100 PPY	$200 PPY
Fourth Quarter Deductible Carryover	No		
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		20%	40%
Individual Out of Pocket Maximum PPY, includes deductible, coinsurance and copay if applicable	Family OOP max 3X Individual	$1,500 PPY	Not Applicable
Office Visit Cost Share		Deductible, then 20%	Deductible, then 40%
Annual Plan Maximum		Unlimited	Unlimited
FACILITY CARE			
Inpatient Facility		Deductible, then 20%	Deductible, then 40%
Outpatient Surgery Facility		Deductible, then 20%	Deductible, then 40%
Outpatient Facility		Deductible, then 20%	Deductible, then 40%
Skilled Nursing Facility	60 Days PPY	Deductible, then 20%	Deductible, then 40%
Hospice Inpatient Facility	10 days Inpatient; within the 6 month lifetime maximum	Deductible, then 20%	Deductible, then 40%
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (Waive copay if admitted to inpatient facility)		$150 Copay, applies to the Out of Pocket Maximum; then Deductible, 20%	$150 Copay, applies to the Out of Pocket Maximum; then Deductible, 20%
Emergency Room Physician		Deductible, then 20%	Deductible, then 20%
Ambulance Transportation	Unlimited	Deductible, then 20%	Deductible, then 20%
Air Ambulance	Unlimited	Deductible, then 20%	Deductible, then 20%
DIAGNOSTIC SERVICES			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered In Full	Deductible, then 40%
Preventive Mammography		Covered In Full	Deductible, then 40%
Other Professional Diagnostic Imaging		Deductible, then 20%	Deductible, then 40%
Diagnostic Mammography		Deductible, then 20%	Deductible, then 40%
Other Professional Diagnostic Laboratory/Pathology		Deductible, then 20%	Deductible, then 40%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit	Unlimited	Covered in Full	Deductible, then 40%
Immunizations	Unlimited	Covered in Full	Deductible, then 40%
Preventive Colon Health		Covered In Full	Deductible, then 40%
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		Deductible, then 20%	Deductible, then 40%
Inpatient Professional Services		Deductible, then 20%	Deductible, then 40%
Contraceptive Management	Unlimited	Covered In Full	Deductible, then 40%
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	Deductible, then 20%	Deductible, then 40%

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Sterilization - Female	Unlimited	Covered In Full	Deductible, then 40%
Sterilization - Male	Unlimited	Covered In Full	Deductible, then 40%
OTHER SERVICES			
Infertility	Not Covered	Not Covered	Not Covered
Mental Health Inpatient Facility Care	Unlimited	Deductible, then 20%	Deductible, then 40%
Mental Health Outpatient Facility Care	Unlimited	Deductible, then 20%	Deductible, then 40%
Mental Health Outpatient Professional Care	Unlimited	Deductible, then 20%	Deductible, then 40%
Mental Health Residential Care (groups effective 7/1/2014 and after)		Deductible, then 20%	Deductible, then 40%
Acupuncture	12 Visits PPY	Deductible, then 20%	Deductible, then 40%
Manipulations (Spinal and other)	12 Visits PPY	Deductible, then 20%	Deductible, then 40%
Naturopathy Services	Unlimited	Deductible, then 20%	Deductible, then 40%
Nutritional Therapy	Unlimited	Covered In Full	Deductible, then 40%
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro dev & Mental Health) (groups effective 7/1/2014 and after, no limit)	12 Hours PPY; INN: Deductible, then 20%; OON: Deductible, then 40%	12 Hours PPY; INN: Deductible, then 20%; OON: Deductible, then 40%	12 Hours PPY; INN: Deductible, then 20%; OON: Deductible, then 40%
Rehab Inpatient Facility	30 Days PPY	Deductible, then 20%	Deductible, then 40%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab; and Chronic Pain	45 Visits PPY	Deductible, then 20%	Deductible, then 40%
Autism Rehab and Neurodevelopmental Therapy Outpatient Professional Care (groups effective 7/1/2014 and after, benefit is covered under mental health benefit)		Deductible, then 20%	Deductible, then 40%
Autism Rehab and Neurodevelopmental Therapy Outpatient Facility Care (groups effective 7/1/2014 and after, benefit is covered under mental health benefit)		Deductible, then 20%	Deductible, then 40%
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	MS: Unlimited, ME: Unlimited, Pro: Unlimited	Deductible, then 20%	Deductible, then 40%
Foot Orthotics, Orthopedic Shoes and Accessories	$300 PPY (Unlimited Diabetes Related)	Deductible, then 20%	Deductible, then 40%
Chemical Dependency Inpatient Facility Care	Unlimited	Deductible, then 20%	Deductible, then 40%
Chemical Dependency Outpatient Facility Care	Unlimited	Deductible, then 20%	Deductible, then 40%
Chemical Dependency Outpatient Professional Care	Unlimited	Deductible, then 20%	Deductible, then 40%
Home Health Care	130 Visits PPY	Deductible, then 20%	Deductible, then 40%
Hospice Care	Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum	Deductible, then 20%	Deductible, then 40%
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)	Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)	Covered as any other service	Covered as any other service
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered
Allergy/Therapeutic Injections		Deductible, then 20%	Deductible, then 40%
SUPPLEMENTAL BENEFITS			
Routine Vision Exam	1 PPY	Deductible, then 20%	Deductible, then 20%

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Vision Hardware	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam	1 PPY under age 19	Waive Deductible, then 20%	Waive Deductible, then 20%
Pediatric 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	Yes		

Medical Benefits apply after the plan-year deductible is met unless otherwise noted, or if the cost share is a copay.

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