TCC Benefits Administrator℠

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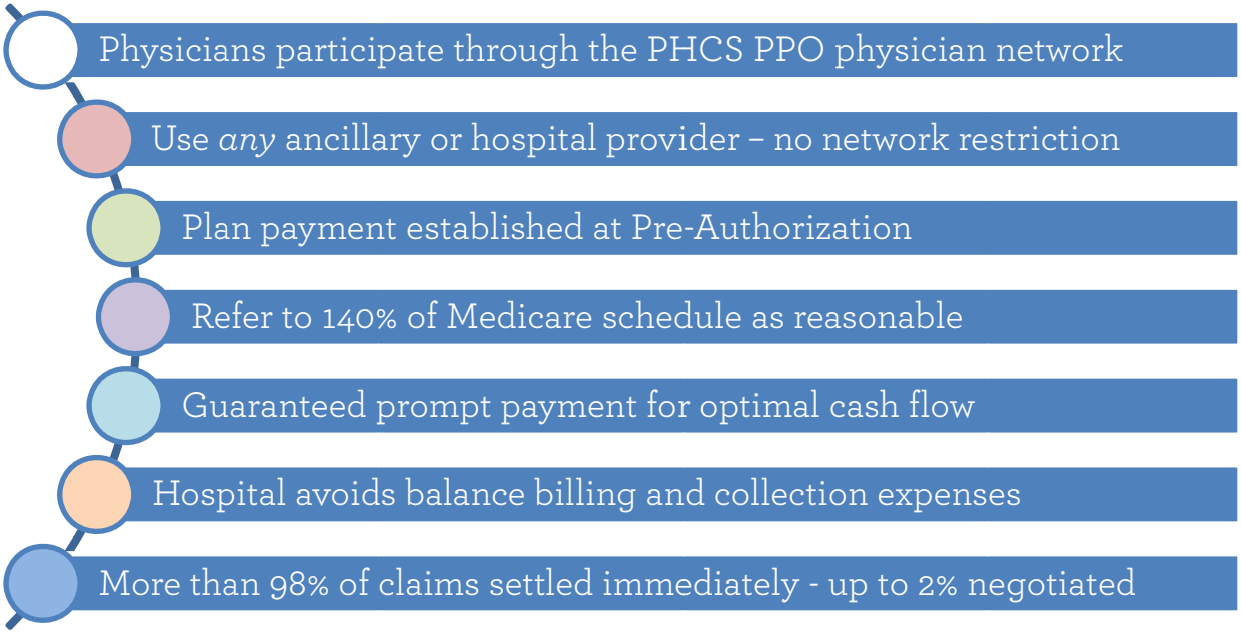
Value-Based Plan reduces your health plan expense

The *Value-Based Plan* takes a collaborative approach to hospital and ancillary payments, rather than a discount from billed charges. The pre-authorization conversation begins with a transparent benchmark of actual cost and value, using Medicare and proprietary reference databases, and then adds a significant margin for reasonable provider profit. For example:

Hospital Claim	PPO Plan	Value-Based Plan
Where we begin	**$40,000** billed charges	**$9,000** actual cost
Plan payment	**$22,000** discount of 45%	**$12,600** cost + 40% profit
Employer pays claim at 90%	**$19,800**	**$11,340**
Employee pays coinsurance at 10%	**$2,200**	**$1,260**

Health care providers deserve fair, accurate, timely, and full payment

The *Value-Based Plan* eliminates non-network hospital and ancillary benefit reductions – all hospitals and ancillary providers are eligible for full benefits. Physician benefits are covered under the PHCS Practitioner-Only PPO.



With transparent, upfront communication, each provider confirms the *Value-Based Plan* payment before rendering care. All billed charges are also reviewed and verified to be accurate, reasonable, and allowed under the plan. The *Value-Based Plan* guarantees timely reimbursement in full to improve provider cash flow, and minimize provider collection effort and expense.

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Your employees and their families deserve quality care at the right price

The *Value-Based Plan* protects patients' health, finances and credit. The *Pre-Pricing Navigator* establishes the cost and value of hospital and ancillary services prior to delivery, disclosing plan payment to both patient and provider.

Top tier benefit level at any hospital or ancillary provider

No balance bills to pay

Members never pay a balance bill under the *Value Based Plan*. In the rare event of a balance bill under the *Value-Based Plan*, the *Patient Advocacy Center* intercedes on the patient's behalf, and handles all communications with the provider to settle the claim. The Federal Fair Credit Reporting Act mandates that the provider may not threaten the patient's credit rating or report them delinquent while a claim is in discussion with the Patient Advocate. Plan payments above the reference amount are not charged to the member.

Compare to traditional network plans:

1/3 of network plan hospital patients receive unexpected balance bills

Value-Based Plan:

Settles more than 98% of claims immediately

Patient Advocacy Center negotiates the other 2% of claims

Patient Advocacy Center:

Legal challenge of excessive charges - never once lost a challenge

Members never pay a balance bill

Sustain your employee group health plan with affordable inflation strategies

Peg your annual increases to the *Value-Based Plan's* managed reference benchmarks rather than to skyrocketing health care inflation. The proof is in the quote. Ask for a *Value-Based Plan* proposal today: marketing@tccba.com