# METCOM
## Medical Plan Comparison

April 1, 2016

| | PPO 500 Gold (Current) | | PPO 1500 Gold (Current) | | Essence 5000 Bronze | |
|---|---|---|---|---|---|---|
| **Medical** | **In-Network** | | **In-Network** | | **In-Network** | |
| Individual Deductible | $500 | | $1,500 | | $5,000 | |
| Family Deductible | $1,000 | | $3,000 | | $10,000 | |
| Individual OOP Max | **$5,000** | | **$5,000** | | **$6,850** | |
| Family OOP Max | **$10,000** | | **$10,000** | | **$13,700** | |
| OOP Max includes Copays | YES; Including Prescription Copays | | YES; Including Prescription Copays | | YES; Including Prescription Copays | |
| Preventative Office Visit | Covered in Full | | Covered in Full | | Covered in Full | |
| **Office Visit** | **$20 Copay, Ded. Waived** | | **$20 Copay, Ded. Waived** | | **$75 Copay, Ded. Waived** | |
| Urgent Care Visit | **$20 Copay, Ded. Waived** | | **$20 Copay, Ded. Waived** | | **$75 Copay, Ded. Waived** | |
| Specialist Office Visit | **$40 Copay, Ded. Waived** | | **$40 Copay, Ded. Waived** | | **$120 Copay, Ded. Waived** | |
| Maternity Provider Fees | 20% | | 20% | | 50% | |
| Maternity Hospital Stay | 20% | | 20% | | 50% | |
| Hospital Services | 20% | | 20% | | 50% | |
| Outpatient Services | 20% | | 20% | | 50% | |
| Diagnostic Lab/X-Ray | 20%, Ded. Waived | | 20%, Ded. Waived | | 50% | |
| CT, PET, MRI & MRA Lab | 20% | | 20% | | 50% | |
| Emergency Room Services | $250 Copay plus 20%, Ded. Waived | | $250 Copay plus 20%, Ded. Waived | | $250 Copay plus 50% | |
| Ambulance Services (Ground) | 20% | | 20% | | 50% | |
| Physical Therapy | $40 Copay, Ded. Waived | | $40 Copay, Ded. Waived | | $120 Copay, Ded. Waived | |
| Durable Medical Equipment | 20% | | 20% | | 50% | |
| Allergy Injections | 20% | | 20% | | 50% | |
| Pediatric Vision | Exam - $20 Copay, Ded Waived<br>Hardware - 20%, Ded Waived | | Exam - $20 Copay, Ded Waived<br>Hardware - 20%, Ded Waived | | Exam - $75 Copay, Ded Waived<br>Hardware - 50%, Ded Waived | |
| **Prescription** | **30 Day** | **90 Day Mail** | **30 Day** | **90 Day Mail** | **30 Day** | **90 Day Mail** |
| Deductible | N/A | | N/A | | Medical deductible applies to all tiers except value | |
| Value | $2 | $6 | $2 | $6 | $2 | $6 |
| Select | $10 | $30 | $10 | $30 | 40% | 40% |
| Preferred | $30 | $90 | $30 | $90 | 40% | 40% |
| Brand | $60 | $180 | $60 | $180 | 50% | 50% |
| Specialty | 50% | Not covered | 50% | Not covered | 50% | Not covered |
| **Alternative Care** | **Acup., Chiro, Naturopath** | | **Acup., Chiro, Naturopath** | | **Acup., Chiro, Naturopath** | |
| Copay | $20 Copay, Ded. Waived | | $20 Copay, Ded. Waived | | Not Covered | |
| Benefit Maximum | $1500 per person | | $1500 per person | | Not Covered | |
| **Vision** | | | | | | |
| Exam | Covered in Full | | Covered in Full | | Covered in Full | |
| Hardware Allowance | $300 per person, Ded. Waived | | $300 per person, Ded. Waived | | $300 per person, Ded. Waived | |

| | Employee | Employer | Employee | Employer | Employee | Employer |
|---|---|---|---|---|---|---|
| Employee Only | -25.38 | $539.07 | -52.55 | $539.07 | -206.37 | $539.07 |
| Employee + Spouse | 55.38 | $973.14 | 1.05 | $973.14 | -306.59 | $973.14 |
| Employee + Family | 113.19 | $1,342.11 | 35.76 | $1,342.11 | -402.62 | $1,342.11 |
| Employee + Child(ren) | 32.42 | $908.05 | -17.84 | $908.05 | -302.41 | $908.05 |

| | Excess Premium to HRA VEBA | Excess Premium to HRA VEBA | Excess Premium to HRA VEBA |
|---|---|---|---|
| Employee Only | $513.69 | $486.52 | $332.70 |
| Employee + Spouse | $1,028.52 | $974.19 | $666.55 |
| Employee + Family | $1,455.30 | $1,377.87 | $939.49 |
| Employee + Child(ren) | $940.47 | $890.21 | $605.64 |

*This comparison is for illustrative purposes only. If a conflict arises, carrier information takes precedence.*