WHA INSURANCE

METCOM
Medical Plan Comparison
Regence - All Options
April 1, 2017

	Planinum 250		Planinum 500		Gold 1000		Gold 2000		Silver Essential 4000	
	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$4000 Deductible	
Medical & Prescription Benefits	In-Network		In-Network		In-Network		In-Network		In-Network	
Individual Deductible	$250		$500		$1,000		$2,000		$4,000	
Family Deductible	$500		$1,000		$2,000		$4,000		$8,000	
Individual OOP Max	$3,000		$2,500		$6,000		$5,000		$6,500	
Family OOP Max	$6,000		$5,000		$12,000		$10,000		$13,000	
OOP Max includes Deductible	*YES*		*YES*		*YES*		*YES*		*YES*	
OOP Max includes Copays	*YES; Including Prescription Copays*		*YES; Including Prescription 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		Covered in Full		Covered in Full	
Office Visit	$20 Copay, Ded. Waived		$20 Copay, Ded. Waived		$30 Copay, Ded. Waived		$30 Copay, Ded. Waived		$30 Copay, Ded. Waived 1st 3, then deductible, then 10%	
Urgent Care Visit	$30 Copay, Ded. Waived		$30 Copay, Ded. Waived		$45 Copay, Ded. Waived		$45 Copay, Ded. Waived		$30 Copay, Ded. Waived 1st 3, then deductible, then 10%	
Specialist Office Visit	$30 Copay, Ded. Waived		$30 Copay, Ded. Waived		$45 Copay, Ded. Waived		$45 Copay, Ded. Waived		$30 Copay, Ded. Waived 1st 3, then deductible, then 10%	
Maternity Provider Fees	10%		10%		20%		20%		10%	
Maternity Hospital Stay	10%		10%		20%		20%		10%	
Hospital Services	10%		10%		20%		20%		10%	
Outpatient Services	10%		10%		20%		20%		10%	
Diagnostic Lab/X-Ray	First $400 covered in full, Ded. Waived; then 10%		First $400 covered in full, Ded. Waived; then 10%		First $400 covered in full, Ded. Waived; then 20%		First $400 covered in full, Ded. Waived; then 20%		10%	
CT, PET, MRI & MRA Lab	10%		10%		20%		20%		10%	
Emergency Room Services	$250 Copay		$250 Copay		$300 Copay		$300 Copay		10%	
Ambulance Services (Ground)	10%		10%		20%		20%		10%	
Physical Therapy	10%		10%		20%		20%		10%	
Durable Medical Equipment	10%		10%		20%		20%		10%	
Allergy Injections	10%		10%		20%		20%		10%	
Pediatric Vision	Exam covered in full, Hardware $150 allowance; Ded. Waived		Exam covered in full, Hardware $150 allowance; Ded. Waived		Exam covered in full, Hardware $150 allowance; Ded. Waived		Exam covered in full, Hardware $150 allowance; Ded. Waived		Exam covered in full, Hardware $150 allowance; Ded. Waived	
Pediatric Dental	Preventive Covered in Full, 20% Basic, 50% Major, Ded Waived		Preventive Covered in Full, 20% Basic, 50% Major, Ded Waived		Preventive Covered in Full, 20% Basic, 50% Major, Ded Waived		Preventive Covered in Full, 20% Basic, 50% Major, Ded Waived		Preventive Covered in Full, 20% Basic, 50% Major, Ded Waived	
Prescription	30 Day	90 Day Mail	30 Day	90 Day Mail	30 Day	90 Day Mail	30 Day	90 Day Mail	30 Day	90 Day Mail
Deductible	N/A		N/A		N/A		N/A		Medical deductible applies to tierd 2, 3, 4, 5 & 6 only	
Tier 1 (Preferred Generic)	$4	$8	$4	$8	$4	$8	$4	$8	$8	$16
Tier 2 (Non-Preferred Generic)	25%	20%	25%	20%	25%	20%	25%	20%	25%	20%
Tier 3 (Preferred Brand)	$25	$50	$25	$50	$40	$80	$40	$80	25%	20%
Tier 4 (Non-Preferred Brand)	50%	45%	50%	45%	50%	45%	50%	45%	50%	45%
Tier 5 (Preferred Specialty)	20%		20%		20%		20%		20%	N/A
Tier 6 (Non-Preferred Specialty)	50%		50%		50%		50%		50%	N/A
Alternative Care	Acup., Chiro, Naturopath		Acup., Chiro, Naturopath		Acup., Chiro, Naturopath		Acup., Chiro, Naturopath		Acup., Chiro, Naturopath	
Copay	$25 Copay, Ded. Waived		$25 Copay, Ded. Waived		$25 Copay, Ded. Waived		$25 Copay, Ded. Waived		$25 Copay, Ded. Waived	
Benefit Maximum	$1500 per person		$1500 per person		$1500 per person		$1500 per person		$1500 per person	
Vision										
Exam	Covered in Full		Covered in Full		Covered in Full		Covered in Full		Covered in Full	
Hardware Allowance	$150 per person, Ded. Waived		$150 per person, Ded. Waived		$150 per person, Ded. Waived		$150 per person, Ded. Waived		$150 per person, Ded. Waived	

	Employee	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee	Employer
Employee Only	2.78	$566.02	-7.93	$566.02	-73.08	$566.02	-110.93	$566.02	-201.07	$566.02
Employee + Spouse	115.81	$1,021.79	94.39	$1,021.79	-35.91	$1,021.79	-111.61	$1,021.79	-291.89	$1,021.79
Employee + Family	211.87	$1,409.21	181.34	$1,409.21	-4.33	$1,409.21	-112.21	$1,409.21	-369.10	$1,409.21
Employee + Child(ren)	98.84	$953.44	79.02	$953.44	-41.50	$953.44	-111.53	$953.44	-278.28	$953.44
			Excess Premium to HRA VEBA		Excess Premium to HRA VEBA		Excess Premium to HRA VEBA		Excess Premium to HRA VEBA	
Total Premium										
Employee Only	$568.80		$558.09		$492.94		$455.09		$364.95	
Employee + Spouse	$1,137.60		$1,116.18		$985.88		$910.18		$729.90	
Employee + Family	$1,621.08		$1,590.55		$1,404.88		$1,297.00		$1,040.11	
Employee + Child(ren)	$1,052.28		$1,032.46		$911.94		$841.91		$675.16	