

City of Bellingham Renewal



Effective January 1, 2019

Company	Premera	Premera	Premera	United Healthcare	United Healthcare
Provider Website	www.premera.com/wa/visitor	www.premera.com/wa/visitor	www.premera.com/wa/visitor	www.welcometouhc.com/navigate	www.welcometouhc.com/navigate
Plan	Zero Ded Plan	250 Ded Plan	HDHP HSA Plan	\$10 Copay Plan MF-W MOD1/Rx F5 Mod1	\$200 Ded (\$20 Copay) MF-W MOD2/Rx F5 Mod2
Network	Heritage Plus PPO	Heritage Plus PPO	Heritage Plus PPO	Navigate	Navigate
Coordination or Maintenance of Benefits	Coordination of Benefits COB	Coordination of Benefits COB	Coordination of Benefits COB	Coordination of Benefits COB	Coordination of Benefits COB
IN NETWORK:					
Office Calls	\$10 Copay	10% After Deductible	20% After Deductible	\$10 Copay	\$20 Copay + 10% Coinsurance
Prescription Copay	\$4 \$15 \$35	\$5 \$25 \$50 \$100	20% After Deductible	\$10 \$10 \$50	\$10 \$20 \$40
Deductible per Person/Family	Zero	\$250/\$750	\$1,500/\$3,000	Zero	\$200/\$400
Emergency Room	\$75 Copay, Coin Applies	\$75 Copay, Ded & Coin Apply	20% After Deductible	\$50 Copay	\$75 Copay, Ded & Coin Apply
Diagnostic Lab	Covered in Full	10% After Deductible	20% After Deductible	Covered in Full	10% Coins, Ded. Waived
Hospital Coverage	\$150 Copay, Coins Apply	10% After Deductible	20% After Deductible	\$100 Copay/Day up to \$400 per Admit	10% After Deductible
Coinsurance %	10%	10%	20%	None	10%
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Out of Pocket Max per Person/Family (includes Deductible & Copays)	\$1,100/\$2,200	\$3,000/\$6,000	\$5,000/\$10,000 Embedded	\$2,100/\$4,200	\$2,500/\$5,000
Vision Exam	\$20 Copay 1 PCY	\$20 Copay 1 PCY	Not Covered	\$10 Copay Every 12 Months	\$10 Copay Every 12 Months
Vision Hardware	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Acupuncture	\$10 copay 12 Visits PCY	10% after Ded 12 Visits PCY	20% after Ded 12 Visits PCY	\$10 Copay/12 Visits PCY w/PCP Referral	\$20 Copay, Coin Applies 12 Visits PCY w/PCP Referral
Chiropractic	\$10 Copay 15 visits PCY	10% after Ded 15 Visits PCY	20% after Ded 10 Visits PCY	\$10 Copay/20 Visits PCY	\$20 Copay + 10% Coin 20 Visits PCY
Naturopath	Paid Same as Phycian's Office Visit	Paid Same as Phycian's Office Visit	Paid Same as Phycian's Office Visit	Paid Same as Phycian's Office Visit w/PCP Referral	Paid Same as Phycian's Office Visit w/PCP Referral
Rehabilitation Therapy (PT, Massage, Speech, OT)	\$10 Copay, 99 Visits PCY with Prescription	10% after Ded/99 visits PCY with Prescription	20% after Ded 25 Visits PCY	\$10 Copay/20 Visits PCY Per Therapy Type	\$20 Copay + 10% Coin 20 Visits PCY Per Therapy Type
OUT OF NETWORK:					
Deductible per Person/Family	Shared with In-Network	Shared with In-Network	Shared with In-Network	N/A	N/A
Coinsurance %	30%	30%	40%	N/A	N/A
Out of Pocket Max Person/Family (includes Deductible)	Shared with In-Network	Shared with In-Network	Ullimited	N/A	N/A

PPO = Preferred Provider Organization HDHP = High Deductible Health Plan HSA = Health Savings Account Ded = Deductible Coin = Coinsurance PCY = Per Calendar Year COB = Coordination of Benefits