

WSSD Design Comparison for Health Plans for Union groups effective 1/1/17

In-Network Coverage	Independence Blue Cross Personal Choice 20/30/70	Independence Blue Cross Personal Choice C3-F2-O2 (core plan)	Independence Blue Cross Personal Choice Alternative Gold Copay
Deductible	None	None	None
Coinsurance	N/A	N/A	N/A
Out of Pocket Maximum	\$1,500 Individual/ \$3,000 Family	\$2,000 Individual/ \$4,000 Family	\$3,000 Individual/ \$6,000 Family
Office Visits	\$20 Copay	\$20 Copay	\$35 Copay
Specialist Visits	\$30 Copay	\$40 Copay	\$45 Copay
Preventive Care	100% (No Copay)	100% (No Copay)	100% (No Copay)
Hospital Inpatient	\$150/day Max 5 Copays/Admission (\$750)	\$100/day Max 5 Copays/Admission (\$500)	\$300/day Max 5 Copays/Admission (\$1500)
Emergency Room	\$40 Copay (Waived if Admitted)	\$100 Copay (Not Waived if Admitted)	\$250 Copay (Waived if Admitted)
Laboratory	100% (No Copay)	100% (No Copay)	100% (No Copay)
Outpatient Radiology	\$30 Copay	Routine/Diagnostic \$40 Copay, MRI/CT/PET \$80 Copay	\$45 Copay
Outpatient Surgery	\$150 Copay	\$50 Copay	\$250 Copay
Maternity	First OB Visit \$20 Copay Hospital \$150/Day, Max 5 Copays/Admission	First OB Visit \$20 Copay Hospital \$100/Day, Max 5 Copays/Admission	First OB Visit \$35 Copay Hospital \$300/day, Max 5 Copays/Admission
Physical/Occupational & Speech Therapy	\$20 [Visits 1-30] \$30 [Visits 31-60] 60 Visits/Year	\$40 Copay PT/OT 30 Visits/Year; Speech 20 Visits/Year	\$35 [Visits 1-30] \$45 [Visits 31-60] 60 Visits/Year
Spinal Manipulation	\$30 Copay 30 Visits/Year	\$40 Copay 20 Visits/Year	\$45 Copay 30 Visits/Year
Injectable Medications (Administered by a physician in a doctor's office)	100%	Standard Injectables 100%, Biotech/Specialty Injectables \$100 Copay	Standard Injectables 100%, Biotech/Specialty Injectables \$100 Copay
Psychiatric Outpatient Visits	\$30 Copay	\$40 Copay	\$45 Copay
Private Duty Nursing	100% (No Copay) 360 Hours/Year	90% 360 Hours/Year	100% (No Copay) 360 Hours/Year
Skilled Nursing Facility	100% (No Copay) 120 Days/Year	\$50/day Max 5 Copays/Admission (\$250) 120 Days/Year	100% (No Copay) 120 Days/Year
Hospice and Home Health Care	100% (No Copay)	100% (No Copay)	100% (No Copay)
Durable Medical Equipment	\$30 Copay	70% After Deductible	\$45 Copay
Referrals	None	None	None
OUT-OF-NETWORK COVERAGE			
Deductible	\$500 Individual/ \$1,000 Family	\$1,500 Individual/ \$4,500 Family	\$2,500 Individual/ \$5,000 Family
Coinsurance	70%	50%	70%
Out of Pocket Maximum	\$3,000 Individual/ \$6,000 Family	\$10,000 Individual/ \$30,000 Family	\$5,500 Individual/ \$11,000 Family