WSWHE Consortium Benefit Comparison

WSWHE Consortium	PPO		Alternate PPO		HRA	
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Provider Network	Blue Access Network				PPO Network	
Deductible	N/A	$200 Individual $500 Family	N/A	$200 Individual $500 Family	$1,500 Individual $3,000 Family (Employer funds $1,000 individual, $2,000 family)	$1,500 Individual $3,000 Family (Employer funds $1,000 individual, $2,000 family)
					*Deductible is combined In and Out of Network. **For 2-person and family contracts, one individual can satisfy the full $3,000 Family deductible.	
Coinsurance	N/A	20%	N/A	20%	10%	30%
Annual Coinsurance Stop-Loss	N/A	$5,000 ind/$12,500 fam in covered services PCY, payments increase to 100% of U&C	N/A	$5,000 ind/$12,500 fam in covered services PCY, payments increase to 100% of U&C	$19,250 ind/$38,500 fam in covered services PCY, payments increase to 100% of U&C	$20,000 ind/$40,000 fam in covered services PCY, payments increase to 100% of U&C
Annual Out-of-Pocket Max	$5,080 ind/$12,700 fam	$1,200 ind / $3,000 fam	$5,080 ind/$12,700 fam	$1,200 ind / $3,000 fam	$3,425 ind / $6,850 fam	$7,500 ind / $15,000 fam
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Dependent Children	Dependent children to age 26 (cutoff at end of month)	Dependent children to age 26 (cutoff at end of month)	Dependent children to age 26 (cutoff at end of month)	Dependent children to age 26 (cutoff at end of month)	Dependent children to age 26 (cutoff at end of month)	Dependent children to age 26 (cutoff at end of month)
Inpatient1 (Except Mental Health) Unlimited days, semi-private room and board	$0 (Covered in full)	Deductible/ Coinsurance	$0 (Covered in full)	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Inpatient Physical Therapy, Physical Medicine, or Rehabilitation1	$0 90 days PCY	Deductible/ Coinsurance 90 days PCY	$0 90 days PCY	Deductible/ Coinsurance 90 days PCY	Deductible/ Coinsurance 90 days PCY	Deductible/ Coinsurance 90 days PCY
Mental Health1 2 3	$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY
Alcohol/Substance Abuse Detox1 2 3	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Alcohol/substance rehab1 2 3	$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY
Outpatient ambulatory surgery1, pre-surgical testing, chemotherapy, radiation therapy, mammography, and cervical cancer screening	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Emergency Room/Facility Initial visit for emergency care	**$35 per visit (waived if admitted to hospital within 24 hours)**	**$35 per visit (waived if admitted to hospital within 24 hours)**	**$200 per visit (waived if admitted to hospital within 24 hours)**	**$200 per visit (waived if admitted to hospital within 24 hours)**	Deductible/ Coinsurance	Deductible/ Coinsurance
Urgent Care	**$10 copay**	**$10 copay**	**$50 copay**	**$50 copay**	Deductible/ Coinsurance	Deductible/ Coinsurance

	PPO		Alternate PPO		HRA	
OTHER FACILITY BENEFITS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Alcohol/Substance Abuse1 2 3	Outpatient facility: $0 copay **Office setting:** **$10 copay** Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Outpatient facility: $0 copay **Office setting:** **$30 copay** Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY
Home Health Care	$0 Up to 200 visits PCY	20% Coins only. No Ded. 200 visits PCY	$0 200 visits PCY	20% Coins only. No Deductible 200 visits PCY	Coinsurance No Deductible 200 visits PCY	Coinsurance No Deductible 200 visits PCY
Home Infusion Therapy	$0	Not covered	$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance
Outpatient Kidney Dialysis	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Hospice (Unlimited Days	$0	Not covered	$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance
Skilled Nursing Facility1	$0 120 days PCY	Not covered	$0 120 days PCY	Not covered	Deductible/ Coinsurance 120 days PCY	Deductible/ Coinsurance 120 days PCY
MEDICAL BENEFITS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Home/Office Visits	**$10 co-pay**	Deductible/ Coinsurance	**$30/$50 co-pay**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Annual Physical Exam	$0	Not covered	$0	Not covered	$0 (Covered in full)	Deductible/ Coinsurance
Well Child Care (Including necessary immunizations)	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance
Well Woman Care	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance
Inpatient Visits	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Diagnostic Screening & Mammography	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Maternity	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Surgery	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Infertility (Artificial Insemination, IVF effective 7/1/2020) IVF Coverage is limited to 3 cycles per lifetime	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Surgical Assistant	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Anesthesiology	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Lab, X-ray	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
MRI1	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Mental Health2 3	Outpatient facility: $0 copay **Office setting:** **$10 copay** Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	**Outpatient facility:** $0 copay **Office setting:** **$30 copay** Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY

	PPO		Alternate PPO		HRA	
MEDICAL BENEFITS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Allergy Testing & Treatment	**$10 copay (waived for treatment)**	Deductible/ Coinsurance	**$30/$50 copay (waived for treatment)**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Nutritional Counseling (expanded coverage effective 07/01/2021, now covered for all diagnoses)	**$10 copay**	Deductible/Coinsurance	**$30/$50 co-pay**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Second Surgical Opinion	**$10 co-pay**	Deductible/ Coinsurance	**$30/$50 co-pay**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Physical Therapy1	**$10 co-pay**	Not covered	**$30/$50 co-pay**	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance
	90 visits PCY		90 visits PCY		90 visits PCY	90 visits PCY
Other Therapies1	**$10 co-pay**	Not covered	**$30/$50 co-pay**	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance
(Occupational, Speech)	30 visits PCY		30 visits PCY		30 visits PCY	30 visits PCY
Cardiac Rehabilitation	**$10 co-pay per outpatient visit**	Deductible/ Coinsurance	**$30/$50 co-pay per outpatient visit**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Medical Supplies	$0	Difference between the allowed amount and the total charge (ded/coins do not apply)	$0	Difference between the allowed amount and the total charge (ded/coins do not apply)	Deductible/ Coinsurance	Deductible/ Coinsurance
Durable Medical Equipment	$0	Not covered	$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance
Prosthetics, & Orthotics1	$0	Not covered	$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance
Ambulance	$0	You pay the difference between the allowed amount and the total charge	$0	You pay the difference between the allowed amount and the total charge	Deductible/ Coinsurance	Deductible/ Coinsurance
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Air Ambulance	$0 up to the allowed amount	Subject to in-network benefits	$0 up to the allowed amount	Subject to in-network benefits	Deductible/ Coinsurance	Deductible/ Coinsurance
Chiropractic Care	**$10 co-pay**	Deductible/ Coinsurance	**$30**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Hearing Aids	Not Covered	Not covered	Not covered	Not covered	Not covered	Not covered
Prescription Drug	**$5 generic/$10 brand/$25 non-formulary brand**	Covered in-network only	**$10 generic/$25 brand/$50 non-formulary brand**	Covered in-network only	After deductible is met:	Covered in-network only
	Mail Order – 2 copays per 90 day supply		**Mail Order – 2 copays per 90 day supply**		**$10 generic/$20 brand/$40 non-formulary brand** *Drugs on the Enhanced PreventiveRX will bypass deductible and only apply copays.*	

	PPO		Alternate PPO		HRA	
MEDICAL BENEFITS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Gym Reimbursement	Not Covered	Not covered	Covered for qualified gyms only	Not covered	$200 every 6 months/$400 PCY (subscriber and dependents over 18)	Covered for qualified gyms only
Routine Vision Benefits through Blue View Vision Must use the BVV -Insight Network	$5 copay for	Up to $30 reimbursement for exams	$5 copay for	Up to $30 reimbursement for exams	$5 copay for	Up to $30 reimbursement for exams
	1 exam every 24 months	Up to $64 reimbursement for frames	1 exam every 24 months	Up to $64 reimbursement for frames	1 exam every 24 months	Up to $64 reimbursement for frames
	$115 allowance for frames	Up to $25 reimbursement for Single vision lenses, $35 for bifocal lenses, and $45 for trifocal lenses	$115 allowance for frames	Up to $25 reimbursement for Single vision lenses, $35 for bifocal lenses, and $45 for trifocal lenses	$115 allowance for frames	Up to $25 reimbursement for Single vision lenses, $35 for bifocal lenses, and $45 for trifocal lenses
	$10 copay for lenses,		$10 copay for lenses,		$10 copay for lenses,	
	$75 allowance for contact lenses	Up to $75 reimbursement for Contact lenses	$75 allowance for contact lenses	Up to $75 reimbursement for Contact lenses	$75 allowance for contact lenses	Up to $75 reimbursement for Contact lenses

Anthem

* PCY = Per Calendar Year

(1) For PPO and HRA - you are responsible for obtaining precertification from Anthem's Medical Management Program for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.

(2) For services received from an Anthem PPO provider, the provider must precertify in-network services; Anthem PPO providers cannot bill members beyond the copayment for covered services. Outside Anthem's network area, you must obtain precertification from Anthem's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Anthem's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

(3) Per the Federal Mental Health Parity Mandate, effective 7/1/2010 the consolidated WSWHE benefit plan will offer existing mental health and substance abuse coverage in parity with medical and surgical benefits. This requires benefit modifications, which may include, but not be limited to changes for coinsurance amounts, copayment amounts, visit maximums, inpatient day limitations, and outpatient stay maximums.

Alternate PPO: The following practitioners receive the lower (primary) copay for services provided in an office: Patient's PCP, obstetrics, gynecologists, certified nurse midwives, chiropractors, and physical, occupational, speech and vision therapists. The higher (specialist) copay will apply for all other specialists when a copay is required, and for services received in an outpatient facility for physical and other speech, language, occupational, vision and cardiac therapy.

This is a benefit comparison only, and is subject to the terms, conditions, limitations, and exclusions set forth in the contract.

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