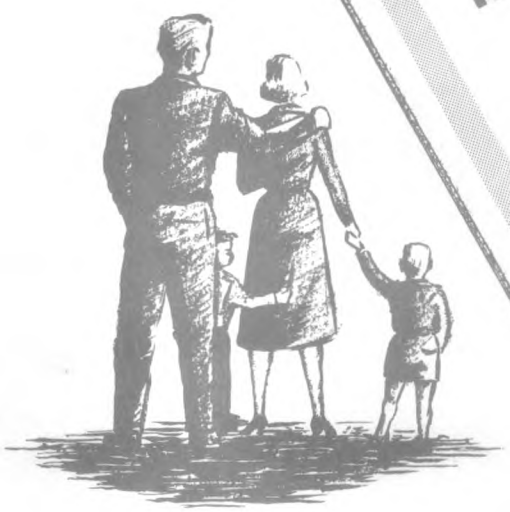
HEALTH and INSURANCE PLANS UNDER COLLECTIVE BARGAINING



Surgical and Medical Benefits

Late Summer 1959

Bulletin No. 1280
UNITED STATES DEPARTMENT OF LABOR
James P. Mitchell, Secretary
Ewan Clague, Commissioner
BUREAU OF LABOR STATISTICS

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Preface

This study of the surgical and medical benefit features of health and insurance plans under collective bargaining, based on an analysis of 300 selected plans, is the third in a series of bulletins dealing separately with the various components of health and insurance plans. The first bulletin described accident and sickness benefits in effect in the fall of 1958 (BLS Bull. 1250, June 1959), and the second bulletin described hospital benefits in effect in early 1959 (BLS Bull. 1274, March 1960). Subsequent reports will deal with major medical benefits, and with life insurance and accidental death and dismemberment benefits. As a whole, this series brings up to date the Bureau of Labor Statistics earlier bulletin, Analysis of Health and Insurance Plans Under Collective Bargaining, Late 1955 (BLS Bull. 1221, November 1957).

Each of the 300 plans analyzed was in effect in the late summer of 1959 and covered at least 1,000 workers. In total, the selected plans provided benefit coverage to almost 5 million workers, or about two-fifths of the estimated coverage of all health and insurance plans under collective bargaining.

Summary articles of this study appeared in the June and July 1960 issues of the Monthly Labor Review. A few differences in the data reported, due to later revisions, will be found in this final bulletin.

This study was conducted and the report was prepared in the Bureau's Division of Wages and Industrial Relations by Dorothy R. Kittner and Harry E. Davis, under the direction of Donald M. Landay.

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Introduction

Surgical and medical benefits in private health and insurance plans defray, in whole or in part, physicians' charges for surgical procedures (including obstetrics) and for medical care not involving surgery. These benefits are almost invariably provided for nonoccupational disabilities only since expenses incurred as a result of occupational disabilities are covered by workmen's compensation benefits.

Surgical and medical benefits take the form of cash allowances or services provided at little or no charge. Plans providing cash benefits reimburse covered persons for the physician's charges up to stipulated maximums. The individual is responsible for the difference, if any, between the doctor's charges and the amount paid by the plan. This type of benefit is usually made available through group contracts purchased from commercial insurance carriers.

Service benefits, under some plans, are provided all subscribers, regardless of their income. These service-without-income-limit plans cover virtually the entire cost of the physician's services. Other service plans, the service-with-income-limit plans, restrict service benefits to workers and dependents whose incomes are less than a specified amount (e.g., $4,000 a year for a single person and $6,000 for family coverage); those with higher incomes get cash benefits.

Service-without-income-limit plans, with few exceptions, utilize group practice prepayment programs such as the Health Insurance Plan of Greater New York and the Kaiser Foundation Health Plan, on the West Coast.[1] Service-with-income-limit plans purchase group insurance contracts from local Blue Shield organizations and other nonprofit groups, commonly referred to as individual practice prepayment plans.[2] Some plans provide self-insured cash or service benefits, that is, benefits are provided by the employer or from a fund to which contributions are made.

The main characteristics of surgical and medical benefits provided by selected collectively bargained health and insurance programs in effect in late summer 1959 are described in this report. A similar study,[3] based on plans in effect in late 1955, provides a basis for indicating the changes that have been made in surgical and medical benefits over the past few years.

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[1] Physicians participating in these programs practice as a group in a common center or centers. However, under some programs, such as Group Health Insurance, Inc. (New York City) and Spokane (Wash.) County Medical Bureau, that provide service benefits to all members regardless of income, participating physicians practice on an individual basis.

[2] Doctors participating in these programs maintain individual practices. The allowances under these plans are provided in accordance with a fee schedule approved by participating doctors. Blue Shield plans are sponsored by State or local medical societies.

[3] Analysis of Health and Insurance Plans Under Collective Bargaining, Late 1955 (BLS Bull. 1221, 1957).

This report does not describe the supplementary benefits that are included in some health and insurance programs, such as major medical (also referred to as extended medical or catastrophe) benefits, poliomyelitis insurance, out-patient laboratory and X-ray benefits, and supplemental accident benefits. Generally, where provided, such benefits were in addition to the basic hospital-surgical-medical benefits.

Scope of Study

The 300 selected plans studied were in effect in late summer 1959.[4] They ranged in coverage from 1,000 to a half million workers, and, in total, provided health and insurance benefits to 4.9 million workers (table 1) or about 40 percent of the estimated number of workers under all health and insurance plans under collective bargaining agreements. Virtually every major manufacturing and nonmanufacturing industry was represented in the sample studied (tables 2 and 3). Almost 3 out of 4 plans (219), covering two-thirds of the workers, were in manufacturing industries. About a third of the plans (95), covering more than 40 percent of the workers, were negotiated by multiemployer groups.

Under some of the plans operated by multiemployer groups or multiplant companies covering wide geographic areas, the types and amounts of benefits varied from area to area. Where such variations occurred, the benefits covering the largest group of workers were analyzed for this study and assigned the weight (i.e., the coverage) of all workers covered by the plan.

Prevalence of Benefits

Of the 300 plans studied, surgical benefits were provided active workers and their dependents[5] by 293 and 282 plans, respectively (table 2).[6] Retired workers and their dependents received surgical benefits under 103 and 100 plans,

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[4] The same sample of plans was used in Health and Insurance Plans Under Collective Bargaining: Accident and Sickness Benefits, Fall 1958 (BLS Bull. 1250, 1959); and Hospital Benefits, Early 1959 (BLS Bull. 1274, 1960).

The current sample was comprised of 271 plans also covered in the Bureau's 1955 study and 29 substitutes that were required for the following reasons: Decrease in plan coverage to fewer than 1,000 workers; merger or company shutdown; or lack of sufficient current data.

All coverage data reported in this study relate to the number of active workers (men and women) covered by the plans. For example, when reference is made to dependent coverage, the extent of such coverage is expressed in terms of the number of active workers covered by plans which extend or provide the specified benefits for dependents. No attempt was made to determine the number of women workers, dependents, retired workers, or dependents of retired workers covered by the plans.

[5] Dependents include the worker's spouse and children under a stated age, usually 19 years.

[6] Five of the seven plans that did not provide benefits for the active worker covered workers in the maritime industry who receive free care in U.S. Public Health Service hospitals and out-patient facilities, under the United States maritime law. However, all of these plans covered their dependents and three covered retired workers and their dependents.

Table 1. Health and insurance plans studied by size, industry division, and type of bargaining unit, late summer 1959 [1]

(Workers in thousands)

Workers covered	All industries					
	Total		Single employer		Multiemployer	
	Plans	Workers	Plans	Workers	Plans	Workers
All plans studied	300	4,933.2	205	2,806.7	95	2,126.5
1,000 and under 5,000 workers	137	351.7	102	262.4	35	89.3
5,000 and under 10,000 workers	59	419.1	39	272.0	20	147.1
10,000 and under 15,000 workers	34	387.0	20	224.6	14	162.4
15,000 and under 25,000 workers	26	472.0	17	302.9	9	169.1
25,000 and under 50,000 workers	28	928.8	17	532.0	11	396.8
50,000 and under 100,000 workers	5	306.6	4	250.8	1	55.8
100,000 workers and over	11	2,068.0	6	962.0	5	1,106.0

Workers covered	Manufacturing				Nonmanufacturing			
	Single employer		Multiemployer		Single employer		Multiemployer	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans studied	179	2,650.4	40	672.5	26	156.3	55	1,454.0
1,000 and under 5,000 workers	86	218.6	14	39.5	16	43.8	21	49.8
5,000 and under 10,000 workers	34	240.7	11	77.6	5	31.3	9	69.5
10,000 and under 15,000 workers	17	188.6	8	90.8	3	36.0	6	71.6
15,000 and under 25,000 workers	16	287.9	1	18.0	1	15.0	8	151.1
25,000 and under 50,000 workers	16	501.8	3	109.8	1	30.2	8	287.0
50,000 and under 100,000 workers	4	250.8	1	55.8	-	-	-	-
100,000 workers and over	6	962.0	2	281.0	-	-	3	825.0

[1] All coverage data reported in this study relate to the number of active workers (men and women) covered by the plans. No attempt was made to determine the number of women workers, dependents, retired workers, or dependents of retired workers covered by the plans.

respectively, covering about 40 percent of all workers in the 300 plans studied.[7] Benefits for retired persons were provided by about two out of five of the single employer plans studied and by about one out of five of the multiemployer plans (table 6).

Medical benefits were provided by 7 out of 10 of the plans studied (213). Both active workers and their dependents received these benefits under 179 plans (table 4). An additional 31 plans provided medical benefits to workers only, and 3 plans provided coverage for their dependents only.[8] Retired workers and their dependents received medical benefits under 74 and 71 plans, respectively, covering over 30 percent of the workers in the sample.

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[7] The term "retired worker" as used in this report does not necessarily cover all pensioners. Workers retired before the extension of benefits to pensioners are sometimes not covered. See Extension of Health Benefits to Prior Pensioners (in Monthly Labor Review, August 1960). Also excluded from plan coverage are retired workers who did not meet prescribed eligibility requirements. The data in this report do not reflect the increase in the number of plans that have extended benefits to retired workers and their dependents since late summer 1959.

[8] Workers under these three plans are in the maritime industry. See footnote 6.

Table 2. Health and insurance plans studied by industry and groups eligible for surgical benefits, late summer 1959[1]

(Workers in thousands)

Industry	Total		All plans providing surgical benefits for—							
			Active workers		Dependents of active workers		Retired workers		Dependents of retired workers	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans studied	300	4,933.2	[2]293	4,837.0	282	4,759.1	103	2,007.2	100	1,997.2
Manufacturing	219	3,322.9	219	3,322.9	208	3,249.9	75	1,644.8	72	1,634.8
Food and kindred products	17	168.1	17	168.1	16	161.3	5	31.6	5	31.6
Tobacco manufactures	3	24.0	3	24.0	3	24.0	-	-	-	-
Textile mill products	11	44.7	11	44.7	7	32.2	-	-	-	-
Apparel and other finished products	6	395.1	6	395.1	5	383.1	2	281.0	2	281.0
Lumber and wood products, except furniture	3	44.5	3	44.5	3	44.5	-	-	-	-
Furniture and fixtures	5	68.1	5	68.1	5	68.1	1	1.3	1	1.3
Paper and allied products	13	49.5	13	49.5	13	49.5	2	8.8	2	8.8
Printing, publishing, and allied industries	6	21.7	6	21.7	5	19.2	3	16.0	1	9.0
Chemicals and allied products	10	109.4	10	109.4	10	109.4	6	79.6	6	79.6
Petroleum refining and related industries	8	92.7	8	92.7	7	71.5	4	48.3	4	48.3
Rubber and miscellaneous plastics products	8	108.3	8	108.3	8	108.3	6	105.8	6	105.8
Leather and leather products	11	68.7	11	68.7	8	50.7	1	7.3	1	7.3
Stone, clay, and glass products	10	76.8	10	76.8	10	76.8	7	46.4	7	46.4
Primary metal industries	21	499.2	21	499.2	21	499.2	3	17.5	3	17.5
Fabricated metal products	11	98.1	11	98.1	11	98.1	2	6.0	2	6.0
Machinery, except electrical	22	147.0	22	147.0	22	147.0	12	110.2	11	107.2
Electrical machinery, equipment, and supplies	16	330.2	16	330.2	16	330.2	7	268.8	7	268.8
Transportation equipment	23	902.0	23	902.0	23	902.0	9	598.0	9	598.0
Instruments and related products	8	33.4	8	33.4	8	33.4	4	16.5	4	16.5
Miscellaneous manufacturing industries	7	41.4	7	41.4	7	41.4	1	1.7	1	1.7
Nonmanufacturing	81	1,610.3	74	1,514.1	74	1,509.2	28	362.4	28	362.4
Mining, crude petroleum, and natural gas production	4	194.9	4	194.9	4	194.9	3	193.6	3	193.6
Transportation	22	870.7	16	804.7	21	864.7	8	69.4	8	69.4
Communications	2	38.3	1	8.1	1	8.1	-	-	-	-
Utilities: Electric and gas	11	35.2	11	35.2	11	35.2	9	26.6	9	26.6
Wholesale and retail trade	12	60.4	12	60.4	11	59.2	2	22.5	2	22.5
Hotels and restaurants	5	67.1	5	67.1	4	58.2	-	-	-	-
Services	9	140.1	9	140.1	7	89.1	3	39.0	3	39.0
Construction	15	196.4	15	196.4	14	192.6	2	4.1	2	4.1
Miscellaneous nonmanufacturing industries	1	7.2	1	7.2	1	7.2	1	7.2	1	7.2

[1] See footnote 1, table 1. Excludes supplementary benefits such as major medical.

[2] 2 plans did not provide surgical benefits. 5 plans did not provide surgical benefits for active workers; these plans covered workers in the maritime industry who receive care in U. S. Public Health Service Hospitals and out-patient facilities free of charge. However, all of these 5 plans covered the dependents of active workers and 3 of them covered retired workers and their dependents.

Table 3. Health and insurance plans studied by industry and groups eligible for medical benefits, late summer 1959[1]

(Workers in thousands)

Industry group	Total		All plans providing medical benefits for—							
			Active workers		Dependents of active workers		Retired workers		Dependents of retired workers	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans studied	300	4,933.2	210	3,684.2	182	3,431.4	74	1,675.4	71	1,579.5
Manufacturing	219	3,322.9	152	2,487.3	130	2,305.5	52	1,342.7	50	1,248.1
Food and kindred products	17	168.1	14	157.6	12	144.6	5	31.6	5	31.6
Tobacco manufactures	3	24.0	2	22.5	2	22.5	-	-	-	-
Textile mill products	11	44.7	6	31.5	2	19.0	-	-	-	-
Apparel and other finished products	6	395.1	5	383.1	5	383.1	4	375.6	2	281.0
Lumber and wood products, except furniture	3	44.5	3	44.5	3	44.5	-	-	-	-
Furniture and fixtures	5	68.1	5	68.1	2	3.3	1	1.3	1	1.3
Paper and allied products	13	49.5	6	23.2	5	21.1	1	5.5	1	5.5
Printing, publishing, and allied industries	6	21.7	3	8.8	2	4.3	-	-	-	-
Chemicals and allied products	10	109.4	9	96.2	8	93.0	4	60.0	4	60.0
Petroleum refining and related industries	8	92.7	6	73.5	5	52.3	3	33.3	3	33.3
Rubber and miscellaneous plastics products	8	108.3	8	108.3	8	108.3	6	105.8	6	105.8
Leather and leather products	11	68.7	7	54.0	5	39.0	-	-	-	-
Stone, clay, and glass products	10	76.8	4	40.0	4	40.0	2	18.0	2	18.0
Primary metal industries	21	499.2	9	58.0	8	51.2	2	6.0	2	6.0
Fabricated metal products	11	98.1	7	75.3	7	75.3	1	3.0	1	3.0
Machinery, except electrical	22	147.0	17	125.3	15	123.3	8	86.2	8	86.2
Electrical machinery, equipment and supplies	16	330.2	11	185.8	9	178.0	2	9.0	2	9.0
Transportation equipment	23	902.0	18	868.1	17	841.7	8	589.2	8	589.2
Instruments and related products	8	33.4	7	31.8	7	31.8	4	16.5	4	16.5
Miscellaneous manufacturing industries	7	41.4	5	31.7	4	29.2	1	1.7	1	1.7
Nonmanufacturing	81	1,610.3	58	1,196.9	52	1,125.9	22	332.7	21	331.4
Mining, crude petroleum, and natural gas production	4	194.9	4	194.9	4	194.9	3	193.6	3	193.6
Transportation	22	870.7	13	614.7	14	653.4	7	66.9	6	65.6
Communications	2	38.3	1	8.1	1	8.1	-	-	-	-
Utilities: Electric and gas	11	35.2	10	32.6	10	32.6	7	22.1	7	22.1
Wholesale and retail trade	12	60.4	9	53.2	9	53.2	2	22.5	2	22.5
Hotels and restaurants	5	67.1	5	67.1	4	58.2	-	-	-	-
Services	9	140.1	4	83.7	2	32.7	1	18.0	1	18.0
Construction	15	196.4	11	135.4	7	85.6	1	2.4	1	2.4
Miscellaneous nonmanufacturing industries	1	7.2	1	7.2	1	7.2	1	7.2	1	7.2

[1] See footnote 1, tables 1 and 2. 87 plans did not provide medical benefits. 3 plans did not provide medical benefits for active workers; however, dependents of active workers were covered by these plans (see footnote 2, table 2).

Table 4. Classification of plans providing surgical and medical benefits[1] by eligible groups, late summer 1959[2]

(Workers in thousands)

Eligible group				Plans	Workers
Active workers	Dependents of active workers	Retired workers	Dependents of retired workers		
Total with surgical benefits				298	4,897.0
x	x	-	-	178	2,733.9
x	x	x	x	97	1,957.7
x	-	-	-	15	135.4
-	x	x	x	[3]3	39.5
-	x	-	-	[3]2	20.5
x	x	x	-	2	7.5
x	-	x	-	1	2.5
Total with medical benefits				213	3,738.2
x	x	-	-	*108	*1,740.3
x	x	x	x	* 69	*1,542.5
x	-	-	-	30	305.5
x	x	x	-	2	94.6
-	x	x	x	[4]2	37.0
-	x	-	-	[4]1	17.0
x	-	x	-	1	1.3

[1] Excludes supplementary benefits, such as major medical and poliomyelitis benefits.

[2] Based on a study of 300 health and insurance plans under collective bargaining covering approximately 5 million workers. All coverage data relate to the number of active workers (men and women) covered by the plans which provided the specified benefit. No attempt was made to determine the number of women workers, dependents of active workers, retired workers, or dependents of retired workers covered by the plans.

[3] Plans did not provide surgical benefits for active workers because they covered workers in the maritime industry who are entitled to medical care in U.S. Public Health Service hospitals and out-patient facilities free of charge.

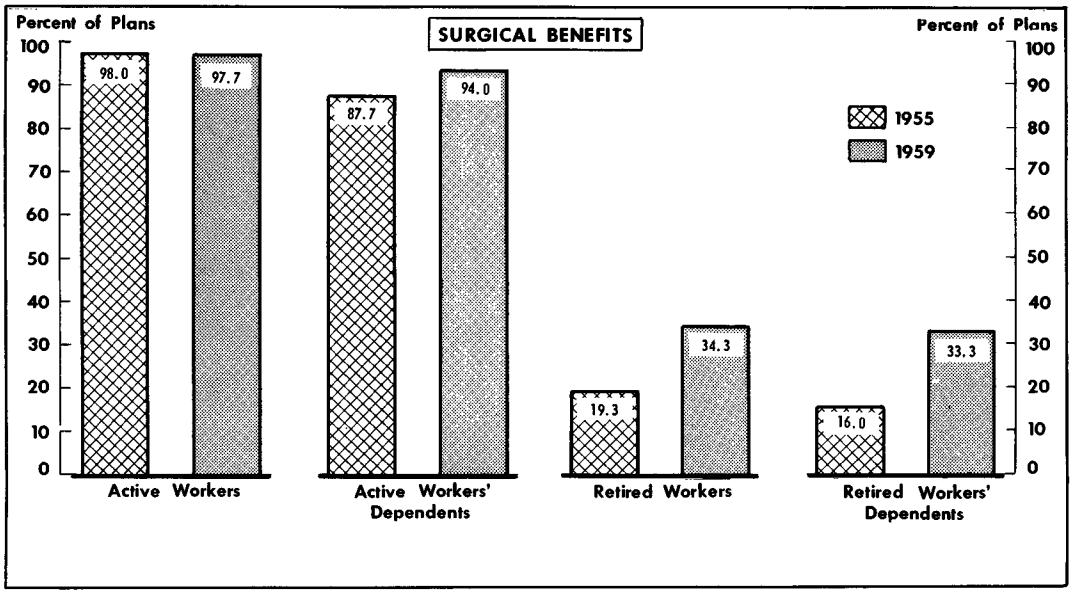
[4] Plans did not provide medical benefits for active workers. See footnote 3.

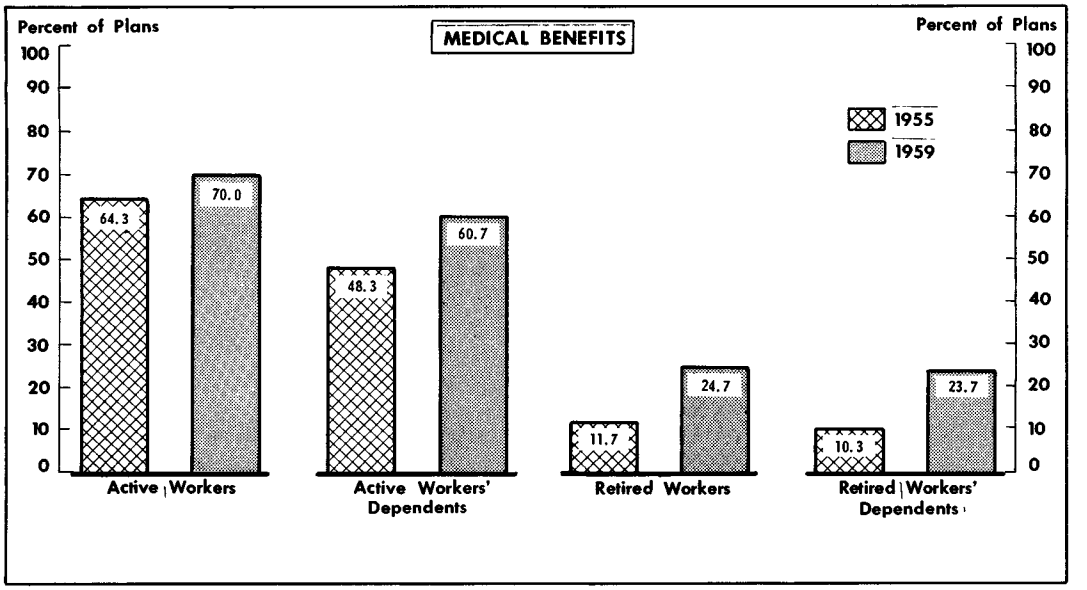
* Preliminary data published in the July 1960 issue of the Monthly Labor Review (p. 711, table 1) have been revised.

Since 1955, the number of plans providing surgical coverage for retired workers increased from 19 percent of all plans studied to 34 percent, and coverage for their dependents rose from 16 percent to 33 percent of the plans (see chart). Although the proportion of plans providing medical benefits for active workers increased by only 6 percentage points, active workers' dependents' coverage rose from 48 percent of the plans studied to 61 percent. Coverage of retired workers by medical benefits increased from 12 percent to 25 percent of the plans studied and for their dependents, from 10 percent to 24 percent.

Under most plans, identical surgical and medical benefits were provided all eligible groups (table 5). Active workers and their dependents (both children and adults) had the same surgical and medical benefits in about 3 out of 4 of the plans covering both groups; more than 9 out of 10 plans gave active workers and their adult dependents (e.g., spouse) identical surgical benefits. Retired and active workers received identical surgical benefits under 70 of the 100 plans covering both groups, and identical medical benefits under 49 of the 72 plans.

Percent of Health and Insurance Plans Providing Surgical and Medical Benefits
to Active and Retired Workers and Their Dependents
Late 1955 and Late Summer 1959





Based on 300 plans under collective bargaining studied, in late 1955 and late summer 1959. (See text footnote 4.)

Table 5. Relationship of nonmaternity surgical and medical benefits provided active workers and their dependents, active and retired workers, retired workers and their dependents, and dependents of active and retired workers, late summer 1959[1]

(Workers in thousands)

Groups covered and benefit level	Surgical benefits		Medical benefits	
	Plans	Workers	Plans	Workers
Active workers and their dependents				
All plans providing benefits for active workers and dependents	277	4,699.1	179	3,377.4
Benefits for dependents:				
Same as benefit for active workers	205	3,377.1	145	2,558.3
Different from active workers' benefit in one or more respects	[2]72	1,322.0	34	819.1
Active and retired workers				
All plans providing benefits for active workers and retired workers	100	1,967.7	72	1,638.4
Benefits for retired workers:				
Same as benefit for active workers	70	1,565.4	49	1,312.7
Different from active workers' benefit in one or more respects	30	402.3	23	325.7
Retired workers and their dependents				
All plans providing benefits for retired workers and dependents	100	1,997.2	71	1,579.5
Benefits for dependents:				
Same as benefit for retired workers	91	1,818.7	65	1,539.9
Different from retired workers' benefit in one or more respects	9	178.5	6	39.6
Dependents of active and retired workers				
All plans providing benefits for dependents of active and retired workers	100	1,997.2	71	1,579.5
Benefits for dependents of retired workers:				
Same as benefit for dependents of active workers	72	1,726.5	50	1,317.3
Different from benefit for dependents of active workers in one or more respects	28	270.7	21	262.2

[1] See footnotes 1 and 2, table 4. 293 and 210 plans provided surgical and medical benefits, respectively, for active workers; 282 and 182 plans provided surgical and medical benefits, respectively, to dependents of active workers; 103 and 74 plans provided surgical and medical benefits, respectively, to retired workers; and 100 and 71 plans provided surgical and medical benefits, respectively, to dependents of retired workers.

[2] Includes 49 plans which provided the same allowance for active workers and dependent adults but a less liberal allowance for dependent children under a specified age.

Financing[9]

The employer paid the full cost of the active worker's surgical and medical insurance under more than three out of five of the plans with these benefits (tables 6 and 7). Jointly financed benefits were provided under the remaining plans.[10]

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[9] The method of financing benefits for active workers and their dependents has changed in some plans since late summer 1959. These revisions, occurring primarily in the plans negotiated by the steelworkers' union, which changed from a contributory to a noncontributory basis, are not reflected in the data included in this report.

[10] If the worker contributed toward the cost of a health and insurance program as a whole (with the employer paying the remaining cost), each benefit was classified as jointly financed.

Table 6. Method of financing surgical benefits by groups eligible and type of bargaining unit, late summer 1959[1]

(Workers in thousands)

Groups covered and method of financing[2]	Total		Type of bargaining unit			
			Single employer		Multiemployer	
	Plans	Workers	Plans	Workers	Plans	Workers
Active workers						
All plans providing benefits	293	4,837.0	203	2,770.5	90	2,066.5
Employer only	[3]183	3,000.1	94	942.6	89	2,057.5
Employer and worker	110	1,836.9	109	1,827.9	1	9.0
Dependents of active workers						
All plans providing benefits	282	4,759.1	198	2,736.8	84	2,022.3
Employer only	[4]127	2,391.1	50	437.3	77	1,953.8
Employer and worker	[5]123	2,049.4	119	2,021.7	4	27.7
Worker only	32	318.6	29	277.8	3	40.8
Retired workers						
All plans providing benefits	103	2,007.2	84	1,401.3	19	605.9
Employer only	47	1,071.8	30	489.9	17	581.9
Employer and retired worker	[6]28	204.5	27	198.5	1	6.0
Employer and active worker	1	18.0	-	-	1	18.0
Retired worker only	27	712.9	27	712.9	-	-
Dependents of retired workers						
All plans providing benefits	100	1,997.2	83	1,398.3	17	598.9
Employer only	38	1,004.2	24	436.6	14	567.6
Employer and retired worker	[6]28	238.6	27	232.6	1	6.0
Employer and active worker	1	18.0	-	-	1	18.0
Retired worker only	33	736.4	32	729.1	1	7.3

[1] See footnotes 1 and 2, table 4.

[2] If the worker contributed toward the cost of the health and insurance program as a whole (with the employer paying the remaining cost), the benefit was classified as jointly financed.

[3] Includes 1 plan under which the benefit for workers with less than 1 year's service was financed solely by the worker.

[4] Includes 1 plan under which the benefit for dependents of workers with less than 1 year's service was financed solely by the worker.

[5] Includes 1 plan under which the benefit for dependents of workers with less than 1 year's service was financed solely by the worker; and 1 plan under which the benefit for the first dependent was financed solely by the employer and the benefit for all other dependents was financed by the employer and the worker.

[6] Includes 1 plan under which the benefit was financed by the employer and the local union.

Dependents' surgical and medical benefits were financed by the employer in about 45 percent of the plans with dependents' coverage. Almost as many plans provided for joint financing. Workers paid the entire cost of benefits under the remaining plans; under these plans, dependents have the advantage of group insurance that might otherwise not have been available to them.[11]

Benefits for retired workers were paid for by the employer under about 45 percent of the plans with surgical and medical benefits for this group (tables

[11] It is generally recognized that group insurance contracts have the following advantages over individual insurance policies: Lower premiums; the absence of medical, age, and other restrictions on coverage; and the rarity of contract cancellations.

6 and 7). Retired worker-financed surgical and medical benefits were provided by about a fourth of the plans.[12] The remaining plans had jointly financed benefits.

Table 7. Method of financing medical benefits by groups eligible and type of bargaining unit, late summer 1959[1]

(Workers in thousands)

Groups covered and method of financing[2]	Total		Type of bargaining unit			
			Single employer		Multiemployer	
	Plans	Workers	Plans	Workers	Plans	Workers
Active workers						
All plans providing benefits	210	3,684.2	142	1,959.4	68	1,724.8
Employer only	[3] 138	2,402.5	70	677.7	68	1,724.8
Employer and worker	72	1,281.7	72	1,281.7	-	-
Dependents of active workers						
All plans providing benefits	182	3,431.4	128	1,864.2	54	1,567.2
Employer only	[4] 84	1,870.2	35	355.2	49	1,515.0
Employer and worker	76	1,310.6	73	1,2919	3	18.7
Worker only	22	250.6	20	217.1	2	33.5
Retired workers						
All plans providing benefits	74	1,675.4	59	1,002.4	15	673.0
Employer only	36	883.6	23	234.6	13	649.0
Employer and retired worker	[5] 16	130.4	15	124.4	1	6.0
Employer and active worker	1	18.0	-	-	1	18.0
Retired worker only	21	643.4	21	643.4	-	-
Dependents of retired workers						
All plans providing benefits	71	1,579.5	58	1,001.1	13	578.4
Employer only	29	738.7	18	184.3	11	554.4
Employer and retired worker	[5] 16	166.1	15	160.1	1	6.0
Employer and active worker	1	18.0	-	-	1	18.0
Retired worker only	25	656.7	25	656.7	-	-

[1] See footnotes 1 and 2, table 4.
[2] See footnote 2, table 6.
[3] See footnote 3, table 6.
[4] See footnote 4, table 6.
[5] See footnote 6, table 6.

Dependents of retired workers received employer-financed surgical and medical benefits under about two out of five plans, while the retired worker paid the full cost under one out of three plans. Under all except one of the remaining plans, the retired worker paid a portion of the cost. Almost all multiemployer plans provided employer-financed benefits for all covered groups; in contrast, the majority of single-employer programs required the workers (active and retired) to pay a part or all of the cost of coverage for themselves and their dependents.

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[12] Where the retired employee pays the entire premium, he still has the advantages of remaining under group coverage. Usually he is also given the advantage of a low rate determined by the average cost of providing benefits for active employees and their dependents as well as for retired employees and their dependents. Since the active workers, being on the whole much younger, have lower utilization rates than retired workers, the combined rate is particularly advantageous to the latter.

Surgical and medical benefits of dependents were generally financed in the same manner as those for active and retired workers (table 8). However, retired workers' benefits were often financed differently than active workers' benefits. For example, over a fifth of the plans that provided employer-financed benefits to active workers required the worker to pay the full cost of his benefits after retirement, and about a fourth of the plans providing jointly financed benefits for active workers provided employer-financed benefits after retirement.

Table 8. Relationship of method of financing surgical and medical benefits for active workers and their dependents, retired workers and their dependents, and active and retired workers, late summer 1959[1]

(Workers in thousands)

Groups covered and method of financing[2]	Surgical benefits		Medical benefits	
	Plans	Workers	Plans	Workers
Active workers and their dependents[3]				
All plans providing benefits for active workers and their dependents	277	4,699.1	179	3,377.4
Benefit for active worker financed by employer	167	2,862.2	111	2,106.1
Benefit for dependents financed: By employer	122	2,331.1	81	1,816.2
By worker and employer	19	293.0	12	114.0
By worker	26	238.1	18	175.9
Benefit for active worker financed by worker and employer	110	1,836.9	68	1,271.3
Benefit for dependents financed: By worker and employer	104	1,756.4	64	1,196.6
By worker	6	80.5	4	74.7
Retired workers and their dependents[3]				
All plans providing benefits for retired workers and their dependents	100	1,997.2	71	1,579.5
Benefit for retired worker financed by employer	44	1,061.8	34	789.0
Benefit for dependents financed: By employer	38	1,004.2	29	738.7
By retired workers and employer	1	37.0	1	37.0
By retired worker	5	20.6	4	13.3
Benefit for retired worker financed by retired worker and employer	28	204.5	15	129.1
Benefit for dependents financed: By retired worker and employer	27	201.6	15	129.1
By retired worker	1	2.9	-	-
Benefit for retired worker financed by active worker and employer	1	18.0	1	18.0
Benefit for dependents financed: By active worker and employer	1	18.0	1	18.0
Benefit for retired worker financed by retired worker	27	712.9	21	643.4
Benefit for dependents financed: By retired worker	27	712.9	21	643.4
Active workers and retired workers[3]				
All plans providing benefits for active worker and retired worker	100	1,967.7	72	1,638.4
Benefit for active worker financed by employer	49	950.0	39	845.4
Benefit for retired worker financed: By employer	32	845.8	27	792.1
By retired worker and employer	4	20.5	2	7.6
By active worker and employer	1	18.0	1	18.0
By retired worker	12	65.7	9	27.7
Benefit for active worker financed by worker and employer	51	1,017.7	33	793.0
Benefit for retired worker financed: By employer	12	186.5	7	54.5
By retired worker and employer	24	184.0	14	122.8
By retired worker	15	647.2	12	615.7

[1] See footnotes 1 and 2, table 4.
[2] See footnote 2, table 6.
[3] See footnote 1, table 5.

Eligibility Requirements

As in the case of other health and insurance benefits, the newly hired worker generally had to be on the job for a specified time before surgical or

medical benefits became available to him or his dependents (table 9).[13] About a fifth of the plans commenced coverage either immediately on hiring or within a month after hiring, but about four out of five plans provided coverage by the end of 4 months of employment. Presumably for accounting reasons, surgical or medical coverage was deferred by almost 3 out of 10 plans until the first of the month following the completion of the specified period of employment.

Virtually all of the plans with surgical and medical benefits made these benefits available without regard to the worker's or dependent's age when coverage began (table 10). Only three plans provided newly hired older workers less liberal surgical benefits than those provided younger workers becoming insured at the same time. Under these plans and one other, dependents entering the plan at an advanced age were also provided reduced benefits. Reduced medical benefits were provided workers commencing coverage at an advanced age under seven plans and dependents under one plan. Only three surgical and four medical plans withheld coverage entirely from newly hired older workers and dependents entering the plan at an advanced age. None of the plans limited or withheld coverage because of the sex of workers or dependents.

Continuance of Coverage During Layoff.—If the worker's employment stopped owing to layoff or other reasons, his benefits terminated immediately or at the end of the month in which employment ceased, unless agreement had been reached on continuance of group coverage beyond that date.[14] Laid-off workers continued to be covered by about half of the 293 plans providing surgical benefits and by about the same proportion of plans providing medical benefits. The period of coverage after layoff ranged from 14 days to 2 years. About a third of the plans provided coverage for 7 months or more. Most frequently, however, coverage was continued for 1 month following the month in which the layoff occurred. A few plans (5) maintained benefits for an indefinite period at the workers' expense.

Benefits for laid-off workers were financed by the same method as for active workers in about three out of five of the plans continuing surgical and medical benefits following layoff. All except a few of the plans that extended coverage for less than 6 months following date of layoff financed the benefits for laid-off workers by the same method used to finance the benefits for actively employed workers. However, most of the plans that provided for the extension of benefits to laid-off workers for 6 months or more required the laid-off worker to assume the full cost of his benefits immediately upon being laid off or at the first of the following month.

Surgical Benefits

Surgical benefits in virtually all of the plans were restricted to operations incident to nonoccupational disabilities—only three plans covered procedures

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[13] Eligibility requirements as discussed in this section refer only to the period of employment required of the worker before he is eligible to participate in the plan. Under some plans, in addition to specifying an employment requirement, a period of union membership was also required. This period rarely exceeded the employment requirement. The waiting requirements for the nonmaternity medical benefits and the maternity surgical and medical benefits are discussed in the applicable sections of this report.

[14] Workers usually have the right under Blue Shield plans and some commercial insurance policies to convert, at their own expense, to an individual policy without proving insurability.

Table 9. Eligibility requirements for surgical and medical benefits,[1] late summer 1959[2]

(Workers in thousands)

Effective date of coverage	Surgical benefits		Medical benefits	
	Plans	Workers	Plans	Workers
All plans studied	300	4,933.2	300	4,933.2
All plans providing benefits	[3]298	4,897.0	[4]213	3,738.2
After employment for—				
Under 1 month	42	726.6	30	634.3
1 and under 2 months	34	291.9	25	261.4
2 and under 3 months	21	127.7	12	66.8
3 and under 4 months	60	569.5	46	375.9
4 and under 5 months	3	78.0	-	-
5 and under 6 months	-	-	1	35.0
6 and under 7 months	37	610.2	24	547.8
8 and under 9 months	1	6.3	1	6.3
12 and under 13 months	2	40.8	2	40.8
13 months or more	1	1.3	-	-
First day of month following completion of employment for—				
Under 1 month	25	596.1	13	191.1
1 and under 2 months	26	385.5	22	344.9
2 and under 3 months	10	1,031.7	8	875.2
3 and under 4 months	13	124.1	9	89.3
4 and under 5 months	1	13.3	1	13.3
6 and under 7 months	6	93.2	6	93.2
12 and under 13 months	2	5.9	-	-
Other	14	194.9	13	162.9

[1] See footnote 1, table 4.
[2] See footnote 1, table 1.
[3] Includes 5 plans which provided benefits for dependents of active workers but not for active workers (see footnote 2, table 2).
[4] Includes 3 plans which provided benefits for dependents of active workers but not for active workers (see footnote 1, table 3).

Table 10. Effect of age when coverage commences on availability or level of surgical and medical benefit for active workers and their dependents, late summer 1959[1]

(Workers in thousands)

Provision	Surgical benefits				Medical benefits			
	Workers		Dependents		Workers		Dependents	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing benefits	293	4,837.0	282	4,759.1	210	3,684.2	182	3,431.4
Availability or level of benefit not affected by age when coverage commences	287	4,780.3	275	4,694.7	199	3,609.6	177	3,411.7
Reduced benefit provided if coverage commences after age—								
60	[2]3	51.3	[2]3	51.3	[2]6	61.6	-	-
65	-	-	1	7.7	1	2.5	1	2.5
Benefit not available if coverage commences after age—								
55	1	1.0	1	1.0	1	1.0	-	-
65	1	3.1	1	3.1	3	9.5	4	17.2
70	1	1.3	1	1.3	-	-	-	-

[1] See footnotes 1 and 2, table 4.
[2] Includes 1 plan which provided workers hired after age 60 and their dependents who were over age 60 when first insured a reduced benefit during the first 36 months of coverage.

resulting from occupational disabilities.[15] Benefits for the obstetrical procedure required in normal delivery maternity cases were provided by all but 17 plans covering women workers and 13 covering dependent wives, as shown in the following tabulation:

Disabilities covered	Women workers		Dependent wives	
	Plans	Workers (thousands)	Plans	Workers (thousands)
All plans providing surgical benefits	293	4,837.0	282	4,759.1
Nonmaternity and maternity	276	4,510.6	269	4,544.1
Nonmaternity only	17	326.4	13	215.0

Active Workers' and Dependents' Nonmaternity Benefits.—Cash surgical benefits for nonmaternity disabilities were provided active workers and their dependents in 223 and 215 plans, respectively (table 11).[16] Usually, under these plans, covered persons were reimbursed for the cost of operations up to a maximum scheduled allowance for each procedure. The individual was responsible for the difference, if any, between the amount the surgeon charged and the allowance provided in the schedule. However, six plans covering workers and five plans covering dependents provided the cash benefits on a co-insurance basis. These plans paid a percentage (usually 75 to 80 percent) of the insured's "out-of-pocket" surgical, medical, and hospital expenses that exceeded a specified amount, commonly referred to as the "deductible."[17]

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[15] The three plans which covered surgical procedures incident to occupational disabilities paid the difference between the workmen's compensation benefit and the amount provided by the plan.

Most plans specifically excluded one or more surgical procedures, such as cosmetic and dental surgery, and procedures for the treatment of self-inflicted injuries.

[16] Plans were classified solely according to type of benefits (cash or service) provided, without regard to the party (the doctor or the insured) to whom payment was made, or to the type of insurer (commercial insurance carriers or nonprofit prepayment organizations such as Blue Shield).

The definition of cash and service benefits used for classifying plans included in this report differs from the definition used in the 1955 survey; hence, no comparison between the prevalence of cash or service benefits in 1955 and 1959 should be made. For the 1955 study, plans providing cash benefits to all covered persons, regardless of income, and plans that provided cash benefits to workers whose annual income was over a specified limit were classified as "cash" plans. For this report, if cash benefits were applicable to individuals with annual incomes exceeding a specified limit and service benefits applied to workers with income less than this amount, the plan was classified as a "service-with-income-limit" plan.

[17] This type of benefit is usually called a "comprehensive benefit." It differs from the "major medical expense benefit" provided on a co-insurance basis to cover expenses not covered by the "basic" hospital, surgical, and medical benefits, in that all or virtually all benefits are on a co-insurance basis. This report includes comprehensive benefits but not major medical benefits.

Table 11. Types of surgical benefits and location of surgical care of nonmaternity disabilities by groups eligible, late summer 1959[1]

(Workers in thousands)

Type and location	Active workers		Dependents of active workers		Retired workers		Dependents of retired workers	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing benefits	293	4,837.0	282	4,759.1	103	2,007.2	100	1,997.2
Benefit provided in form of—								
Cash	223	3,444.3	215	3,385.3	71	1,080.7	69	1,072.7
Service	70	1,392.7	67	1,373.8	32	926.5	31	924.5
With income limits	44	929.5	44	929.5	23	684.9	23	684.9
Without income limits	26	463.2	23	444.3	9	241.6	8	239.6
Benefit provided for operations in—								
Hospital, doctor's office, and home[2]	272	4,001.7	262	3,925.8	87	1,190.8	85	1,182.8
Hospital and doctor's office[2]	14	776.8	14	776.8	12	767.8	12	767.8
Hospital only	7	58.5	6	56.5	4	48.6	3	46.6

[1] See footnote 1 and 2, table 4.
[2] For this table "medical" or "health" center was considered "doctor's office."

Table 12. Income limits of service benefit surgical plans and service benefit medical plans[1]

(Workers in thousands)

Annual income limits[2]	Surgical benefits				Medical benefits			
	Active workers		Retired workers		Active workers		Retired workers	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All service plans	70	1,392.7	32	926.5	[3]70	1,664.3	[3]35	1,303.9
Service plans without income limits	26	463.2	9	241.6	30	764.5	15	637.7
Service plans with income limits	[4]44	929.5	23	684.9	[5]40	899.8	20	666.2
Income limits for— Individual / Family of— 2 persons / 3 or more persons								
$2,000 — $2,500 — $3,000	-	-	1	1.5	-	-	1	1.5
$2,400 — $3,200 — $4,000	1	6.5	-	-	1	6.5	-	-
$2,400 — $3,600 — $3,600	1	10.0	-	-	1	10.0	-	-
$2,400 — $4,000 — $4,000	1	6.6	-	-	1	6.6	-	-
$2,500 — $4,000 — $4,000	[6]8	139.0	4	23.4	5	111.9	2	7.3
$2,990 — $4,498 — $5,980	1	11.0	-	-	1	11.0	-	-
$3,000 — $4,000 — $5,000	3	46.0	-	-	3	46.0	-	-
$3,000 — $4,800 — $4,800	1	3.8	-	-	1	3.8	-	-
$3,000 — $5,000 — $5,000	2	11.4	2	11.4	2	11.4	2	11.4
$3,000 — $5,500 — $5,500	1	2.6	1	2.6	-	-	-	-
$3,750 — $5,000 — $5,000	1	1.3	1	1.3	1	1.3	1	1.3
$4,000 — $6,000 — $6,000	4	26.8	2	14.0	4	26.8	2	14.0
$5,000 — $5,000 — $5,000	1	1.0	1	1.0	1	1.0	1	1.0
$5,000 — $6,000 — $7,500	[6]6	27.3	1	5.8	6	27.3	1	5.8
$5,000 — $7,500 — $7,500	4	48.0	3	46.6	4	48.0	3	46.6
$6,000 — $6,000 — $6,000	1	4.4	-	-	1	4.4	-	-
$7,500 — $7,500 — $7,500[7]	8	583.8	7	577.3	8	583.8	7	577.3

[1] See footnotes 1 and 2, table 4. 293 and 103 plans provided surgical benefits for active and retired workers, respectively; 210 and 74 plans provided medical benefits, for active and retired workers, respectively.
[2] For workers with family coverage, the limits were applicable to the entire family income.
[3] Includes 1 plan which provides service benefits for hospital treatments and cash benefits for home and office treatments.
[4] Includes 34 plans which also provide this type of benefit for maternity disabilities.
[5] These plans do not provide medical benefits for maternity cases.
[6] Income limits under 5 of these plans were not applicable to maternity disabilities; under these 5 plans all women workers and dependent wives, regardless of income, received a cash allowance for disabilities resulting from pregnancy.
[7] Applicable only to worker's income.

Service benefits were provided workers and dependents by 70 and 67 plans, respectively. More than a third of these plans provided full service benefits.[18] The remaining 44 service plans utilized Blue Shield and provided service-with-income-limit benefits. The income limits specified in these 44 plans for single active workers and for those with 3 or more persons in their family are summarized below.[19] Most of the 11 plans which restricted service benefits to families with incomes of $4,000 or less covered workers in industries where annual earnings were relatively low (e.g., women's garments, tobacco products, toys, paper products, and building service). However, some of the plans with low limits covered workers in industries with relatively high annual earnings, such as public utilities and the manufacture of instruments and automotive parts.

Annual income limit[1]	Single individuals	Family (3 or more persons)
All service-with-income-limit plans	44	44
Under $3,000	12	0
$3,000 through $3,750	8	1
$4,000	4	10
$4,800 through $5,000	11	8
$5,500 through $6,000	1	7
$7,500	8	18

[1] Except for 8 plans which considered only the worker's income, the family limits applied to the income of the entire family, including the earnings of dependents.

The same type of benefit (cash or service) was furnished both workers and their dependents in all but 2 of 277 programs with surgical benefits for both groups (table 13). Under these two plans, service benefits were provided the worker and cash benefits were provided his dependents.

Surgical benefits were always available for procedures performed in the hospital and usually for those in the doctor's office or at home (table 11). However, some plans specifically limited benefits for care outside of the hospital to "minor" procedures.

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[18] Under some of the service-without-income-limit plans, certain minor surgical procedures were not covered, e.g., tonsillectomies; in others, a nominal charge was made in connection with certain minor procedures. Among the organizations that provided service surgical and medical benefits regardless of income were the Health Insurance Plan of Greater New York, the Kaiser Foundation Health Plan, the United Mine Workers Welfare and Retirement Fund, Group Health Insurance, Inc., and the St. Louis Labor Health Institute. For a summary description of some of these programs, see the appendixes of Digest of One Hundred Selected Health and Insurance Plans Under Collective Bargaining, Early 1958 (BLS Bull. 1236, October 1958).

[19] For more details, see table 12.

Table 13. Relationship of surgical benefits provided active workers and their dependents, retired workers and their dependents, and active and retired workers, late summer 1959[1]

(Workers in thousands)

Provision	Provision specified for both—					
	Active workers and their dependents		Retired workers and their dependents		Active and retired workers	
	Plans	Workers	Plans	Workers	Plans	Workers
Type of benefit (cash or service)	277	4,699.1	100	1,997.2	100	1,967.7
No variation	275	4,689.1	99	1,995.2	100	1,967.7
Variation	2	10.0	1	2.0	-	-
Benefit provided for:						
Most expensive operation	277	4,699.1	100	1,997.2	100	1,967.7
No variation	253	4,000.9	96	1,986.5	91	1,918.2
Variation	24	698.2	4	10.7	9	49.5
Appendectomy	277	4,699.1	100	1,997.2	100	1,967.7
No variation	253	4,000.9	196	1,986.5	93	1,931.2
Variation	24	698.2	4	10.7	7	36.5
Tonsillectomy	[2]276	4,519.1	([3])	([3])	([3])	([3])
No variation	204	3,197.1	([3])	([3])	([3])	([3])
Variation	[4]72	1,322.0	([3])	([3])	([3])	([3])

[1] See footnotes 1 and 2, table 4. 293, 282, 103, and 100 plans provided surgical benefits for active workers, dependents of active workers, retired workers, and dependents of retired workers, respectively.

[2] Excludes 1 plan which did not provide tonsillectomy benefits.

[3] Data on the tonsillectomy benefits for retired workers and their dependents were not analyzed.

[4] Includes 49 plans which provided less liberal allowances for dependent children, usually those under age 12, than for active workers and adult dependents.

For this study, surgical fee schedules, which are usually set forth in detail in plans with cash benefits and in those providing service benefits with income limits, were classified according to the allowance provided for the most expensive operation listed, commonly called the "maximum schedule allowance." Allowances specified for an appendectomy and a tonsillectomy, two of the more common surgical procedures, were also tabulated to indicate the variation in schedule allowances found among plans.[20]

The allowance provided for the most expensive operation ranged from $100 to $600 for workers and from $128 to $600 for dependents (tables 14 and 15). About two out of five plans specified a maximum schedule allowance of $300—the amount provided by the median plan. The maximum allowance averaged $307 for workers and $298 for dependents.

The allowances provided for an appendectomy ranged from $66.50 to $202.50 for workers and from $58.65 to $200 for dependents. However, the amount most frequently specified for each group was $150. The average allowance was $144 for workers and $138 for dependents. In the majority of plans, the amount provided for an appendectomy was one-half the allowance for the most

[20] The allowances described are the maximum amounts payable under the cash plans and service-with-income limit plans for each procedure. These plans pay only what the doctor charges if less than the maximum allowed by the plan. The amounts payable under the plans providing cash benefits on a co-insurance basis were not computable and, therefore, were excluded from this section.

Table 14. Appendectomy allowance by maximum schedule allowance for active workers, late summer 1959[1]

(Workers in thousands)

Maximum schedule allowance[2]	Total		Maximum allowance for appendectomy							
			$100		$125		Over $125 and under $150		$150	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances[3]	261	4,168.0	[4]58	434.8	[5]48	789.1	5	32.5	108	1,936.6
$150	8	67.7	8	67.7	-	-	-	-	-	-
$200	46	297.9	43	285.2	1	7.2	1	1.0	1	4.5
$225	16	97.3	3	26.4	-	-	-	-	13	70.9
$240	4	20.1	-	-	3	11.1	-	-	1	9.0
$250	36	797.7	2	9.3	27	664.0	1	11.5	1	18.0
$275	2	12.6	-	-	1	6.6	1	6.0	-	-
$300	[6]110	1,915.2	-	-	9	67.7	1	13.0	[6]86	1,699.8
$350	7	78.0	-	-	1	6.0	-	-	-	-
$360	2	94.6	-	-	-	-	-	-	2	94.6
$375	5	20.8	-	-	-	-	1	1.0	-	-
$400	3	47.0	-	-	-	-	-	-	1	19.3
$450	9	586.2	-	-	-	-	-	-	1	2.4
$500	7	40.2	-	-	5	25.3	-	-	1	8.1
$600	2	27.3	-	-	-	-	-	-	1	10.0
Other[7]	4	65.4	2	46.2	1	1.2	-	-	-	-
Average maximum schedule allowance[8]	$307									
Average allowance for appendectomy[8]	$144									

	Over $150 and under $175		$175		Over $175 and under $200		$200	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances[3]	13	664.9	11	103.0	3	38.9	[9]15	168.2
$150	-	-	-	-	-	-	-	-
$200	-	-	-	-	-	-	-	-
$225	-	-	-	-	-	-	-	-
$240	-	-	-		-	-	-	-
$250	4	63.1	-	-	1	31.8	-	-
$275	-	-	-	-	-	-	-	-
$300	-	-	1	8.2	1	3.3	12	123.2
$350	-	-	6	72.0	-	-	-	-
$360	-	-	-	-	-	-	-	-
$375	-	-	3	16.0	1	3.8	-	-
$400	-	-	-	-	-	-	2	27.7
$450	8	583.8	-	-	-	-	-	-
$500	-	-	1	6.8	-	-	-	-
$600	-	-	-	-	-	-	1	17.3
Other[7]	1	18.0	-	-	-	-	-	-

[1] See footnotes 1 and 2, table 4. 293 plans provided surgical benefits for active workers.

[2] Refers to the surgical fee allowance for the most expensive operation of all operations listed in the surgical schedule.

[3] Includes 44 service plans with income limits; the allowances under these plans were applicable to workers with individual or family income of more than specified limits. Excludes 6 plans which provided the cash benefits on a co-insurance basis.

[4] Includes 4 plans which provided an allowance of less than $100.

[5] Includes 4 plans which provided an allowance of $120.

[6] Includes 2 plans which provided a lesser amount during the first year of coverage.

[7] Includes 4 plans which provided maximum schedule allowances, respectively, of $100, $175, $213, and $430.

[8] Amount provided by each plan weighted by number of workers covered.

[9] Includes 1 plan which provided an allowance of $202.50.

Table 15. Appendectomy allowance by maximum schedule allowance for dependents of active workers, late summer 1959[1]

(Workers in thousands)

Maximum schedule allowance[2]	Total		Maximum allowance for appendectomy							
			$100		$125		Over $125 and under $150		$150	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances[3]	254	4,130.2	[4]63	513.3	[5]52	1,305.5	6	67.5	99	1,360.3
$150	12	89.2	12	89.2	-	-	-	-	-	-
$200	44	329.1	43	321.9	1	7.2	-	-	-	-
$225	17	96.9	3	26.4	-	-	-	-	14	70.5
$240	5	22.1	-	-	4	13.1	-	-	1	9.0
$250	38	1,298.1	2	9.3	30	1,178.4	2	41.5	-	-
$275	2	12.6	-	-	1	6.6	1	6.0	-	-
$300	[6]98	1,318.5	1	17.0	9	67.7	1	13.0	[6]78	1,146.4
$350	7	78.0	-	-	1	6.0	-	-	-	-
$360	2	94.6	-	-	-	-	-	-	2	94.6
$375	4	17.0	-	-	-	-	1	1.0	-	-
$400	2	45.7	-	-	-	-	-	-	1	19.3
$450	9	586.2	-	-	-	-	-	-	1	2.4
$500	7	40.2	-	-	5	25.3	-	-	1	8.1
$600	2	27.3	-	-	-	-	-	-	1	10.0
Other[7]	5	74.7	2	49.5	1	1.2	1	6.0	-	-
Average maximum schedule allowance[8]	$298									
Average allowance for appendectomy[8]	$138									

	Over $150 and under $175		$175		Over $175 and under $200		$200	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances[3]	12	638.9	11	103.0	2	35.1	9	106.6
$150	-	-	-	-	-	-	-	-
$200	-	-	-	-	-	-	-	-
$225	-	-	-	-	-	-	-	-
$240	-	-	-	-	-	-	-	-
$250	3	37.1	-	-	1	31.8	-	-
$275	-	-	-	-	-	-	-	-
$300	-	-	1	8.2	1	3.3	7	62.9
$350	-	-	6	72.0	-	-	-	-
$360	-	-	-	-	-	-	-	-
$375	-	-	3	16.0	-	-	-	-
$400	-	-	-	-	-	-	1	26.4
$450	8	583.8	-	-	-	-	-	-
$500	-	-	1	6.8	-	-	-	-
$600	-	-	-	-	-	-	1	17.3
Other[7]	1	18.0	-	-	-	-	-	-

[1] See footnotes 1 and 2, table 4. 282 plans provided surgical benefits for dependents of active workers.
[2] See footnote 2, table 14.
[3] Includes 44 service plans with income limits; the allowances under these plans were applicable to dependents with family incomes which exceeded the specified limits. Excluded 5 plans which provided the cash benefits on a co-insurance basis.
[4] Includes 5 plans which provided an allowance of less than $100.
[5] See footnote 5, table 14.
[6] See footnote 6, table 14.
[7] Includes 5 plans which provided maximum schedule allowances, respectively, of $128, $133, $175, $260, and $430.
[8] See footnote 8, table 14.

Table 16. Tonsillectomy allowance for active workers and their dependents, late summer 1959[1]

(Workers in thousands)

Tonsillectomy allowance	Workers		Dependents			
			Adults		Children[2]	
	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances[3]	261	4,168.0	254	4,130.2	254	4,130.2
Under $25	1	1.2	4	86.0	4	86.0
$25	7	61.6	10	58.6	11	59.8
$30	38	284.2	38	320.9	57	643.4
$30.01 and under $35	2	46.0	-	-	-	-
$35	6	53.3	4	36.8	10	175.6
$35.01 and under $40	22	397.1	26	911.7	30	976.3
$40	6	44.4	6	44.4	8	65.6
$40.01 and under $45	6	71.7	5	45.7	6	49.7
$45	[4]48	985.1	[4]41	421.1	[4]44	436.8
$45.01 and under $50	1	15.8	1	15.8	-	-
$50	60	945.4	60	964.5	47	700.5
$50.01 and under $60	12	141.0	11	116.0	12	87.4
$60	21	252.6	18	243.9	6	73.4
$60.01 and under $70	16	665.5	16	665.5	13	622.2
$70 and under $80	13	194.9	13	194.9	6	153.5
$80 and over	2	8.2	1	4.4	-	-
Average tonsillectomy allowance[5]	$50		$49		$45	

[1] See footnotes 1 and 2, table 4. 293 and 282 plans provided surgical benefits for active workers and their dependents, respectively.

[2] The data reflects lower allowances provided by 49 plans for young children, usually those age 12 or under.

[3] Includes 44 service plans with income limits; the allowances under these plans were applicable to active workers and their dependents with individual or family incomes of more than specified limits. Excludes 6 plans covering active workers and 5 plans covering dependents which provided the cash benefits on a co-insurance basis.

[4] See footnote 6, table 14.

[5] See footnote 8, table 14.

expensive operation. However, plans with high maximum schedule allowances (over $350) had appendectomy allowances that ranged from 25 percent to 47 percent, but most frequently 35 percent, of the maximum schedule allowance. Conversely, under plans with a low maximum schedule allowance (under $200) the appendectomy allowance was at least two-thirds of the allowance for the most expensive operation.

Tonsillectomy allowances for workers ranged from $16.50 to $93.75; for adult dependents, from $20.40 to $91; and for child dependents, from $20.40 to $78. The median plan provided $45 for workers and dependents (table 16). All except 10 of the 44 plans providing service benefits with income limits had tonsillectomy allowances within the range of $50 to $67.50. In 49 plans, children under a stated age (e.g., 12 years) were provided smaller allowances than other dependents. With few exceptions, these plans provided adult dependents $50 or more and dependent children less than $50. The average allowance for workers was $50; for adult dependents, $49; and for child dependents (12 years or under in most plans), $45.

The allowances paid by service plans with income limit were higher, on the average, than those paid by the cash benefit plans. For example, the average appendectomy allowance provided by the service plans was 5 percent more for workers and 10 percent more for dependents than the average paid by the cash benefit plans. The differences between the allowances for the more complicated procedures were substantially greater. For example, the maximum allowance provided by the service plans averaged about 50 percent more than that provided by the cash benefit plans.

Identical allowances for all surgical procedures were provided workers and adult dependents in 226 of the 248 programs with cash allowances for both groups. Where a lower benefit was made available for the adult dependent, it was usually at least 60 percent of the amount provided the worker.

The maximum schedule allowance provided both workers and dependents increased by about 17 percent, on the average, since late 1955. The appendectomy allowances rose by 13 percent on the average, and tonsillectomy allowances for workers and adult dependents by approximately 17 percent. A slightly larger increase occurred in the tonsillectomy allowance provided dependent children. [21]

Reduction of Benefits During Active Employment.—Surgical benefits provided workers and dependents were modified by only four small plans during a worker's active employment (table 17). Two plans reduced benefits when the insured individual (worker or spouse) reached age 60. Under one of these plans,

Table 17. Maintenance of surgical and medical benefits during active employment for active workers and their dependents, late summer 1959 [1]

(Workers in thousands)

Provision	Surgical benefits				Medical benefits			
	Workers		Dependents		Workers		Dependents	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing benefits	293	4,837.0	282	4,759.1	210	3,684.2	182	3,431.4
Maintained at constant level regardless of age	289	4,826.3	278	4,748.4	203	3,662.0	180	3,425.8
Reduced at age—								
60	2	6.3	2	6.3	5	16.6	-	-
65	-	-	-	-	1	2.5	1	2.5
Discontinued at age—								
65	1	3.1	1	3.1	1	3.1	1	3.1
70	1	1.3	1	1.3	-	-	-	-

[1] See footnotes 1 and 2, table 4.

individuals over age 60 could receive only half of the benefits available to them prior to that age. Under the other plan, the maximum amount payable was reduced from $200 per disability before age 60 to $200 per year for individuals over 60. Surgical benefits were discontinued by one plan at age 65, and by another at age 70.

[21] These increases compare with a 6-percent increase from December 1955 to September 1959 in the Bureau of Labor Statistics index of surgeons' fees for an appendectomy and with a 12-percent increase for a tonsillectomy (see BLS Consumer Price Index: Price Indexes for Selected Items and Groups, September 1959 and February 1960 issues).

Retired Workers and Their Dependents.[22]—Identical surgical benefits were provided active and retired workers by 70 of the 100 plans with benefits for both groups (table 5). About the same number of plans (72) provided dependents of retired workers with benefits identical to those available to active workers' dependents. The remaining plans reduced benefits by either of two methods. One method, the one most frequently used, limited the amount of benefits provided during the entire retirement period. For example, after retirement, the maximum schedule allowance under some plans became the lifetime limit on the amount the retiree or his spouse could receive; thus, one expensive operation might exhaust surgical coverage for a person. Other plans specified a maximum amount applicable to all surgical, hospital, and where provided, medical expenses. Some plans applied these restrictions to the benefits available to a retired worker's entire family rather than to each individual. The second method was to reduce benefit levels directly, i.e., the schedule of allowances was lower than that provided active workers and their dependents.

Retired workers and their dependents continued to be covered by the same type of benefits—cash or service—that was available to them during active employment (table 13). Almost a third of the service-without-income-limit plans and over half of the 44 service-with-income-limit plans that covered active workers and their dependents extended these types of benefits to retired workers and their dependents (table 11). As shown below, income limits in the 23 service-with-income-limit plans covering retired workers and their dependents were, with only one exception, $4,000 or higher for a pensioner and his spouse—probably high enough to provide most retired workers and their spouses with service benefits (table 12).

Annual income limit	Single individuals	Family (2 persons)
All service-with-income-limit plans	23	23
Under $3,000	5	1
$3,000 through $3,750	4	-
$4,000	2	4
$4,800 through $5,000	5	4
$5,500 through $6,000	-	4
$7,500	7	10

The maximum amount payable for the most expensive operation (the maximum schedule allowance) ranged from $150 to $500 in the 90 plans that provided cash allowances for retired workers and the 88 plans covering their dependents (tables 18 and 19).[23] The maximum allowance averaged about $325 for each group.[24] The appendectomy allowance provided retired workers varied from $75 to $200 and from $75 to $175 for their dependents—averaging $138 for each group.

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[22] See footnote 7.

[23] The allowances described here are the amounts payable under the cash plans and the service-with-income-limit plans. The amounts payable by the four plans providing cash benefits on a co-insurance basis were not computable and, therefore, were excluded.

[24] The average maximum schedule allowances for retired workers were greater than for active workers because benefits were extended to retired workers by a higher proportion of the high benefit plans than of the low benefit plans.

Table 18. Appendectomy allowance by maximum schedule allowance for retired workers, late summer 1959 [1]

(Workers in thousands)

Maximum schedule allowance [2]	Total		Maximum allowance for appendectomy			
			$100		$125	
	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances [3]	90	1,635.9	[4] 17	141.0	[5] 23	626.8
$150	1	35.0	1	35.0	-	-
$180	1	10.0	1	10.0	-	-
$200	13	87.1	12	84.1	-	-
$225	7	48.5	2	10.4	-	-
$240	1	3.0	-	-	1	3.0
$250	19	617.8	-	-	18	606.3
$275	1	6.0	-	-	-	-
$300	34	213.1	1	1.5	2	5.7
$350	2	10.0	-	-	1	6.0
$375	2	3.0	-	-	-	-
$400	1	19.3	-	-	-	-
$450	7	577.3	-	-	-	-
$500	1	5.8	-	-	1	5.8
Average maximum schedule allowance [6]	$325					
Average allowance for appendectomy [6]	$138					

Maximum schedule allowance [2]	Maximum allowance for appendectomy—Continued					
	Over $125 and under $150		$150		Over $150	
	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances [3]	3	18.5	37	265.3	10	584.3
$150	-	-	-	-	-	-
$180	-	-	-	-	-	-
$200	-	-	1	3.0	-	-
$225	-	-	5	38.1	-	-
$240	-	-	-	-	-	-
$250	1	11.5	-	-	-	-
$275	1	6.0	-	-	-	-
$300	-	-	30	204.9	[7] 1	1.0
$350	-	-	-	-	[8] 1	4.0
$375	1	1.0	-	-	[8] 1	2.0
$400	-	-	1	19.3	-	-
$450	-	-	-	-	[9] 7	577.3
$500	-	-	-	-	-	-

[1] See footnotes 1 and 2, table 4. 103 plans provided surgical benefits for retired workers.
[2] See footnote 2, table 14.
[3] Includes 23 service plans with income limits; the allowances under these plans were applicable to retired workers with individual or family income of more than specified limits. Excludes 4 plans which provided the cash benefits on a co-insurance basis.
[4] Includes 3 plans which provided an allowance of under $100.
[5] Includes 1 plan which provided an allowance of $120.
[6] See footnote 8, table 14.
[7] Plan provided an allowance of $200.
[8] Plan provided an allowance of $175.
[9] Plans provided an allowance of $157.50.

Table 19. Appendectomy allowance by maximum schedule allowance for dependents of retired workers, late summer 1959 [1]

(Workers in thousands)

Maximum schedule allowance [2]	Total		Maximum allowance for appendectomy			
			$100		$125	
	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing cash allowances [3]	88	1,627.9	[4] 18	142.3	[5] 24	632.2
$150	2	36.3	2	36.3	-	-
$180	1	10.0	1	10.0	-	-
$200	13	87.1	12	84.1	-	-
$225	8	49.5	2	10.4	-	-
$240	1	2.0	-	-	1	2.0
$250	20	624.2	-	-	19	612.7
$275	1	6.0	-	-	-	-
$300	29	197.4	1	1.5	2	5.7
$350	2	10.0	-	-	1	6.0
$375	2	3.0	-	-	-	-
$400	1	19.3	-	-	-	-
$450	7	577.3	-	-	-	-
$500	1	5.8	-	-	1	5.8
Average maximum schedule allowance [6]	$324					
Average allowance for appendectomy [6]	$138					

Maximum schedule allowance [2]	Maximum allowance for appendectomy—Continued					
	Over $125 and under $150		$150		Over $150	
All plans providing cash allowances [3]	3	18.5	34	251.6	9	583.3
$150	-	-	-	-	-	-
$180	-	-	-	-	-	-
$200	-	-	1	3.0	-	-
$225	-	-	6	39.1	-	-
$240	-	-	-	-	-	-
$250	1	11.5	-	-	-	-
$275	1	6.0	-	-	-	-
$300	-	-	26	190.2	-	-
$350	-	-	-	-	[7] 1	4.0
$375	1	1.0	-	-	[7] 1	2.0
$400	-	-	1	19.3	-	-
$450	-	-	-	-	[8] 7	577.3
$500	-	-	-	-	-	-

[1] See footnotes 1 and 2, table 4. 100 plans provided surgical benefits for dependents of retired workers.
[2] See footnote 2, table 14.
[3] Includes 23 service plans with income limits; the allowances under these plans were applicable to retired workers' dependents with family income of more than specified limits. Excludes 4 plans which provided the cash benefits on a co-insurance basis.
[4] See footnote 4, table 18.
[5] See footnote 5, table 18.
[6] See footnote 8, table 14.
[7] See footnote 8, table 18.
[8] See footnote 9, table 18.

Virtually all of the plans provided surgical benefits for the entire retirement period. Of the six plans covering retired workers and five covering their dependents that did not provide benefits during the entire retirement period, four of them provided benefits only during the first year.

Medical Benefits

Some medical benefits—usually only doctors' visits in the hospital—were provided by 7 out of 10 of the 300 plans analyzed. With one exception, every plan restricted medical benefit coverage to nonoccupational disabilities.[25] Only 35 plans provided medical benefits for maternity as well as nonmaternity cases.[26]

Disabilities covered	Workers		Dependents	
	Plans	Workers (thousands)	Plans	Workers (thousands)
All plans providing medical benefits	210	3,684.2	182	3,431.4
Nonmaternity and maternity	35	635.0	35	732.5
Nonmaternity only	175	3,049.2	147	2,698.9

Active Workers' and Dependents' Nonmaternity Benefits.—Coverage for physicians' care during hospital confinement was provided by almost all plans (table 20). Doctors' services used by workers outside of the hospital, either at the doctor's office, at the health center, or at home, were covered by slightly less than half of the plans (100). Only 1 out of 4 plans (46) provided out-of-hospital medical benefits for dependents.

Cash medical benefits were provided workers under 140 plans and their dependents under 115 plans (table 20).[27] Usually the plan specified the maximum amount payable per visit for medical care by a general practitioner or specialist (e.g., up to $5), and the maximum allowance per disability (e.g., up to $300).[28] However, as in the case of surgical benefits, six plans covering workers and five plans covering their dependents provided the cash medical benefits on a co-insurance basis.

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[25] The plan which provided medical benefits for occupational disabilities paid the difference between the workmen's compensation benefit and the benefit provided under the plan.

[26] Many plans provided only hospital maternity benefits and benefits for obstetrical procedures. The hospital benefits are described in Health and Insurance Plans Under Collective Bargaining: Hospital Benefits, Early 1959 (BLS Bull. 1274, 1960); and the obstetrical as well as medical maternity benefits are described in this report, pp. 33–39).

[27] See footnote 16.

[28] Although most plans limited reimbursements to charges made by licensed physicians, some plans provided the same or different allowances for treatment rendered by chiropractors or Christian Science practitioners. These allowances are not discussed in this report.

Table 20. Types of medical benefits and location of medical care of nonmaternity disabilities by groups eligible, late summer 1959[1]

(Workers in thousands)

Type and location	Active workers		Dependents of active workers		Retired workers		Dependents of retired workers	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
All plans providing benefits	210	3,684.2	182	3,431.4	*74	*1,675.4	*71	*1,579.5
Benefit provided in form of—								
Cash	140	2,019.9	115	1,786.0	*39	* 371.5	*39	* 372.2
Service	[2]70	1,664.3	[2]67	1,645.4	[2]35	1,303.9	[2]32	1,207.3
With income limits	40	899.8	40	899.8	20	666.2	20	666.2
Without income limits	[2]30	764.5	[2]27	745.6	[2]15	637.7	[2]12	541.1
Benefit provided for medical care in—								
Hospital, doctor's office, and home[3]	93	1,630.8	37	603.0	16	112.7	9	71.8
Hospital and doctor's office[3]	1	10.0	4	42.0	1	35.0	2	39.0
Hospital and home	1	2.7	-	-	-	-	-	-
Hospital only	110	1,731.0	136	2,476.7	51	1,131.6	56	1,167.2
Doctor's office only[3]	[4]5	309.7	[4]5	309.7	[4]6	396.1	[4]4	301.5

[1] See footnotes 1 and 2, table 4.
[2] Includes 1 plan which provided service benefits for hospital visits and cash benefits for home and office visits.
[3] For this table "medical" or "health" center was considered "doctor's office."
[4] These plans provided benefits only for visits to the medical center.
* Preliminary data published in the July issue of the Monthly Labor Review (p. 712, table 2) have been revised.

Of the 70 and 67 plans that provided service benefits to workers and dependents, respectively, 40 using Blue Shield programs provided service-with-income-limit benefits for a specified number of treatments. The patient was responsible for the cost of additional treatments. These plans, like cash plans, covered general practitioners' or specialists' visits, and limited the maximum allowance payable for each visit and for all visits during a single disability. The income limits specified for single active workers and for workers with three or more persons in their family are summarized below.[29]

Annual income limit[1]	Single individuals	Family (3 or more persons)
All service-with-income-limit plans	40	40
Under $3,000	9	-
$3,000 through $3,750	7	1
$4,000	4	7
$4,800 through $5,000	11	8
$5,500 through $6,000	1	6
$7,500	8	18

[1] Except for 8 plans which considered only the worker's income, the family limits applied to the income of the entire family, including the earnings of dependents.

[29] For more details, see table 12.

Table 21. Relationship of medical benefits provided active workers and their dependents, retired workers and their dependents, and active and retired workers, late summer 1959[1]

(Workers in thousands)

Provision	Provision specified for both—					
	Active workers and their dependents		Retired workers and their dependents		Active and retired workers	
	Plans	Workers	Plans	Workers	Plans	Workers
Type of plan (cash or service)	179	3,377.4	72	1,695.5	73	1,754.4
No variation	178	3,375.4	71	1,693.5	71	1,659.8
Variation	1	2.0	1	2.0	2	94.6
Location of visits covered	179	3,377.4	72	1,695.5	73	1,754.4
No variation	149	2,617.7	66	1,655.9	66	1,634.5
Variation	30	759.7	6	39.6	7	119.9
Waiting requirement for sickness benefits in the:						
Hospital	174	3,067.7	68	1,394.0	67	1,358.3
No variation	171	3,037.2	68	1,394.0	66	1,351.0
Variation	3	30.5	-	-	1	7.3
Doctor's office[2]	44	917.7	12	226.8	16	221.4
No variation	43	891.7	12	226.8	16	221.4
Variation	1	26.0	-	-	-	-
Home	37	603.0	10	187.8	16	221.4
No variation	36	577.0	10	187.8	16	221.4
Variation	1	26.0	-	-	-	-
Waiting requirement for accident benefits in the:						
Hospital	174	3,067.7	68	1,394.0	67	1,358.3
No variation	174	3,067.7	68	1,394.0	66	1,351.0
Variation	-	-	-	-	1	7.3
Doctor's office[2]	44	917.7	12	226.8	16	221.4
No variation	44	917.7	12	226.8	15	220.1
Variation	-	-	-	-	1	1.3
Home	37	603.0	10	187.8	16	221.4
No variation	37	603.0	10	187.8	15	220.1
Variation	-	-	-	-	1	1.3
Benefit provided for each visit or day of visits in the:						
Hospital	174	3,067.7	68	1,394.0	67	1,358.3
No variation	165	2,501.5	67	1,392.0	66	1,351.0
Variation	9	566.2	1	2.0	1	7.3
Doctor's office[2]	44	917.7	12	226.8	16	221.4
No variation	44	917.7	12	226.8	16	221.4
Variation	-	-	-	-	-	-
Home	37	603.0	10	187.8	16	221.4
No variation	37	603.0	10	187.8	16	221.4
Variation	-	-	-	-	-	-
Maximum benefit provided during a specified period	179	3,377.4	72	1,695.5	73	1,754.4
No variation	151	2,633.9	71	1,693.5	69	1,642.5
Variation	28	743.5	1	2.0	4	111.9

[1] See footnotes 1 and 2, table 4, and footnote 1, table 5.
[2] For this table "medical" or "health" center was considered "doctor's office."

Table 22. Waiting requirements for nonmaternity medical benefits for active workers and their dependents by location of medical care, late summer 1959[1]

(Workers in thousands)

When benefits begin	Medical care in—					
	Hospital		Doctor's office		Home	
	Plans	Workers	Plans	Workers	Plans	Workers
Active Workers						
All plans providing medical benefits[2]	199	3,168.7	88	1,435.0	88	1,427.7
For sickness—						
Immediately	161	2,783.8	36	443.9	34	429.9
After—						
First visit	10	52.6	15	129.2	15	129.2
Second visit	8	83.8	19	188.5	19	188.5
Third visit	4	80.9	9	598.7	11	605.4
Fourth visit	-	-	1	12.0	1	12.0
First day of disability	2	27.6	2	27.6	2	27.6
Second day of disability	-	-	1	1.8	1	1.8
Seventh day of disability	5	33.3	5	33.3	5	33.3
Third day of hospitalization	8	85.7	-	-	-	-
Fourth day of hospitalization	1	21.0	-	-	-	-
For accidents—						
Immediately	187	3,048.4	77	866.6	75	852.6
After—						
First visit	-	-	1	500.0	1	500.0
Second visit	2	28.2	4	33.6	4	33.6
Third visit	-	-	3	16.4	5	23.1
Fourth visit	-	-	1	12.0	1	12.0
Third day of disability	1	4.9	1	4.9	1	4.9
Seventh day of disability	1	1.5	1	1.5	1	1.5
Third day of hospitalization	8	85.7	-	-	-	-
Dependents						
All plans providing medical benefits[2]	172	2,937.1	36	460.4	32	418.4
For sickness—						
Immediately	156	2,760.5	24	326.0	22	321.0
After—						
First visit	2	19.7	2	16.4	2	16.4
Second visit	4	48.7	8	115.1	6	78.1
Third visit	-	-	1	1.4	1	1.4
Seventh day of disability	1	1.5	1	1.5	1	1.5
Third day of hospitalization	8	85.7	-	-	-	-
Fourth day of hospitalization	1	21.0	-	-	-	-
For accidents—						
Immediately	163	2,849.9	33	453.5	29	411.5
After—						
Second visit	-	-	2	5.4	2	5.4
Seventh day of disability	1	1.5	1	1.5	1	1.5
Third day of hospitalization	8	85.7	-	-	-	-

[1] See footnotes 1 and 2, table 4. 210 and 182 plans provided medical benefits for active workers and their dependents, respectively.

[2] Excludes plans which provided benefits only for treatment in the medical or health center and plans under which the waiting period was not directly related to the number of visits or days of disability, i.e., plans that provided the cash benefits on a co-insurance basis.

Most single-employer service benefit plans were service-with-income-limit plans, but most multiemployer service benefit plans were service-without-income-limit plans. These all-service plans provided general medical and specialist services in the doctor's office or at health centers and, with few exceptions, in the hospital or at the home as well.[30] Insured individuals were encouraged to use the health centers for preventive care.

With one exception, the 179 plans providing benefits to both workers and dependents covered both groups with the same type of benefit (table 21).

Although plans that provided service benefits to all members, regardless of income, made these benefits available immediately, plans providing cash allowances (cash and service-with-income-limit benefits) stipulated the number of visits or days after the onset of each disability for which no benefits were payable. Generally, the requirements for accident benefits were more liberal than for sickness benefits, and those for in-hospital care more liberal than those applying to home and office visits. Only a small proportion of patients received these preferences, however, because of the low frequency of accident and in-hospital cases. More than 9 out of 10 of the plans made in-hospital benefits available immediately if the disability was the result of an accident (table 22). In-hospital medical benefits for workers under 8 out of 10 plans were immediately available if their confinement was caused by illness; but only 2 out of 5 plans provided immediate coverage of illness treated in the home or office. With few exceptions, the waiting requirements for dependents' benefits were the same as for workers (table 21).

Although medical benefits were, in general, based on the number of visits made by the physician or the patient, many cash plans restricted benefits to one call a day. They usually accomplished this by basing the maximum payment on the number of days' treatment or number of days the patient was in the hospital.

In all plans providing cash or service-with-income-limit benefits, the allowance per visit or per day for home and office care remained the same throughout the entire period of disability.[31] However, in some plans, the allowance for hospital visits was greater in the first 1 to 10 days than subsequently. A few plans paid the allowance on a per visit basis during the first 1 or 2 days of confinement; thereafter, the benefit was payable on a per day basis. Plans using this method stipulated the maximum number of visits that would be covered on a per visit basis.

Although the maximum cash allowance[32] for each hospital visit or day of treatment in the hospital varied considerably, ranging from $2.50 to $7.50, almost 60 percent of the plans paid $4 or more and about half that proportion provided $5 or more (table 23).[33] The average in-hospital allowance provided under

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[30] See footnote 18.

[31] A separate disability was usually described as being due to a different or unrelated cause or separated by a return to work or by a specified period of time.

[32] The plans pay only what the doctor charges if less than the maximum allowed by the plan. The amounts payable by the few plans that provided the benefits on a co-insurance basis were not computable and, therefore, were not included.

[33] For plans providing higher allowances for the first few visits or days, the lower amounts which applied subsequently were used for this study; for plans providing a higher allowance for an extended number of visits or days and then a reduced amount, the higher amounts were used.

Table 23. Cash allowances for nonmaternity medical care provided active workers and their dependents by location of medical care, late summer 1959[1]

(Workers in thousands)

Maximum allowance per treatment or per day[2]	Medical care provided in—					
	Hospital		Doctor's office		Home	
	Plans	Workers	Plans	Workers	Plans	Workers
Active workers						
All plans providing cash allowances[3]	174	2,713.9	66	1,174.5	66	1,167.2
$2	-	-	13	103.3	-	-
$3	67	638.6	31	354.9	15	98.6
$3.50	2	31.0	2	18.1	1	16.0
$4	37	883.2	16	645.1	6	41.4
$4.50	4	41.4	-	-	3	31.4
$5	47	439.6	2	4.3	29	854.5
$6	11	598.0	-	-	9	75.5
$7.50	2	15.3	-	-	-	-
Other[4]	4	66.8	2	48.8	3	49.8
Average allowance[5]	$4.33		$3.43		$4.73	
Dependents						
All plans providing cash allowances[3]	150	2,501.2	18	226.5	15	185.5
$2	-	-	2	38.9	-	-
$3	59	1,089.8	10	152.8	2	38.9
$3.50	2	31.0	1	7.5	-	-
$4	37	411.5	4	24.0	3	11.1
$4.50	1	10.0	-	-	-	-
$5	37	341.6	1	3.3	8	114.0
$6	10	594.2	-	-	2	21.5
$7.50	2	15.3	-	-	-	-
Other[4]	2	7.8	-	-	-	-
Average allowance[5]	$4.20		$2.98		$4.64	

[1] See footnotes 1 and 2, table 4. 210 and 182 plans provided medical benefits for active workers and their dependents, respectively.

[2] For plans providing higher allowances for the first few visits or days, the lower amounts which applied subsequently were used for the purposes of this tabulation; for plans providing a higher allowance for an extended number of visits or days and then a reduced amount, the higher amounts were used.

[3] Includes the allowances provided under the 40 service-with-income-limit plans; excludes 6 plans covering workers and 5 plans covering dependents which provided the cash benefits on a co-insurance basis.

[4] Includes plans with amounts other than the exact amounts specified above.

[5] See footnote 8, table 14.

these plans was $4.33 for workers and $4.20 for dependents. Allowances for office visits were usually less than the amount provided for in-hospital care; the allowance for office visits averaged $3.43 for workers and $2.98 for their dependents.

The amount payable for each visit to the patient's home was generally higher than that provided for treatment in the doctor's office or, less often, in the hospital. About 3 out of 5 of the 66 plans providing allowances for home care for workers paid $5 or more for each home treatment. The average allowance for workers was $4.73 per home visit; for dependents, under only 15 plans, it was slightly less.

Additional allowances were provided by some plans for night calls, or if more than one member of the family was treated during the same visit, or if the home visit took place more than a given distance from the doctor's office.

An evaluation of the maximum protection for lengthy disabilities as provided by cash allowance plans may be based, in part, on the maximum amount

payable during a single disability or a specified period.[34] Although cash allowance plans usually provide a maximum amount for each disability, 23 plans covering workers and 19 plans covering dependents applied maximum allowances to all treatments received during a 6- or 12-month period (table 24). Under these plans, the amount available after the first disability was the unused portion of

Table 24. Maximum cash allowance for nonmaternity medical care for active workers and their dependents by basis of payment, late summer 1959[1]

(Workers in thousands)

Maximum allowance for all visits	Total		Basis of payment					
			Per disability		Per year		Other	
	Plans	Workers	Plans	Workers	Plans	Workers	Plans	Workers
Active workers								
All plans providing cash allowances[2]	[3] 174	2,713.9	141	1,855.8	16	196.5	[4] 17	661.6
Under $100	12	72.9	12	72.9	-	-	-	-
$100 and under $150	9	179.0	7	149.0	2	30.0	-	-
$150 and under $200	26	236.3	23	154.0	2	54.3	1	28.0
$200 and under $250	23	240.8	19	203.7	4	37.1	-	-
$250 and under $300	20	207.9	14	147.4	1	1.7	5	58.8
$300 and under $350	13	71.4	7	40.2	2	11.4	4	19.8
$350 and under $400	18	174.8	17	160.1	-	-	1	14.7
$400 and under $500	12	128.4	9	73.4	2	43.0	1	12.0
$500 and under $600	6	68.5	4	51.5	1	10.6	1	6.4
$600 and under $700	21	681.7	19	663.8	-	-	2	17.9
$700 and over	9	539.0	5	26.6	2	8.4	2	504.0
Other	5	113.2	5	113.2	-	-	-	-
Average maximum allowance[5]	$517							
Dependents								
All plans providing cash allowances[2]	[3] 150	2,501.2	127	2,232.3	17	213.6	[6] 6	55.3
Under $100	14	90.2	13	67.1	-	-	1	23.1
$100 and under $150	12	666.0	10	648.0	1	16.0	1	2.0
$150 and under $200	15	146.1	12	82.2	2	54.3	1	9.6
$200 and under $250	22	241.7	18	210.5	4	31.2	-	-
$250 and under $300	15	163.3	12	124.6	3	38.7	-	-
$300 and under $350	8	60.3	5	38.3	3	22.0	-	-
$350 and under $400	18	182.8	17	168.1	-	-	1	14.7
$400 and under $500	14	140.1	11	90.7	3	49.4	-	-
$500 and under $600	4	27.9	4	27.9	-	-	-	-
$600 and under $700	19	654.7	18	652.8	-	-	1	1.9
$700 and over	5	24.9	3	18.9	1	2.0	1	4.0
Other	4	103.2	4	103.2	-	-	-	-
Average maximum allowance[5]	$332							

[1] See footnotes 1 and 2, table 4. 210 and 182 plans provided medical benefits for active workers and their dependents, respectively.
[2] See footnote 3, table 23.
[3] Excludes 1 plan which provided service benefits for hospital visits and cash benefits for home and office visits.
[4] Includes 7 plans under which the basis of payment was a 6-month period.
[5] See footnote 8, table 14.
[6] Includes 2 plans under which the basis of payment was a 6-month period.

[34] Where the maximum allowance was not specified it was computed by multiplying the allowances per visit or per day by the number of visits or days for which benefits were payable. Under plans providing different allowances for hospital, office, and home care, the most liberal allowance was used in computing the maximum allowance.

the maximum allowance provided for the year or 6-month period. A few plans specified separate maximum allowances for hospital visits and for home and office visits. Under these plans the total allowance for hospital care was payable on a per disability basis, and the maximum amount for home and office treatment on a per year or 6-month basis.[35]

The maximum allowance (per disability, year, or half year) in the 174 plans providing cash allowances for workers ranged from $51 to $2,500. The range for dependents was about the same. About one out of five plans, including a few covering a large number of workers, paid $500 or more. The average maximum allowance for workers was $517 and for dependents, $332.[36]

Thirty plans that provided benefits for workers, regardless of the location of visits, covered only the in-hospital treatment of dependents (table 21). Also, nine plans paid dependents smaller benefits for in-hospital medical treatment. Both of these types of reductions usually, although not always, reduced the maximum benefit. Altogether, maximum benefits were lower for dependents than for active workers in 28 plans. With these exceptions, workers and dependents were usually provided identical medical benefits (table 5) just as they usually received identical hospital and surgical benefits.

An allowance for specialist consultation, if requested by the attending physician, was provided workers by 34 plans, and dependents by 32 plans. Most of the plans covered only one such consultation per disability and paid $10 or $15 toward the specialist's charge.

Reduction of Benefits During Active Employment.—Workers' medical benefits were reduced in only six plans during active employment (table 17). Five plans limited workers over 60 to the same number of treatments in a year as was previously available for each disability, and one plan reduced from 70 to 31 the maximum number of days of benefits when the individual reached age 65. Only one plan discontinued benefits for workers and their dependents when they reached an advanced age—age 65 in this case.

Retired Workers and Their Dependents.[37]—Retired workers and their dependents were extended benefits by 74 and 71 plans, respectively (table 3). About two-thirds of these plans provided identical benefits for both active and retired workers and to the dependents of active and retired workers (table 5). The remaining plans reduced benefits for retired workers and their dependents by one or more of the following methods: (1) Restricting the location of treatments; (2) narrowing the basis of payment; or (3) placing an overall maximum on the amount payable for medical, surgical, and hospital expenses incurred during the retirement period. Plans utilizing the first method generally limited benefits to in-hospital care. Those using the second method usually provided the same schedule allowances available prior to retirement, but restricted the total amount payable during the retirement period to the maximum previously

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[35] For this report, the maximum allowance under each of these plans was the sum of the two separate allowances.

[36] The substantial difference in average maximum allowances for workers and dependents is attributable to several factors. A few of the large plans (in terms of workers covered) did not provide benefits for dependents. Many plans provided more comprehensive coverage for workers than dependents. In a few plans, benefits were available to workers for a longer period of time than for dependents. In some others, the allowance per visit was greater for workers than for dependents.

[37] See footnote 7.

payable for each disability. For example, one plan that would pay active workers up to $3 for each day of hospital confinement with a maximum allowance of $93 for each disability, allowed pensioners a maximum of $93 for the rest of their lives. Plans utilizing the third method of curtailing medical benefits, like those using the second method, provided the same allowances for retired as for active workers, but added an overall lifetime limit for all health benefits. One plan, for example, would pay retired workers no more than $1,500 for all medical care expenses (hospital, surgical, and medical) incurred after retirement.

Cash benefits were provided by more than half of the 74 and 71 plans with benefits for retired workers and their dependents, respectively (table 20). All except three of these plans paid specified allowances for doctors' treatments.[38] Service benefits were provided retired workers by the remaining 35 plans, and their dependents by the remaining 32 plans; 20 of these plans provided service-with-income-limit benefits for both retired workers and their dependents. As in the case of surgical benefits, these limits appeared, on the whole, to be high relative to the reduced incomes of retired workers (table 12).

Only in-hospital care was provided retired workers and their dependents by 51 and 56 plans, respectively. Under all but one plan, allowances for visits to retirees and dependents confined to the hospital were payable beginning with the doctor's first visit (table 25). Most frequently, the maximum amounts provided by plans specifying cash allowances for hospital visits were $3 and $5 per visit or day (table 26). Six of the nine plans providing retired workers a cash allowance for office treatments paid $3 for each office call. Three of the eight plans covering home visits for retired workers paid a maximum of $5 per visit; all except one of the remaining plans paid less than this amount.

The maximum allowance provided retired workers and their dependents for a specified period (usually per disability) ranged from $63 to $2,250 (table 27). About three out of five plans provided $350 or more.

Maternity Benefits

Obstetrical procedures were covered by nearly all of the plans providing surgical benefits for other types of operations. Some of the surgical plans also included medical care required prior to or after the termination of a pregnancy in the benefit provided for the obstetrical procedure. In contrast, fewer than a fifth of the plans with medical benefits for nonmaternity disabilities covered prenatal and postnatal care in the doctor's office, at the patient's home, or in the hospital.

This section describes the surgical and medical benefits provided for "normal delivery" maternity cases. Different benefits were generally available for miscarriages and for complicated cases, such as those involving a Caesarean section or ectopic pregnancy. The cash allowances for normal delivery were usually larger than for a miscarriage, but smaller than those provided for a Caesarean section or an ectopic pregnancy.

Surgical Benefits.—Surgical benefits for obstetrical procedures were provided women workers by 276 of the 293 plans with nonmaternity surgical benefits and for dependent wives by 269 of the 282 plans. Most of the 17 plans that did not provide such benefits for workers were in industries (such as construction and transportation) where few women workers are employed.

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[38] Cash benefits were provided on a co-insurance basis by the three plans that did not provide a cash allowance.

Table 25. Waiting requirements for medical benefits for retired workers and their dependents by location of medical care, late summer 1959[1]

(Workers in thousands)

When benefits begin	Benefit provided for medical care in—					
	Hospital		Doctor's office		Home	
	Plans	Workers	Plans	Workers	Plans	Workers
Retired workers						
All plans providing medical benefits[2]	65	1,265.6	15	136.4	14	101.4
For sickness—						
Immediately	64	1,259.6	10	82.5	9	78.5
After—						
First visit	-	-	1	1.3	1	1.3
Second visit	-	-	2	39.3	1	4.3
Third visit	-	-	1	1.3	2	5.3
Fourth visit	-	-	1	12.0	1	12.0
Third day of hospitalization	1	6.0	-	-	-	-
For accidents—						
Immediately	64	1,259.6	12	118.8	10	79.8
After—						
Second visit	-	-	1	4.3	1	4.3
Third visit	-	-	1	1.3	2	5.3
Fourth visit	-	-	1	12.0	1	12.0
Third day of hospitalization	1	6.0	-	-	-	-
Dependents						
All plans providing medical benefits[2]	64	1,264.3	9	99.5	7	60.5
For sickness—						
Immediately	63	1,258.3	7	60.2	6	56.2
After—						
Second visit	-	-	2	39.3	1	4.3
Third day of hospitalization	1	6.0	-	-	-	-
For accidents—						
Immediately	63	1,258.3	8	95.2	6	56.2
After—						
Second visit	-	-	1	4.3	1	4.3
Third day of hospitalization	1	6.0	-	-	-	-

[1] See footnotes 1 and 2, table 4. 74 and 71 plans provided medical benefits for retired workers and their dependents, respectively.
[2] See footnote 2, table 22.

Table 26. Cash allowance for in-hospital medical care for retired workers and their dependents, late summer 1959[1]

(Workers in thousands)

Maximum cash allowance per visit or per day in hospital[2]	Retired workers		Dependents	
	Plans	Workers	Plans	Workers
Plans providing cash allowances[3]	56	1,024.0	56	1,024.7
$3	20	198.8	19	197.5
$4	8	40.1	9	42.1
$5	15	159.0	15	159.0
$6	8	583.3	8	583.3
Other[4]	5	42.8	5	42.8

[1] See footnotes 1 and 2, table 4. 74 and 71 plans provided medical benefits for retired workers and their dependents, respectively.
[2] See footnote 2, table 23.
[3] Includes the allowances provided under the 20 service-with-income-limit plans; excludes the 3 plans covering retired workers and their dependents which provided the cash benefits on a co-insurance basis.
[4] Includes plans providing cash allowances in amounts not shown separately.

Table 27. Maximum cash allowance for medical care for retired workers and their dependents by basis of payment, late summer 1959[1]

(Workers in thousands)

Maximum allowance for all visits	Total		Basis of payment			
			Per disability		Other	
	Plans	Workers	Plans	Workers	Plans	Workers
Retired workers						
All plans providing cash allowances[2]	56	1,024.0	43	900.8	[3]13	123.2
Under $100	2	14.6	2	14.6	-	-
$100 and under $150	3	46.6	3	46.6	-	-
$150 and under $200	5	48.9	2	11.3	3	37.6
$200 and under $250	4	13.5	2	6.4	2	7.1
$250 and under $300	8	79.5	5	32.5	3	47.0
$300 and under $350	1	10.0	-	-	1	10.0
$350 and under $400	9	117.1	9	117.1	-	-
$400 and under $500	4	35.7	3	23.7	1	12.0
$500 and under $600	3	11.5	3	11.5	-	-
$600 and under $700	13	635.7	12	633.8	1	1.9
$700 and over	4	10.9	2	3.3	2	7.6
Dependents						
All plans providing cash allowances[2]	56	1,024.7	44	913.5	[3]12	111.2
Under $100	2	14.6	2	14.6	-	-
$100 and under $150	3	46.6	3	46.6	-	-
$150 and under $200	4	47.6	1	10.0	3	37.6
$200 and under $250	5	25.5	3	18.4	2	7.1
$250 and under $300	9	81.5	6	34.5	3	47.0
$300 and under $350	1	10.0	-	-	1	10.0
$350 and under $400	10	118.1	10	118.1	-	-
$400 and under $500	4	25.0	4	25.0	-	-
$500 and under $600	2	10.5	2	10.5	-	-
$600 and under $700	13	635.7	12	633.8	1	1.9
$700 and over	3	9.6	1	2.0	2	7.6

[1] See footnotes 1 and 2, table 4. 74 and 71 plans provided medical benefits for retired workers and their dependents, respectively.
[2] See footnote 3, table 26.
[3] Includes 4 plans which provided the allowance on a "per year" basis, and 6 plans which provided it on a "retirement period" basis.

The same type of benefit (cash or service) was available for both maternity and nonmaternity cases in all except 15 plans. These 15 plans provided cash benefits for obstetrical and service benefits for other surgical procedures. With one exception, both women workers and dependent wives were covered by the same type of benefit.

Cash maternity benefits were available to women workers and dependent wives in 223 and 217 plans, respectively; service benefits were provided in the remaining plans (table 28). However, service benefits were restricted to subscribers with incomes below specified limits by 34 service plans; those with incomes above the limits received cash benefits.

Table 28. Types of surgical maternity benefits provided women workers and dependent wives, late summer 1959 [1]

(Workers in thousands)

Type of benefit and group covered	Women workers		Dependent wives	
	Plans	Workers [2]	Plans	Workers
All plans providing surgical benefits for maternity cases	276	4,510.6	269	4,544.1
Cash	223	3,524.5	217	3,394.9
Specified obstetrical allowance	190	2,549.2	179	2,433.6
General lump-sum allowance	32	971.1	37	957.1
Co-insurance	1	4.2	1	4.2
Service	53	986.1	52	1,149.2
With income limits	34	795.7	34	795.7
Without income limits	19	190.4	18	353.5

[1] See footnotes 1 and 2, table 4.

[2] Number of workers covered by plans may not indicate the relative frequency of use of maternity benefits since the proportion of women covered varied substantially among plans.

A stipulated amount for normal delivery was provided women workers and dependent wives in 190 and 179 of the plans, respectively, with cash benefits.[39] A general lump-sum allowance that could be used toward obstetrical and other expenses was available in all except one of the remaining cash benefit plans.[40]

Maternity benefits were available immediately to newly insured women workers under 48 plans and to dependent wives under 45 plans (table 29). Almost all of the remaining plans had waiting periods that covered the duration of normal pregnancies.

About one-fifth of the plans provided service benefits in maternity cases,[41] compared with one-fourth in nonmaternity cases. However, more than three out of five had income limits on service benefits.[42]

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[39] Excludes 34 service plans paying cash benefits to those over the income limits and 1 plan which provided maternity benefits on a co-insurance basis.

[40] These general lump-sum allowances which are provided in lieu of all or some of the basic plan benefits are described in Health and Insurance Benefits Under Collective Bargaining: Hospital Benefits, Early 1959 (BLS Bull. 1274, pp. 36 and 37).

[41] Under a few plans, the patient was required to pay an initial maternity fee (e.g., the first $60 of hospital, surgical, and medical expenses); thereafter, benefits were available without further cost.

[42] In addition to paying for obstetrical services, prenatal care was provided by most group practice prepayment plans, but was only rarely included in the service benefits provided by the individual practice plans, such as Blue Shield.

Table 29. Availability of surgical benefits for normal delivery maternity cases to newly insured women workers and dependent wives, late summer 1959[1]

(Workers in thousands)

Availability of benefits	Women workers		Dependent wives	
	Plans	Workers[2]	Plans	Workers
All plans providing surgical benefit for normal delivery maternity cases	276	4,510.6	269	4,544.1
Benefits become available immediately	48	1,001.3	45	1,104.2
If pregnancy commences while insured	118	2,360.8	118	2,382.4
After being insured for—				
Less than 8 months	3	31.3	2	26.3
8 months	8	105.0	8	105.0
9 months	82	818.9	80	742.4
10 months	14	165.8	13	156.3
12 months	1	11.0	1	11.0
Over 12 months	2	16.5	2	16.5

[1] See footnotes 1 and 2, table 4.
[2] See footnote 2, table 28.

The "normal delivery" allowance provided women workers and dependent wives varied from less than $50 to $125 (table 30). The amounts most frequently specified were $50, $75, and $90. The average allowance for women workers was $81; for dependent wives, $74. Higher obstetrical allowances were generally found in plans providing service benefits with income limits than in plans providing cash benefits with no income limits. For example, over half of the plans with the former type of benefit specified a normal delivery allowance of $90 or more as against a third of those providing cash benefits.

Identical amounts were provided women workers and dependent wives in 188 of the 202 plans with a "normal delivery" allowance for both groups. Where a different amount was specified for dependents, it was usually at least 70 percent of the allowance provided women workers. The percent of the normal delivery allowance provided women workers that was provided dependent wives is shown in the following tabulation:

Percent	Plans	Workers (thousands)
All plans with normal delivery allowances for both women workers and dependent wives	202	2,983.6
100 percent	188	2,352.9
80 and under 90 percent	2	502.5
70 and under 80 percent	8	78.2
60 and under 70 percent	1	1.0
50 and under 60 percent	3	49.0

All of the plans with a lower normal delivery allowance for dependent wives also provided a lower maximum schedule allowance for dependents than for workers.

Table 30. Normal delivery maternity surgical allowances for women workers and dependent wives, late summer 1959[1]

(Workers in thousands)

Normal delivery allowance	Women workers		Dependent wives	
	Plans	Workers[2]	Plans	Workers
All plans providing a normal delivery allowance[3]	224	3,344.9	213	3,229.3
Under $50	5	217.2	3	205.0
$50	45	298.2	49	828.6
$60	10	56.0	9	53.0
$60.01 and under $75	11	87.1	14	124.1
$75	76	628.7	68	523.1
$75.01 and under $90	10	78.7	9	78.2
$90	38	1,683.2	37	1,183.2
$100	15	141.4	11	109.7
$105	4	79.1	2	19.1
$125	10	75.3	11	105.3
Average surgical allowance[4]	$81		$74	

[1] See footnotes 1 and 2, table 4. 276 and 269 plans provided maternity surgical benefits for women workers and dependent wives, respectively.
[2] See footnote 2, table 28.
[3] Includes the 34 service plans with income limits; the allowances under these plans were applicable to workers and dependents with individual or family incomes of more than a specified amount. Excludes 32 and 37 plans which provided a general lump-sum allowance for women workers and dependent wives, respectively.
[4] Benefit provided by each plan weighted by number of workers covered.

Table 31. Location of medical care for which benefits for normal delivery maternity cases were provided women workers and dependent wives, late summer 1959[1]

(Workers in thousands)

Location	Women workers					
	Total		Cash		Service	
	Plans	Workers	Plans	Workers[2]	Plans	Workers[2]
All plans providing medical benefits for normal delivery maternity cases	35	635.0	21	482.9	[3]14	152.1
Medical benefit for doctor's care in—						
Hospital only	5	29.8	4	22.0	1	7.8
Hospital, doctor's office, and home	29	597.0	17	460.9	12	136.1
Doctor's office only	1	8.2	-	-	1	8.2
	Dependent wives					
All plans providing medical benefits for normal delivery maternity cases	35	732.5	20	400.5	[3]15	332.0
Medical benefit for doctor's care in—						
Hospital only	7	232.8	5	45.1	2	187.7
Hospital, doctor's office, and home	27	491.5	15	355.4	12	136.1
Doctor's office only	1	8.2	-	-	1	8.2

[1] See footnotes 1 and 2, table 4.
[2] See footnote 2, table 28.
[3] All of these plans provided service benefits regardless of income.

Medical Benefits.—In addition to providing obstetrical benefits, 35 plans provided women workers and dependent wives with medical benefits for prenatal and postnatal care (table 31).[43] Usually out-of-hospital as well as in-hospital treatments were covered. Benefits in the form of services rather than cash were provided by about two-fifths of the plans. Cash benefits—with few exceptions, general lump-sum allowances—were provided by the remaining plans.

Maternity medical benefits were available immediately to newly insured women workers and dependent wives under 13 plans (table 32). The remaining plans covered pregnancies commencing after individuals became insured.

Table 32. Availability of medical benefits for maternity cases to newly insured women workers and dependent wives, late summer 1959[1]

(Workers in thousands)

Conditions governing availability of benefits	Women workers		Dependent wives	
	Plans	Workers[2]	Plans	Workers
Plans providing medical benefits for maternity cases	35	635.0	35	732.5
Benefits become available immediately on becoming insured	13	259.8	13	362.2
Pregnancy commences while insured	16	276.9	16	276.8
After being insured for—				
9 months	4	25.5	4	20.7
10 months	2	72.8	2	72.8

[1] See footnotes 1 and 2, table 4.
[2] See footnote 2, table 28.

[43] In other plans, these prenatal and postnatal treatments were occasionally included with the obstetrical benefit provided under the surgical provisions of the plan.

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