2010 HEALTH CARE PLAN SUMMARIES

Wisconsin Blue Preferred POS

Plan Code: M82

Basic Plan Information			
Plan Type	POS	Member Service	(800) 671-1210
Is a PCP Required?	No	Web Address	www.bcbsil.com/abbott
Group Number	055597	Provider Network	Wisconsin Blue Preferred POS

	Benefits for Covered In-Network Services and Supplies	Benefits for Covered Out-of-Network Services and Supplies*
Preventive Care Benefits		
Annual Physical Exams for Adults	100% coverage; annual physical exam adults age 18+ incl. all related blood and urine laboratory testing performed as part of the annual exam and determined necessary by the patient's doctor****	60% coverage after deductible
Annual Immunizations for Adults	100% coverage; adults age 18+ for adult immunizations as defined by the CDC and U.S. Preventive Services task force (excludes immunizations for travel)****	60% coverage after deductible
Annual Screenings for Adults	100% coverage; adults age 18+ for recommended screenings as part of the annual physical exam incl.: hearing, vision, cholesterol, hypertension, diabetes, skin cancer, discussion of overall health and lifestyle****	60% coverage after deductible
Annual Colorectal Screenings for Adults	100% coverage; adults age 40+ for colorectal cancer screening incl.: fecal occult blood test, flexible sigmoidoscopy, colonoscopy****	60% coverage after deductible
Annual Bone Density Screenings for Adults	100% coverage; adults age 65+****	60% coverage after deductible
Annual PSA Screening	100% coverage; adult males age 40+****	60% coverage after deductible
Annual Well Woman Exam	100% coverage; for annual well-woman exam (in addition to annual physical exam) incl. pap smear (ages 18+) and mammogram (age 35+)****	60% coverage after deductible
Well Child Visits Under Age 2	100% coverage; well child care visits based on American Academy of Pediatrics standards (0-12 months: 6 visits, 12-24 months: 3 visits) incl. all related blood and urine laboratory testing performed as part of the annual well child exam and determined necessary by patient's doctor, incl. lead and TB testing****	60% coverage after deductible
Well Child Visits Over Age 2	100% coverage; one annual well child exam (age 2 to 18) incl. all related blood and urine laboratory testing performed as part of the annual well child exam and determined necessary by patient's doctor, incl. lead and TB testing****	60% coverage after deductible
Childhood Immunizations	100% coverage; all recommended childhood immunizations, incl. HPV vaccine (excludes immunizations for travel)	60% coverage after deductible
Childhood Screenings	100% coverage; recommended screenings as part of the annual exam incl. health and developmental history, hearing, vision, and skin screening****	60% coverage after deductible

Notes: * Benefits are based on reasonable charges. **** In-network benefits for services at ages younger than listed are covered at 80%--in addition in-network services listed outside of the schedule stated above will be paid at 80% (for example, a second physical in same calendar year will be paid at 80%).

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	Benefits for Covered In-Network Services and Supplies	Benefits for Covered Out-of-Network Services and Supplies*
Annual Deductible	Deductibles apply to prescription drugs only	$500 per person; $1,250 per family
Out-of-Pocket Maximum	$3,000 per person; $7,500 per family	$6,000 per person; $15,000 per family
Lifetime Maximum	None	None
Inpatient Benefits	***Prenotification required; $250 penalty applies for failure to prenotify***	
Hospital Services	80% coverage	60% coverage after deductible
Maternity (newborn and delivery)	80% coverage	60% coverage after deductible
In-Hospital Physicians and Surgeons	80% coverage	60% coverage after deductible
Outpatient Benefits		
Ambulatory Surgery	80% coverage**	60% coverage after deductible**
Ambulance	80% coverage	80% coverage; deductible does not apply
Emergency Room	$150 copayment per visit; copayment waived if admitted; if not approved as emergency, covered at 80%	$150 copayment per visit; copayment waived if admitted; if not approved as emergency, covered at 60% after deductible
Urgent Care	$50 copayment per visit	$50 copayment per visit
Diagnostic X-Ray and Lab	80% coverage	60% coverage after deductible
Physician and Professional Services		
Office Visits	$25 copayment per visit; excludes x-ray/lab	60% coverage after deductible
Maternity (physician charges: delivery, prenatal care, first postnatal visit)	$25 copayment for first OB visit, then 80% coverage**	60% coverage after deductible**

Notes: * Benefits are based on reasonable charges. ** Some procedures require prenotification.

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Prescription Drugs		
Prescription Drugs	Administered by Caremark. 100% coverage for Abbott prescription drugs, including diabetic supplies. $10 for 90-day supply of selected generics at CVS Stores and Mail Order. All other prescription drugs and diabetic supplies: Annual deductible of $50 per person; $100 per family. Retail (30-day supply): 75% coverage after deductible. Min. copayment of $5 per generic and $15 per brand prescription; CVS Stores (84-90 day supply): 75% coverage after deductible. Min copayment of $15 per generic and $35 per brand prescription; Mail Order (90-day supply): 80% coverage after deductible. Min. copayment of $15 per generic and $35 per brand prescription. For maintenance drugs, plan requires use of CVS Store or Mail Order for 90 day supply after 2nd 30-day fill (opt out available). Separate out-of-pocket limit of $1,500 per person: $3,000 per family. Call Caremark at (866) 293-8009.	
Mental Health Benefits	***Must precertify inpatient (and most outpatient) services through United Behavioral Health: (866) 808-5075***	
Inpatient Services	80% coverage	60% coverage after deductible; A $250 penalty applies for failure to precertify
Outpatient Services	$25 copayment per visit	60% coverage after deductible
Substance Abuse Benefits	***Must precertify inpatient (and most outpatient) services through United Behavioral Health: (866) 808-5075***	
Inpatient Services	Same as mental health benefits	Same as mental health benefits; A $250 penalty applies for failure to precertify
Outpatient Services	Same as mental health benefits	Same as mental health benefits
Other Benefits		
Chiropractic Services	$25 copayment per visit; $750 benefit max. per calendar year combined in/out-of-network	Refer to in-network benefits
Physical Therapy	80% coverage	60% coverage after deductible
Home Health Care	80% coverage; 60 visits per calendar year combined in/out-of-network**	60% coverage after deductible; 60 visits per calendar year combined in/out-of-network**
Durable Medical Equipment	80% coverage**	60% coverage after deductible**
Hospice Care	80% coverage**	60% coverage after deductible**
Vision Benefits	$25 copayment for one routine exam per calendar year; eyewear not covered; hardware discounts are available; call Davis Vision at (877) 393-8844 for details; combined in/out-of-network benefit	Refer to in-network benefits

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	Benefits for Covered In-Network Services and Supplies	Benefits for Covered Out-of-Network Services and Supplies*
Infertility		
Precertification Requirements/Additional Benefit Limits	Precertification and required use of providers from United Resource Network Centers of Excellence for all infertility consultations with a reproductive endocrinologist, and all infertility treatments (otherwise no coverage); lifetime maximum medical infertility limit for post-diagnosis services of $35,000 while covered under any Abbott medical plan. Services to diagnose infertility are not included in the lifetime maximum	
Infertility Consultation	$25 copayment per visit; precertification required	Not covered
Other Diagnostic Services	80% coverage; precertification required	Not covered
Surgical Services to Treat Cause of Infertility	80% coverage; precertification required	Not covered
Artifical Insemination	80% coverage; precertification required	Not covered
Ovulation Induction	80% coverage; precertification required	Not covered
Gamete Intrafallopian Transfer (GIFT)	80% coverage; precertification required	Not covered
Zygote Intrafallopian Transfer (ZIFT)	80% coverage; precertification required	Not covered
In-Vitro Fertilization	80% coverage; precertification required	Not covered
Fertility Drugs	Covered under prescription drug benefit; lifetime infertility prescription drug max. of $15,000 while covered under any Abbott medical plan	Refer to in-network benefits

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