



WABASH MEMORIAL HOSPITAL ASSOCIATION

2012 HEALTHCARE BENEFIT SUMMARY

Bluebird Plans – Primary

Plans – 3, 4,7, 15, 19

Benefit	In-Network	Out-of-Network
Annual Deductible	\$100 per year	
Lifetime Maximum	<u>\$131,500 (2012 limit) Plan 7 only</u>	
Maximum Out-of-Pocket Expense <i>Does not include dental, vision, or charges. in excess of reasonable and customary</i>	None	
Physician Services – General <i>Office Visits</i>	80% of allowed covered charge	64% of allowed charge
<i>Hospital Visits</i>	80% of allowed covered charge	
<i>Surgical Procedures</i>	80% of allowed covered charge	
<i>Office</i>	80% of allowed covered charge	
<i>Outpatient</i>		
<i>Inpatient</i>		
Physician Services – Preventive** <i>Preventive Exam</i>	80% of allowed covered charge	64% of allowed charge
<i>Mammograms</i>	80% of allowed covered charge	
<i>Pap Tests</i>	80% of allowed covered charge	
<i>Well-Child Care</i>	80% of allowed covered charge	
<i>Immunizations</i>	80% of allowed covered charge	
<i>Screenings</i>	80% of allowed covered charge	
<i>Cholesterol, Osteoporosis</i>	80% of allowed covered charge	
<i>**Based upon U.S. Preventive Services Task Force (USPSTF) guidelines</i>		
Hospital Services <i>Inpatient Care</i>	Pre-certification required 80% of allowed covered charge	
<i>Outpatient Care</i>	80% of allowed covered charge	
Emergency Room	80%% allowed covered charge	
Ambulance	80%% allowed covered charge	
Air Ambulance	Subject to administrative approval	
Allergy Testing, Allergy Injection	80% of allowed covered charge	
Anesthesia	80% of allowed covered charges	
Cardiac or Pulmonary Therapy	80% allowed covered charge to 30 treatments	
Chemotherapy	80% allowed covered charge	
Diagnostic Testing, Imaging and Laboratory Services	80% allowed covered charge to \$10,000 per calendar year(cy)	
Dialysis	80%allowed chg to \$4,000 cy	
Durable Medical Equipment <i>Colostomy Bag (only)</i>	NONE 50%% allowed covered charge	
Home Health Care	80% up to 40 visits cy	
Hospice	Pre-notification required No limit if patient is terminal	
Mammogram, Screening	80% allowed covered charge- 1 per cy	
Mental Health and Substance Abuse	Pre-Certification Required 80% of allowable charges 80% of allowable charges	



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Oxygen	80% allowed covered charge to maximum of \$3,000 per cy	
Prescription Medicine FDA Approved - Generic - Brand	Plan 3,4 &19 has \$750 annual limit with co pay Plan 7 is at 80%, allowed covered chg Plan #15 no benefit	
Physical Therapy Occupational Therapy Speech Therapy	80% allowed covered charge to \$3,000 then 50%	65% to \$3,000 then 50%
Prosthetics -Artificial limb -Breast Prosthesis	80%% allowed covered charge to \$4,000 after a \$500 deductible 80%% allowed covered charge	
Skilled Nursing Care	no benefit	
Transplantation of Vital Organs	no benefit	
NON-ESSENTIAL BENEFITS		
Appliances/Braces & Trusses	80% allowed covered charge up to \$125 per item Orthotic pair = 1 item	
Chiropractic Services	no benefit	
Dental Care due to Accidental Injury	80% allowed covered charge to \$300 per cy	
Dietary Consultation	\$50 once per cy	
Eye Exam	\$40 once per cy	
Hearing Aids	80% allowed covered charge to \$300 per item, once per 5 years	
Hearing Test	80% allowed covered charge - must be physician supervised	
Inpatient Respite Care	80% to \$3,000	
Penile Erection Devise - external	80% allowed covered charge	
Penile Implant – dr. & hosp fees	80% allowed covered charge	
Sterilization (surgical)	80% allowed covered charge	
Stress Test (includes Thallium Stress test)	80% allowed covered charge	
Smoking Cessation	\$500 cy	
Temporomandibular joint Syndrome (TMJ) Treatment/Surgery	50% to a lifetime max of \$1,250 after a \$50 deduct	
Weight Loss Program <i>must be medically supervised</i>	80% to a max of \$3,000 after a \$100 deductible	



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