

Anthem Blue Preferred Primary HMO Coverage Summary

This Plan requires the selection of a Primary Care Physician (PCP) but does not require a referral from the PCP for services provided by other network specialists.

Plan Provision	Network Benefit	Non-Network Benefit
Deductible: the amount you pay each year before the Plan pays benefits for your medical expenses	\$0 per individual \$0 maximum per family	Not Applicable
Out-of-Pocket Maximum: the total you pay in a calendar year for fixed dollar and percentage copayments (other than for prescription drugs and human organ and tissue transplants).	\$500 maximum per individual \$1,000 maximum per family	Not Applicable
Lifetime Maximum Benefit	Unlimited Maximum Benefit	Not Applicable

Service	Network Patient Pays	Non-Network Patient Pays
Physician Office Services: including office visits, office surgeries, and allergy testing/treatment as part of an office visit	\$15 copayment (No copayment for allergy testing and treatment without an office visit charge)	Not Applicable
Preventive Care Services: including mammography, pelvic exam, PAP test, PSA test, immunizations and routine eye and hearing exams	\$15 copayment (No copayment for mammography and immunization without an office visit charge)	Not Applicable
Inpatient Hospital Services: including maternity services	\$250 copayment	Not Applicable
Outpatient Facility Services	Covered in Full	Not Applicable
Inpatient and Outpatient Professional Fees for Surgical and Medical Services	Covered in Full	Not Applicable
Emergency Services	Physician services covered in full \$75 copayment for facility charges	Not Applicable
Urgent Care Services	Physician services covered in full \$35 copayment for facility charges	Not Applicable
Ambulance Services	Covered in full	Not Applicable
Mental Health/Substance Abuse Services: Inpatient care limited to 60 days per year Outpatient care limited to 60 visits per year Limit of 2 substance abuse programs per lifetime	\$250 copayment \$15 copayment	Not Applicable
Inpatient Physical Medicine and Rehabilitation Services: Limit of 60 days per year of inpatient care	\$250 copayment	Not Applicable
Outpatient Therapy: 60 visit limit for physical and occupational therapy; 20 visit limit for speech therapy; and 12 visit limit for spinal manipulation	\$15 copayment	Not Applicable
Hospice Services	Covered in full	Not Applicable
Human Organ Transplants and Tissue Transplants: (excludes kidney & cornea which are covered as normal inpatient/outpatient services). Separate \$1 million lifetime maximum benefit applies.	Covered in full	Not Applicable
Medical Supplies, Equipment and Appliances	20% of covered cost copayment	Not Applicable
Prescription Drugs: up to a 30 day supply	\$8 generic/\$25 brand formulary copayment \$40 non-formulary copayment	Not Applicable
Maintenance Drugs—covered under WSU Maintenance Drug Plan and not Anthem coverages	Not Applicable	Not Applicable