

Anthem Blue Access PPO Coverage Summary

Plan Provision	Network Benefit	Non-Network Benefit
Deductible: the amount you pay each year before the Plan pays benefits for your medical expenses. All Non-Network expenses are subject to the deductible unless otherwise stated.	\$0 per individual \$0 maximum per family	\$250 per individual \$500 maximum per family
Out-of-Pocket Maximum: the total you pay in a calendar year for fixed dollar and percentage copayments and deductibles (other than for prescription drugs and human organ and tissue transplants).	\$1,250 maximum per individual \$2,500 maximum per family	\$2,250 maximum per individual \$4,500 maximum per family
Lifetime Maximum Benefit	\$5 million including Non-Network Benefits	\$5 million including Network Benefits

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	\$20 copayment (No copayment for allergy testing and treatment without an office visit charge)	30% of covered cost copayment
Preventive Care Services: including mammography, pelvic exam, PAP test, PSA test, immunizations and routine eye and hearing exams	\$20 copayment (No copayment for mammography and immunization without an office visit charge)	30% of covered cost copayment
Inpatient Hospital Services: including maternity and surgery services	10% of covered cost copayment	30% of covered cost copayment
Outpatient Facility Services	10% of covered cost copayment	30% of covered cost copayment
Inpatient and Outpatient Professional Fees for Surgical and Medical Services	10% of covered cost copayment	30% of covered cost copayment
Emergency Services	Physician services covered in full \$75 copayment for facility charges	Physician services covered in full \$75 copayment for facility charges
Urgent Care Services	Physician services covered in full \$35 copayment for facility charges	Physician services covered in full \$35 copayment for facility charges
Ambulance Services	Covered in full	Covered in full
Mental Health/Substance Abuse Services: Inpatient care limited to 60 days per year (combined Network/Non-Network) Outpatient care limited to 60 visits per year (combined Network/Non-Network) Limit of 2 substance abuse programs per lifetime per patient.	10% of covered cost inpatient copayment \$20 outpatient copayment	Mental Health Services 50% of covered cost inpatient copayment (Limited to 30 days per year) 30% of covered cost outpatient copayment (Limited to 10 visits per year) Substance Abuse Services 50% of covered cost inpatient copayment 30% of covered cost outpatient copayment (\$550 combined maximum for inpatient and outpatient substance abuse benefits)
Inpatient Physical Medicine and Rehabilitation Services: combined Network and Non-Network limit of 60 days per year	10% of covered cost copayment	30% of covered cost copayment
Outpatient Therapy: 60 visit limit for physical and occupational therapy; 20 visit limit for speech therapy; and 12 visit limit for spinal manipulation	\$20 copayment	30% of covered cost copayment
Hospice Services	Covered in full	Covered in full
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	50% of covered cost copayment
Medical Supplies, Equipment and Appliances	20% of covered cost copayment	40% of covered cost copayment
Prescription Drugs: up to a 30 day supply	\$8 generic/\$25 brand formulary copayment \$40 non-formulary copayment	50% of covered cost copayment Diabetic/asthmatic drugs not covered
Maintenance Drugs—covered under WSU Maintenance Drug Plan and not Anthem coverages	Not Applicable	Not Applicable

*Covered cost is based on Anthem's Maximum Allowable Amount which may be significantly less than the Non-Network billed charge. The patient is responsible for any amount in excess of Anthem's Maximum Allowable Amount for a service provided by a Non-Network provider.