

WRIGHT STATE UNIVERSITY

Summary of Blue Access Benefits

	Network	Non-Network		Network	Non-Network
Annual Deductible (single/family)	\$0/\$0	\$250/\$500	Annual Out of Pocket		
Per Visit Copay	\$20	30%	Maximum	\$1250/\$2500	\$2250/\$4500
Per Admission Copay	10%	30%	Lifetime Maximum	Unlimited	Unlimited

Covered Services	Network	Non-Network
Physician Office Service Office visits Office surgeries Preconception care / education Allergy-testing and treatment -serum and injections (1)	\$20 Copayment	30% Copayment
Preventive Care Medical history Mammographies (1), pelvic exams, and PAP testing Immunizations (1) Routine eye exam and hearing exam	\$20 Copayment	30% Copayment
Outpatient Therapy-(visit limits apply) Physical and occupational therapy: 60 visit limit Spinal manipulations: 12 visit limit Speech therapy: 20 visit limit	\$20 Copayment	30% Copayment
Inpatient Services 60 days for physical medicine/rehab	10% Copayment	30% Copayment
Outpatient Facility Services	10% Copayment	30% Copayment
Inpatient and Outpatient Professional and Ancillary Charges Inpatient and outpatient physician services	10% Copayment	30% Copayment
Home Care Services (Non-Network Visit Limits Apply)	Covered in Full	30% Copayment (30 visits)
Hospice Services	Covered in Full	Covered in Full
Emergency Care/Urgent Care Hospital Emergency Room: Physician services Facility Charges (2) Urgent Care Facility: Physician services Facility charges	Covered in Full \$75 Copayment Covered in Full \$35 Copayment	Covered in Full \$75 Copayment Covered in Full \$35 Copayment
Ambulance Services	Covered in Full	Covered in Full
Maternity Services	10% Copayment	30% Copayment
Mental Health & Substance Abuse Inpatient Facility Services Inpatient Professional Services Physician Home and Office Visits Other Outpatient Services. Outpatient Facility @ Hospital/Alt Care Facility, Outpatient Prof	10% Copayment 10% Copayment \$20 Copayment 10% Copayment	30% Copayment 30% Copayment 30% Copayment 30% Copayment
Human Organ & Tissue Transplants (excludes kidney and cornea which are covered under regular/outpatient services)	Covered in Full	50% Copayment
Medical Supplies, Equipment & Appliances	20% Copayment	40% Copayment
Prescription Drugs (Network Pharmacy)		
Member pharmacies-30 day supply	Not Covered under health plan	Not Covered under health plan
Mail Order		

- (1) *These covered services rendered without an office visit are covered in full.*
- (2) *Emergency Room copayment is waived if moved to Observation Room or admitted as an Inpatient. Outpatient/Inpatient will then apply.*
- (3) **NOTES: Visit limits are applied per benefit period, except where otherwise stated. The out-of-pocket limit includes all copayments and deductibles incurred by a covered person in the same benefit period. The deductible(s) apply only to covered services indicated with a percentage copayment of other than 100%. Sexual dysfunction is excluded**