

# Anthem Blue Traditional Summary

**This plan provides the same level of benefits whether or not the medical provider is an Anthem Blue Cross and Blue Shield network provider.**

Plan Provision	Network Benefit	Non-Network Benefit
<b>Deductible:</b> the amount you pay each year before the Plan pays benefits for your medical expenses	Not Applicable	\$200 per person \$400 per family
<b>Out-of-Pocket Maximum:</b> the total you pay in a calendar year for your deductible and percentage copayments (other than for prescription drugs and human organ and tissue transplants).	Not Applicable	\$800 per person \$1,600 per family
<b>Lifetime Maximum Benefit</b>	Not Applicable	\$5 million

Service	Network Patient Pays	Non-Network Patient Pays
<b>Physician Office Services:</b> including office visits, office surgeries, and allergy testing/treatment as part of an office visit	Not Applicable	20% of covered cost copayment
<b>Preventive Care Services:</b> including mammography, pelvic exam, PAP test, PSA test, immunizations and routine eye and hearing exams	Not Applicable	Covered in Full; Maximum Benefits- Unlimited--birth to age 12 months \$200 per year age 1 through 17 \$500 per year age 18 and above
<b>Inpatient Hospital Services:</b> including maternity services	Not Applicable	20% of covered cost copayment
<b>Outpatient Facility Services</b>	Not Applicable	20% of covered cost copayment
<b>Inpatient and Outpatient Professional Fees for Surgical and Medical Services</b>	Not Applicable	20% of covered cost copayment
<b>Emergency Services</b>	Not Applicable	20% of covered cost copayment
<b>Urgent Care Services</b>	Not Applicable	20% of covered cost copayment
<b>Ambulance Services</b>	Not Applicable	20% of covered cost copayment
<b>Mental Health/Substance Abuse Services:</b> Inpatient care limited to 20 days per year Outpatient care limited to 30 visits per year Limit of 2 substance abuse programs per lifetime	Not Applicable	20% of covered cost copayment  20% of covered cost copayment
<b>Inpatient Physical Medicine and Rehabilitation Services:</b> Limit of 60 days per year of inpatient care	Not Applicable	20% of covered cost copayment
<b>Outpatient Therapy:</b> 60 visit limit for physical and occupational therapy; 20 visit limit for speech therapy; and 12 visit limit for spinal manipulation	Not Applicable	20% of covered cost copayment
<b>Hospice Services</b>	Not Applicable	20% of covered cost copayment
<b>Human Organ Transplants and Tissue Transplants:</b> (excludes kidney & cornea which are covered as normal inpatient/ outpatient services). Separate \$1 million lifetime maximum benefit applies.	Not Applicable	Covered in full in Participating Transplant Facility 50% copayment in Non-Participating Transplant Facility
<b>Medical Supplies, Equipment and Appliances</b>	Not Applicable	20% of covered cost copayment
<b>Prescription Drugs:</b> up to a 30 day supply	Not Applicable	20% of covered cost copayment
<b>Maintenance Drugs—covered under WSU Maintenance Drug Plan and not Anthem coverages</b>	Not Applicable	Not Applicable