



Anthem HealthKeepers

January 1 - December 31, 2017

	Core Plan	Value Plan	HDHP + HSA
IN-NETWORK BENEFITS	You Pay	You Pay	You Pay
Deductible	None	\$500/\$1000	\$3,000/\$6,000
Out-of-Pocket	\$3,000/\$6,000	\$4,000/\$8,000	\$4,000/\$8,000
Inpatient Benefits			
Hospital	\$250 per day (not to exceed \$1250 per admission)	20% after deductible	0% after deductible
Physician Charges	No charge	20% after deductible	0% after deductible
Maternity (Facility charges for delivery)	\$250 per day (not to exceed \$1250 per admission)	20% after deductible	0% after deductible
Mental Health and Substance Abuse (Facility charges)	\$250 per day (not to exceed \$1250 per admission)	20% after deductible	0% after deductible
Outpatient Benefits			
Referrals to Specialist Required	No	No	No
Primary Care Physician (PCP) or Specialist Office Visit	\$25	\$25	0% after deductible
Urgent Care Center	\$25 PCP / \$50 Specialist	\$25 PCP / \$50 Specialist	0% after deductible
Allergy Testing	\$25 PCP / \$50 Specialist	\$25 PCP / \$50 Specialist	0% after deductible
Allergy Serum and Injections	\$25 PCP / \$50 Specialist	\$25 PCP / \$50 Specialist	0% after deductible
Mammogram	No charge	No charge	0% after deductible
Labs, Diagnostic X-rays	\$25 PCP / \$50 Specialist	20% after deductible	0% after deductible
Advanced Diagnostic Imaging	\$250	20% after deductible	0% after deductible
Emergency Room	\$250	20% after deductible	0% after deductible
Outpatient Surgery	\$250	20% after deductible	0% after deductible
Therapy services (Speech, physical, occupational)	\$25	20% after deductible	0% after deductible
Outpatient Mental Health and Substance Abuse	\$25 medication management / \$50 all other	\$25 medication management / \$50 all other	0% after deductible
Spinal Manipulation (30 visit limit)	\$25	\$25	0% after deductible
Durable Medical Equipment	No charge	20% after deductible	0% after deductible
Home Health Care	No charge	20% after deductible	0% after deductible
Skilled Nursing Facility (100 days per admission)	No charge	20% after deductible	0% after deductible
Hospice Care	No charge	20% after deductible	0% after deductible
Maternity Outpatient Services			
Initial office visit to confirm diagnosis	\$25	\$25	0% after deductible
Pre- and post-natal care and delivery	No charge	\$50	0% after deductible

Maternity ultrasounds	No charge	No charge	0% after deductible
Prescription Drugs: Mandatory generic under all benefit plans			
Retail Pharmacy (30 day supply <u>only</u>)	\$10/\$30/\$50/20% (Tier 4: maximum of \$100 per perscription)	\$10/\$30/\$50/20% (Tier 4: maximum of \$100 per perscription)	\$10/\$30/\$50 or 20% (Tier 4: maximum of \$200 per prescription After Deductible)
Mail Order (90 day supply)	\$20/\$60/\$100	\$20/\$60/\$100	\$20/\$60/\$100 or 20% (Tier 3: maximum of \$400 per prescription)
Out of Pocket	\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$8,000 (combined medical and prescription drug)
Routine Vision through Blue View Vision			
Annual Eye Exam	\$15	\$15	\$15
OUT-OF-NETWORK BENEFITS			
Deductible	\$750/\$1,500	\$1,000/\$2,000	\$3,000/\$6,000 (combined in- and out -of-network)
Coinsurance	30%	30%	30%
Out-of-Pocket	\$3,000/\$6,000	\$4,000/\$8,000	\$6,000/\$12,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited