January 1 - December 31, 2016

Anthem HealthKeepers

	Core Plan	Value Plan	HDHP + HSA
IN-NETWORK BENEFITS	**You Pay**	**You Pay**	**You Pay**
Deductible	None	$200/$400	$3,000/$6,000
Out-of-Pocket	$2,000/$4,000	$3,000/$6,000	$4,000/$8,000
Inpatient Benefits			
Hospital	$150 per day (not to exceed $750 per admission)	20% after deductible	0% after deductible
Physician Charges	No charge	20% after deductible	0% after deductible
Maternity (Facility charges for delivery)	$150 per day (not to exceed $750 per admission)	20% after deductible	0% after deductible
Mental Health and Substance Abuse (Facility charges)	$150 per day (not to exceed $750 per admission)	20% after deductible	0% after deductible
Outpatient Benefits			
Referrals to Specialist Required	No	No	No
Primary Care Physician (PCP) or	$25	$25	0% after deductible
Specialist Office Visit	$50	$50	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	$125	$175 after deductible	0% after deductible
Emergency Room	$125	20%	0% after deductible
Outpatient Surgery	$125	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	No charge after deductible	0% after deductible
Home Health Care	No charge	No charge after deductible	0% after deductible
Skilled Nursing Facility (100 days per admission)	No charge	No charge after deductible	0% after deductible
Hospice Care	No charge	No charge after deductible	0% after deductible
Maternity Outpatient Services			
Initial office visit to confirm diagnos	$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 only)	$10/$30/$50	$10/$30/$50	After deductible $10/$30/$50 or 20% (Tier 3: maximum of $200 per prescription)
Mail Order (90 day supply)	$20/$60/$100	$20/$60/$100	After deductible $20/$60/$100 or 20% (Tier 3: maximum of $400 per prescription)
Out of Pocket	$3,500/$7,200	$3,500/$7,200	$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	$2,000/$4,000	$3,000/$6,000	$6,000/$12,000
Lifetime Maximum	**Unlimited**	**Unlimited**	**Unlimited**