

Anthem HealthKeepers Benefit Comparison

January 1, 2027 - December 31, 2027

2027 Benefits	Standard POS	Premier POS	HDHP with HSA
In-Network Deductible (individual/family)	\$500 / \$750	\$400 / \$600	\$3,500 / \$7,000 (combined with out of network)
In-Network Out-of-pocket maximum	Medical and pharmacy combined: \$3,000/\$6,000	Medical and pharmacy combined: \$2,500/\$5,000	Medical and pharmacy combined: \$4,000 / \$8,000
Inpatient benefits: Hospital	30% after deductible	5% after deductible	0% after deductible
Inpatient benefits: Physician charges	30% after deductible	5% after deductible	0% after deductible
Inpatient benefits: Maternity (Facility charges for delivery)	30% after deductible	5% after deductible	0% after deductible
Inpatient benefits: Mental health and substance abuse (Facility charges)	30% after deductible	5% after deductible	0% after deductible
Outpatient benefits: Referrals to specialist required	No	No	No
Outpatient benefits: Preventive care	No charge	No charge	No charge
Outpatient benefits: Virtual Care through LiveHealth Online	No charge	No charge	No charge
Outpatient benefits: Primary care physician (PCP) or OB-GYN office visit	\$25	\$20	0% after deductible
Outpatient benefits: Vera Whole Health Primary Care	No charge	No charge	0% after deductible
Outpatient benefits: Specialist office visit	\$45	\$40	0% after deductible
Outpatient benefits: Urgent care center	\$25 PCP / \$45 specialist	\$20 PCP / \$40 specialist	0% after deductible
Outpatient benefits: Allergy testing	\$25 PCP / \$45 specialist	\$20 PCP / \$40 specialist	0% after deductible
Outpatient benefits: Allergy serum and injections	\$25 PCP / \$45 specialist	\$10	0% after deductible
Outpatient benefits: Mammogram	No charge	No charge	No charge
Outpatient benefits: Labs, diagnostic X-rays	No charge	No charge	0% after deductible
Outpatient benefits: Advanced diagnostic imaging: in office setting	10% after deductible	5% after deductible	0% after deductible
Outpatient benefits: Advanced diagnostic imaging: all other settings	30% after deductible	5% after deductible	0% after deductible
Outpatient benefits: Maternity outpatient services Initial office visit to confirm diagnosis Pre- and post-natal care and delivery Maternity ultrasounds	\$25 \$50 per pregnancy No charge	\$20 \$50 per pregnancy No charge	0% after deductible 0% after deductible 0% after deductible
Outpatient benefits: Emergency room (waived if admitted to the hospital)	\$250	\$250	0% after deductible
Outpatient benefits: Outpatient surgery facility professional provider	30% after deductible	5% after deductible	0% after deductible
Outpatient benefits: Outpatient therapy (occupational, speech, and physical)	\$45	\$25	0% after deductible
Outpatient benefits: Spinal manipulation (30 visit limit per CY)	\$25	\$25	0% after deductible
Outpatient benefits: Outpatient mental health and substance abuse	\$25	\$20	0% after deductible

2027 Benefits	Standard POS	Premier POS	HDHP with HSA
Outpatient benefits: Durable medical equipment	No charge after deductible	No charge after deductible	0% after deductible
Outpatient benefits: Home healthcare (90 visit limit per CY)	\$45 per visit after deductible	No charge after deductible	0% after deductible
Outpatient benefits: Skilled nursing facility (100 days per admission)	30% after deductible	5% after deductible	0% after deductible
Outpatient benefits: Hospice care	30% after deductible	5% after deductible	0% after deductible
Mandatory generic Prescription drugs: Rx deductible (individual/family)	\$150/\$150	\$150/\$150	Plan deductible applies
Mandatory generic Prescription drugs: Retail pharmacy (30 day supply)	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55
Mandatory generic Prescription drugs: Mail order (90 day supply)	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165
Mandatory generic Prescription drugs: Retail 90 (90 day supply purchased at a participating retail pharmacy)	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165
Routine vision — Blue View Vision Annual routine eye exam	\$15	\$15	\$15 (deductible does not apply)
Out-of-Network Deductible (Individual/Family)	\$750/\$1,125	\$600/\$900	\$3,500/\$7,000 (combined with in-network)
Out-of-Network Coinsurance	30%	30%	30%
Out-of-Network Out-of-pocket maximum	\$3,000/\$6,000	\$2,500/\$5,000	\$6,000/\$12,000
Out-of-Network Lifetime maximum	Unlimited	Unlimited	Unlimited