MEA Benefits Trust

Anthem

Benefit Comparison – Plans Effective July 1, 2018

	MEA CHOICE PLUS		MEA STANDARD PLAN		MEA STANDARD PLAN $500 DEDUCTIBLE		MEA STANDARD PLAN $1,000 DEDUCTIBLE	
SERVICE	**Higher Benefit Level**	**Self-referred Benefit Level**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Important Information	Coverage in this column applies to maximum allowances for covered services provided or authorized by your Primary Care Physician.	Coverage described in this column applies to maximum allowances for self-referred, covered services (those not authorized or performed by your Primary Care Physician).	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals in the Blue Choice network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals in the Blue Choice network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals in the Blue Choice network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice network.
Primary Care Physician Required	YES		NO		NO		NO	
Physician Office Visits **Sick Care** **Preventive & Well Care Services**	100% after $15 PCP copay 100% after $25 Specialist copay 100%	65% after deductible Not Covered (members can self-refer to a participating Ob/Gyn for their annual Well Woman exam)	100% after $15 PCP copay 100% after $25 Specialists copay 100%	80% after $15 PCP copay 80% after $25 Specialist copay 80% no deductible	100% after $20 PCP copay 100% after $30 Specialist copay 100%	80% after $20 PCP copay 80% after $30 Specialist copay 80% no deductible	100% after $20 PCP copay 100% after $30 Specialist copay 100%	80% after $20 PCP copay 80% after $30 Specialist copay 80% no deductible
Calendar Year Deductible	$200 per member $400 per family	$250 per member $500 per family	$200 per member $400 per family		$500 per member $1,000 per family		$1,000 per member $2,000 per family	
Coinsurance Limit	$1,000 per member $2,000 per family	$2,250 per member $4,500 per family	$1,000 per member $2,000 per family		$2,000 per member $4,000 per family		$2,000 per member $4,000 per family	
Calendar Year Copayment Maximum (office visit, emergency room, & pharmacy copays apply)	$6,150 per member $12,300 per family		$6,150 per member $12,300 per family		$4,850 per member $9,700 per family		$4,350 per member $8,700 per family	
Total Calendar Year Out-of-Pocket (Deductible + Coinsurance + Copayment Maximum)	$7,350 per member $14,700 per family	$8,650 per member $17,300 per family	$7,350 per member $14,700 per family		$7,350 per member $14,700 per family		$7,350 per member $14,700 per family	
Utilization Management	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization by your Primary Care Physician.	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.		All inpatient admissions, except emergency and maternity admissions, are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.		All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.	
Hospital Services **Inpatient** **Outpatient**	85% after deductible 85% after deductible 100% after $200 copay	65% after deductible 65% after deductible 100% after $200 copay	85% after deductible 85% after deductible 100% after $200 copay	65% after deductible 65% after deductible 100% after $200 copay	80% after deductible 80% after deductible 100% after $200 copay	60% after deductible 60% after deductible 100% after $200 copay	80% after deductible 80% after deductible 100% after $200 copay	60% after deductible 60% after deductible 100% after $200 copay

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	MEA CHOICE PLUS		MEA STANDARD PLAN		MEA STANDARD PLAN $500 DEDUCTIBLE		MEA STANDARD PLAN $1,000 DEDUCTIBLE	
SERVICE	**Higher Benefit Level**	**Self-referred Benefit Level**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Care in ER (Copay is waived if you're admitted)								
Ambulance	85% after deductible	85% after deductible	85% after deductible	85% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Professional Services **Inpatient** **Outpatient Diagnostic Tests** **Outpatient Surgery** **Maternity**	 85% after deductible 85% after deductible 85% after deductible 85% after deductible	 65% after deductible 65% after deductible 65% after deductible 65% after deductible	 85% after deductible 85% after deductible 85% after deductible 85% after deductible	 65% after deductible 65% after deductible 65% after deductible 65% after deductible	 80% after deductible 80% after deductible 80% after deductible 80% after deductible	 60% after deductible 60% after deductible 60% after deductible 60% after deductible	 80% after deductible 80% after deductible 80% after deductible 80% after deductible	 60% after deductible 60% after deductible 60% after deductible 60% after deductible
High Tech Diagnostic Radiology (including but not limited to, CT Scans, MRI/MRA's, Nuclear Cardiology, PET Scans) These services require prior authorization	85% after deductible	65% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Occupational Therapy, Physical Therapy, and Speech Therapy	85% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation No Annual Limit	65% after deductible	85% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	65% after deductible Office visit copay and 20% coinsurance will apply to OT/PT evaluation or re-evaluation	80% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	60% after deductible Office visit copay and 20% coinsurance will apply to OT/PT evaluation or re-evaluation	80% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	60% after deductible Office visit copay and 20% coinsurance will apply to OT/PT evaluation or re-evaluation
Chiropractic Care – Physical Manipulations	85% after deductible Up to 36 visits per calendar year when self-referring to a network provider; after 36 visits, PCP referral is required for payment at the higher benefit level. Limited to 40 visits per member per calendar year	85% after deductible In-Network Provider 65% after deductible Out-of-Network Provider	85% after deductible Up to 40 visits per member per calendar year	65% after deductible	80% after deductible Up to 40 visits per member per calendar year	60% after deductible	80% after deductible Up to 40 visits per member per calendar year	60% after deductible
Nutritional Counseling	100%	65% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Smoking Cessation Education Programs	100%	65% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Physician Follow-up Visits	100%	65% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Prescribed Medications (see list of select medications)	100%	Prescription drug copay applies	100%	Prescription drug copay applies	100%	Prescription drug copay applies	100%	Prescription drug copay applies

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Skilled Nursing Facility	85% after deductible Up to 150 days per member per calendar year	65% after deductible	85% after deductible Up to 150 days per member per calendar year	65% after deductible	80% after deductible Up to 150 days per member per calendar year	60% after deductible	80% after deductible Up to 150 days per member per calendar year	60% after deductible
Home Health Care	85% after deductible	65% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospice	100%	65% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Acupuncture	85% after deductible	85% after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	85% after deductible	65% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible.
Pediatric Dental Varnish (not covered under the retiree plans)	100% up to age 5	Not Covered	100% up to age 5	80% no deductible, up to age 5	100% up to age 5	80% no deductible, up to age 5	100% up to age 5	80% no deductible, up to age 5
Early Intervention Services (Limited for children up to age 36 months of age)	85% after deductible	65% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Autism Spectrum Disorders: Applied Behavior Analysis	100% after $15 PCP copay	65% after deductible	100% after $15 copay	80% after $15 copay	100% after $20 copay	80% after $20 copay	100% after $20 copay	80% after $20 copay
MENTAL HEALTH **Managed by Anthem Behavioral Health and all services require preauthorization. Failure to comply with the requirements outlined in your Certificate of Coverage may result in a penalty up to $300**	**Primary Care Physician referral is not required.** This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.	This coverage level applies when the member does not contact Anthem Behavioral Health at 1-800-755-0851 for preauthorization of inpatient mental health and substance abuse services or chooses to receive services from a provider other than the provider the mental health care manager indicates. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)	. This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.	This coverage level applies when the member does not contact Anthem Behavioral Health at 1-800-755-0851 for preauthorization of inpatient mental health and substance abuse services or chooses to receive services from a provider other than the provider the mental health care manager indicates. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)	This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.	This coverage level applies when the member does not contact Anthem Behavioral Health at 1-800-755-0851 for preauthorization of inpatient mental health and substance abuse services or chooses to receive services from a provider other than the provider the mental health care manager indicates. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)	This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.	This coverage level applies when the member does not contact Anthem Behavioral Health at 1-800-755-0851 for preauthorization of inpatient mental health and substance abuse services or chooses to receive services from a provider other than the provider the mental health care manager indicates. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)
Mental Health and Substance Abuse Services **Inpatient** **Residential Treatment Facility** **Outpatient** **Office Visits**	85% after deductible 85% after deductible 85% (no deductible) 100% after $15 PCP copay	65% after deductible 65% after deductible 65% after deductible 65% after deductible	85% after deductible 85% after deductible 85% (no deductible) 100% after $15 copay	65% after deductible 65% after deductible 65% (no deductible) 80% after $15 copay	80% after deductible 80% after deductible 80% (no deductible) 100% after $20 copay	60% after deductible 60% after deductible 60% (no deductible) 80% after $20 copay	80% after deductible 80% after deductible 80% (no deductible) 100% after $20 copay	60% after deductible 60% after deductible 60% (no deductible) 80% after $20 copay

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Prescription Drug Coverage For each 30-day supply	Tier 1: $10 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay	Tier 1: $10 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay	Tier 1: $10 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay	Tier 1: $10 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay
Mail Order and Select Retail Pharmacies for up to a 90-day supply (please ask your pharmacy if they offer this benefit)	Tier 1: $20 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies	Tier 1: $20 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies	Tier 1: $20 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies	Tier 1: $20 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies

This is an overview of your benefits. For more detailed information please contact your benefits administrator or ask us for a copy of the Certificate of Coverage for your health plan. If there are discrepancies between this benefit overview and the Certificate of Coverage, the Certificate will govern.

Revised: 03/09/2018