MEA Benefits Trust

Anthem

Benefit Comparison – Plans Effective July 1, 2024

	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	$0 for the first visit and then $20 PCP copay 100% after $30 Specialist copay	60% after deductible	$0 for the first visit and then $20 PCP copay 100% after $30 Specialist copay	60% after deductible 60% after-deductible	$0 for the first visit and then $25 PCP copay 100% after $35 Specialist copay	55% after deductible 55% after-deductible	$0 for the first visit and then $25 PCP copay 100% after $35 Specialist copay	55% after deductible 55% after-deductible
Preventive & Well Care Services	100%	Not Covered (members can self-refer to a participating Ob/Gyn for their annual Well Woman exams	100%	80% no deductible	100%	80% no deductible	100%	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	$1,500 per member $3,000 per family	$2,750 per member $5,500 per family	$1,500 per member $3,000 per family		$2,500 per member $5,000 per family		$2,500 per member $5,000 per family	
Calendar Year Copayment Maximum (office visit, emergency room, & pharmacy copays apply)	$7,750 per member $15,500 per family		$7,750 per member $15,500 per family		$6,450 per member $12,900 per family		$5,950 per member $11,900 per family	
Total Calendar Year Out-of-Pocket (Deductible + Coinsurance +	$9,450 per member $18,900 per family	$10,750 per member $21,500 per family	$9,450 per member $18,900 per family		$9,450 per member $18.900 per family		$9,450 per member $18,900 per family	

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Copayment Maximum)								
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** **Emergency Care in ER (Copay is waived if you're admitted)**	 80% after deductible 80% after deductible 100% after $300 copay	 60% after deductible 60% after deductible 100% after $300 copay	 80% after deductible 80% after deductible 100% after $300 copay	 60% after deductible 60% after deductible 100% after $300 copay	 75% after deductible 75% after deductible 100% after $300 copay	 55% after deductible 55% after deductible 100% after $300 copay	 75% after deductible 75% after deductible 100% after $300 copay	 55% after deductible 55% after deductible 100% after $300 copay
Walk In Center	100% after $20 PCP copay	60% after deductible	100% after $20 PCP copay	60% after deductible	100% after $25 PCP copay	55% after deductible	100% after $25 PCP copay	55% after deductible
LiveHealth Online (Preferred On-line visits) **Behavioral Health**	$0 copay No Charge	$0 copay No Charge	$0 copay No Charge	NA NA	$0 copay No Charge	NA NA	$0 copay No Charge	NA NA
Ambulance	80% after deductible	80% after deductible	80% after deductible	80% after deductible	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Professional Services **Inpatient** **Outpatient** **Diagnostic Tests** **Outpatient Surgery** **Maternity**	 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	 75% after deductible 75% after deductible 75% after deductible 75% after deductible	 55% after deductible 55% after deductible 55% after deductible 55% after deductible	 75% after deductible 75% after deductible 75% after deductible 75% after deductible	 55% after deductible 55% after deductible 55% after deductible 55% after deductible
High Tech Diagnostic Radiology	80% after deductible	60% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
	Including but not limited to, CT Scans, MRI/MRA's, Nuclear Cardiology, PET Scans. These services require prior authorization							
Occupational Therapy, Physical Therapy, and Speech Therapy	80% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation	60% after deductible	80% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation	60% after deductible	75% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation	55% after deductible	75% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation	55% after deductible

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	No Annual Limit		60 visits per member per calendar year for all therapies combined		60 visits per member per calendar year for all therapies combined		60 visits per member per calendar year for all therapies combined	
Chiropractic Care – Physical Manipulations	80% 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	80% after deductible In-Network Provider 60% after deductible Out-of-Network Provider	80% after deductible Up to 40 visits per member per calendar year	60% after deductible	75% after deductible Up to 40 visits per member per calendar year	55% after deductible	75% after deductible Up to 40 visits per member per calendar year	55% after deductible
Nutritional Counseling	100%	60% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Smoking Cessation Education Programs	100%	60% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Physician Follow-up Visits	100%	60% 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
Inpatient Rehab/Skilled Nursing Facility	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	75% after deductible Up to 150 days per member per calendar year	55% after deductible	75% after deductible Up to 150 days per member per calendar year	55% after deductible
Home Health Care	80% after deductible	60% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Hospice	100%	60% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Acupuncture	80% after deductible	80% after deductible	80% after deductible Limited to 20 visits per year	60% after deductible	75% after deductible Limited to 20 visits per year	55% after deductible	75% after deductible Limited to 20 visits per year	55% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
TMJ Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Hearing Aids	80% after deductible	60% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
	Children limited to 1 hearing aid per hearing impaired ear every 36 months. Adults limited to $3,000 per hearing aid per hearing impaired ear every 36 months.							
Pediatric Dental Varnish	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

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Early Intervention Services (Limited for children up to age 36 months of age)	80% after deductible	60% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Autism Spectrum Disorders: Applied Behavior Analysis	100% after $20 PCP copay	60% after deductible	100% after $20 copay	60% after deductible	100% after $25 copay	55% after deductible	100% after $25 copay	55% after deductible
BEHAVIORAL 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 reduced benefit.**	**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.)
Behavioral Health Services **Inpatient** **Residential Treatment Facility** **Outpatient** **Office Visits**	 80% after deductible 80% after deductible 80% (no deductible) No Charge	 60% after deductible 60% after deductible 60% after deductible (out of network) 60% after deductible (out of network)	 80% after deductible 80% after deductible 80% (no deductible) No Charge	 60% after deductible 60% after deductible 60% (no deductible) 80% (no deductible)	 75% after deductible 75% after deductible 75% (no deductible) No Charge	 55% after deductible 55% after deductible 55% (no deductible) 75% (no deductible)	 75% after deductible 75% after deductible 75% (no deductible) No Charge	 55% after deductible 55% after deductible 55% (no deductible) 75% (no deductible)

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Prescription Drug Coverage For each 30-day supply	Tier 1a: $10 copay Tier 1b: $15 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay (in-network only)		Tier 1a: $10 copay Tier 1b: $15 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay (in-network only)		Tier 1a: $10 copay Tier 1b: $15 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay (in-network only)		Tier 1a: $10 copay Tier 1b: $15 copay Tier 2: $35 copay Tier 3: $60 copay Tier 4 Specialty Drugs: $85 copay (in-network only)	
Mail Order and Select Retail Pharmacies for up to a 90-day supply (please ask your pharmacy if they offer this benefit)	Tier 1a: $20 copay Tier 1b: $30 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies (in-network only)		Tier 1a: $20 copay Tier 1b: $30 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies (in-network only)		Tier 1a: $20 copay Tier 1b: $30 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies (in-network only)		Tier 1a: $20 copay Tier 1b: $30 copay Tier 2: $70 copay Tier 3: $120 copay Tier 4 Specialty Drugs: Not eligible for 90 day supplies (in-network only)	

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: 3/6/2024