MEA Benefits Trust

Anthem

Benefit Comparison – Plans Effective July 1, 2025

	MEA CHOICE PLUS PLAN		MEA CHOICE PLUS VALUE PLAN		MEA STANDARD PLAN		MEA STANDARD CORE PLAN		MEA STANDARD BASIC PLAN	
SERVICE	**Higher Benefit Level**	**Self-referred Benefit Level**	**Higher Benefit Level**	**Out-of-Network**	**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 provided or authorized 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 who are not in the Blue Choice New England POS 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 PPO 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 PPO 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 PPO 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 PPO 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 PPO network.
Network	HMO Maine		Blue Choice New England POS		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)	
Primary Care Physician Required	YES		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 $25 PCP copay 100% after $35 Specialist copay	55% 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%	Not Covered	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Calendar Year Deductible	$300 per person $600 per family	$350 per person $700 per family	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family	$300 per person $600 per family		$600 per person $1,200 per family		$1,100 per person $2,200 per family	
Coinsurance Limit	$1,500 per person $3,000 per family	$2,750 per person $5,500 per family	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family	$1,500 per person $3,000 per family		$2,500 per person $5,000 per family		$2,500 per person $5,000 per family	
Calendar Year Copayment Maximum (office visit, emergency room, & pharmacy copays apply)	$7,400 per person $14,800 per family		$4,200 per person $8,400 per family		$7,400 per person $14,800 per family		$6,100 person $12,200 per family		$5,600 per person $11,200 per family	
Total Calendar Year Out-of-Pocket (Deductible + Coinsurance + Copayment Maximum)	$9,200 per person $18,400 per family	$10,500 per person $21,000 per family	$9,200 per person $18,400 per family	$14,200 per person $28,400 per family	$9,200 per person $18,400 per family		$9,200 per person $18.400 per family		$9,200 per person $18,400 per family	

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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 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	75% after deductible 75% after deductible 100% after $300 copay	55% after deductible 55% 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 $25 PCP copay	55% 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	$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		75% after deductible		80% 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	75% after deductible 75% after deductible 75% after deductible 75% after deductible	55% after deductible 55% after deductible 55% after deductible 55% 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
Advanced Diagnostic Imaging for example: MRI, PET and CAT scans. These services require prior authorization	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Occupational Therapy, Physical Therapy, and Speech Therapy	80% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation No Annual Limit	60% after deductible	75% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation No Annual Limit	55% after deductible	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	75% 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	55% after deductible	75% 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	55% after deductible

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Chiropractic Care – Physical Manipulations	80% after deductible	80% after deductible In-Network Provider 60% after deductible Out-of-Network Provider	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% 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		. Up to 40 visits per member per calendar year		Up to 40 visits per member per calendar year		Up to 40 visits per member per calendar year		Up to 40 visits per member per calendar year	
Nutritional Counseling	100%	60% after deductible	100%	55% no deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Smoking Cessation Education Programs										
Physician Follow-up Visits	100%	60% after deductible	100%	55% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Prescribed Medications (see list of select medications)	100%	60% after deductible	100%	55% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
	100%	Prescription drug copay applies	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	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
	Up to 150 days per member per calendar year		Up to 150 days per member per calendar year		Up to 150 days per member per calendar year		Up to 150 days per member per calendar year		Up to 150 days per member per calendar year	
Home Health Care	80% after deductible	60% after deductible	75% after deductible	55% 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%	55% no deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Acupuncture	80% after deductible	80% after deductible	75% after deductible	75% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
					Limited to 20 visits per year		Limited to 20 visits per year		Limited to 20 visits per year	
Durable Medical Equipment	80% after deductible	60% after deductible	75% after deductible	55% 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	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Hearing Aids Children 1 per hearing impaired ear every 36 months. Adults limited to $3,000 per hearing impaired ear every 36 months	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible

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Pediatric Dental Varnish	100% up to age 5	Not Covered	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)	80% after deductible	60% after deductible	75% after deductible	55% 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 $25 copay	55% 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.)	**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)	 75% after deductible 75% after deductible 75% (no deductible) No Charge	 55% after deductible 55% after deductible 55% after deductible 55% after deductible	 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) 80% (no deductible)	 75% after deductible 75% after deductible 75% (no deductible) No Charge	 55% after deductible 55% after deductible 55% (no deductible) 80% (no deductible)

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Prescription Drug Coverage For each 30-day supply	Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $45 copay Tier 3: $70 copay Tier 4 Specialty: 20% coinsurance to $150 (in-network only)		Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $45 copay Tier 3: $70 copay Tier 4 Specialty: 20% coinsurance to $150 (in-network only)		Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $45 copay Tier 3: $70 copay Tier 4 Specialty: 20% coinsurance to $150 (in-network only)		Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $45 copay Tier 3: $70 copay Tier 4 Specialty: 20% coinsurance to $150 (in-network only)		Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $45 copay Tier 3: $70 copay Tier 4 Specialty: 20% coinsurance to $150 (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: $40 copay Tier 2: $90 copay Tier 3: $140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)		Tier 1a: $20 copay Tier 1b: $40 copay Tier 2: $90 copay Tier 3: $140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)		Tier 1a: $20 copay Tier 1b: $40 copay Tier 2: $90 copay Tier 3: $140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)		Tier 1a: $20 copay Tier 1b: $40 copay Tier 2: $90 copay Tier 3: $140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)		Tier 1a: $20 copay Tier 1b: $40 copay Tier 2: $90 copay Tier 3: $140 copay Tier 4 Specialty: Not eligible for 90 day supply (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: 3/14/2025