MEA Benefits Trust

Anthem

Benefit Comparison – Plans Effective July 1, 2011

	MEA STANDARD PLAN		MEA CHOICE PLUS	
SERVICE	***In-Network***	***Out-of-Network***	***Higher Benefit Level***	***Self-referred Benefit Level***
Important Information	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 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).
Primary Care Physician Required	No	No	Yes	Yes
Coinsurance Level	85%	65%	85%	65%
Physician Office Visits Sick Care	100% after $15 copayment	80% after $15 copayment	100% after $15 copayment w/ PCP 100% after $25 copayment w/ specialist	65% after deductible
Routine/Preventive (exam)	100%	80% no deductible	100%	Not Covered
OB/GYN Exam (Annual Well Woman)	100%	80% no deductible	100%	100% (members can self refer **to a participating** Ob/GYN for their annual Well Woman exam)
Office Visit Copayment Primary Care Physician	$15	80% after $15 copayment	$15	No copayment, coinsurance applies
Specialist	$15	80% after $15 copayment	$25	No copayment, coinsurance applies
Calendar Year Deductibles General Medical	$200 per member/ $400 per family	$200 per member/ $400 per family	$100 per member/ $200 per family	$250 per member/ $500 per family
Coinsurance Limit	$600 per member/ $1,200 per family	$600 per member/ $1,200 per family	$700 per member/ $1,400 per family	$2,250 per member/ $4,500 per family
Calendar Year Out-of-Pocket Limit (Deductible + Coinsurance)	$800 per member/ $1,600 per family	$800 per member/ $1,600 per family	$800 per member/ $1,600 per family	$2,500 per member/ $5,000 per family
General Medical Lifetime Maximum Benefits	No lifetime limit	No lifetime limit	No lifetime limit	No lifetime limit

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Utilization Management	All inpatient admissions, except emergency and maternity admissions, are subject to preadmission authorization. You, your physician or the provider must call 1-800-392-1016.	All inpatient admissions, except emergency and maternity admissions, are subject to pread-mission authorization. You, your physician or the provider must call 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 1-800-392-1016.
High Tech Diagnostic Radiology (including but not limited to, CT Scans, MRI/MRAs, Nuclear Cardiology, PET Scans) **These services require prior authorization.**	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Hospital Services				
Inpatient	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Outpatient	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Emergency Care in ER (Copayment is waived if you are admitted)	100% after $100 copayment	100% after $100 copayment	100% after $100 copayment	100% after $100 copayment
Professional Services				
Inpatient	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Outpatient Diagnostic Tests	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Outpatient Surgery	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Maternity	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Routine Eye Exams	100%	80%	100%	100%
Occupational Therapy, Physical Therapy and Speech Therapy	85% after deductible Office visit copay will apply to OT/PT evaluation or reevaluation *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 reevaluation	85% after deductible Office visit copay will apply to OT/PT evaluation or reevaluation *No annual limit*	65% after deductible
Chiropractic Care – Physical Manipulations	85% after deductible *Up to 40 visits per member calendar year*	65% after deductible	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% if network provider 65% non-network provider
Nutritional Counseling *(Benefit differs for retired MEA members)*	100% *No annual limit*	80% no deductible	100% *No annual limit*	65% after deductible
Smoking Cessation Education Programs	100%	80% no deductible	100%	65% after deductible
Physician Follow-up Visits	100%	80% no deductible	100%	65% after deductible
Prescribed Medications	Prescription drug copayment applies	Prescription drug copayment applies	Prescription drug copayment applies	Prescription drug copayment applies
Skilled Nursing Facility	85% after deductible *No annual limit*	65% after deductible	85% after deductible *Up to 100 days per member per calendar year*	65% after deductible
Hospice/Home Health Care	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Acupuncture	Not Covered	Not Covered	85% after deductible	65% after deductible
Durable Medical Equipment	85% after deductible *No annual limit*	65% after deductible	85% *No annual limit*	65% after deductible

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			Primary Care Physician authorization is not required. Limits and maximums apply to services received at the highest and self-referred levels of benefits combined.	
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.	This coverage level applies when the member obtains preauthorization from (1-800-755-0851) for all inpatient and outpatient 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 (1-800-755-0851) for preauthorization of 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 (1-800-755-0851) for all inpatient and outpatient 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 (1-800-755-0851) for preauthorization of 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	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Residential Treatment Facilities	85% after deductible	65% after deductible	85% after deductible	65% after deductible
Outpatient	85% (no deductible)	65% (no deductible)	85% (no deductible)	65% after deductible
Office	85% (no deductible)	65% (no deductible)	85% (no deductible)	65% after deductible

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Prescription Drug Coverage		
For each 30-day supply	Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $45 copayment Impotency Drugs $50	Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $45 copayment Impotency Drugs $50
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 copayment Tier 2: $60 copayment Tier 3: $90 copayment Impotency Drugs $100	Tier 1: $20 copayment Tier 2: $60 copayment Tier 3: $90 copayment Impotency Drugs $100

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.