



Benefit Comparison – Plans Effective July 1, 2023

| | 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 \$15 PCP copay 100% after \$25 Specialist copay | 65% after deductible | \$0 for the first visit and then \$15 PCP copay 100% after \$25 Specialist copay | 65% after deductible 65% 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 \$20 PCP copay 100% after \$30 Specialist copay | 60% after deductible 60% 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 | \$1,000 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) | \$7,900 per member \$15,800 per family | | \$7,900 per member \$15,800 per family | | \$6,600 per member \$13,200 per family | | \$6,100 per member \$12,200 per family | |
| Total Calendar Year Out-of-Pocket (Deductible + Coinsurance + | \$9,100 per member \$18,200 per family | \$10,400 per member \$20,800 per family | \$9,100 per member \$18,200 per family | | \$9,100 per member \$18,200 per family | | \$9,100 per member \$18,200 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) | 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 |
| Walk In Center | 100% after \$15 PCP copay | 65% after deductible | 100% after \$15 PCP copay | 65% after deductible | 100% after \$20 PCP copay | 60% after deductible | 100% after \$20 PCP copay | 60% 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 | 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 | 85% after deductible | 65% after deductible | 85% after deductible | 65% after deductible | 80% after deductible | 60% after deductible | 80% after deductible | 60% 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 | 85% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation | 65% after deductible | 85% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation | 65% after deductible | 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 |



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| | Higher Benefit Level | Self-referred Benefit Level | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| | 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 | 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 |
| Inpatient Rehab/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 | 85% after deductible | 65% after deductible Limited to 20 visits per year | 80% after deductible | 60% after deductible Limited to 20 visits per year | 80% after deductible | 60% after deductible Limited to 20 visits per year |
| 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. |
| TMJ Services | 85% after deductible | 65% after deductible | 85% after deductible | 65% after deductible | 80% after deductible | 60% after deductible | 80% after deductible | 60% after deductible |
| Hearing Aids | 85% after deductible | 65% after deductible | 85% after deductible | 65% after deductible | 80% after deductible | 60% after deductible | 80% after deductible | 60% 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) | 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 | 65% after deductible | 100% after \$20 copay | 60% after deductible | 100% after \$20 copay | 60% 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 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 | 85% after deductible 85% after deductible 85% (no deductible) No Charge | 65% after deductible 65% after deductible 65% after deductible (out of network) 65% after deductible (out of network) | 85% after deductible 85% after deductible 85% (no deductible) No Charge | 65% after deductible 65% after deductible 65% (no deductible) 80% (no deductible) | 80% after deductible 80% after deductible 80% (no deductible) No Charge | 60% after deductible 60% after deductible 60% (no deductible) 80% (no deductible) | 80% after deductible 80% after deductible 80% (no deductible) No Charge | 60% after deductible 60% after deductible 60% (no deductible) 80% (no deductible) |



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| SERVICE | Higher Benefit Level | Self-referred Benefit Level | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| 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: 3/1/2023