

Benefit Comparison – Plans Effective July 1, 2016

| SERVICE | MEA CHOICE PLUS | | MEA STANDARD PLAN | | MEA STANDARD PLAN \$500 DEDUCTIBLE | | MEA STANDARD PLAN \$1,000 DEDUCTIBLE | |
|---|---|---|---|---|--|---|---|---|
| | 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 | 100% after \$15 PCP copay 100% after \$25 Specialist copay | 65% after deductible | 100% after \$15 copay (PCP or specialist) | 80% after \$15 copay (PCP or specialist) | 100% after \$20 copay (PCP or specialist) | 80% after \$20 copay (PCP or specialist) | 100% after \$20 copay (PCP or specialist) | 80% after \$20 copay (PCP or specialist) |
| Preventive & Well Care Services | 100% | Not Covered (members can self-refer to a participating Ob/Gyn for their annual Well Woman exam) | 100% | 80% no deductible | 100% | 80% no deductible | 100% | 80% no deductible |
| Calendar Year Deductible | \$100 per member \$200 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 | \$700 per member \$1,400 per family | \$2,250 per member \$4,500 per family | \$600 per member \$1,200 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) | \$6,050 per member \$12,100 per family | | \$6,050 per member \$12,100 per family | | \$4,350 per member \$8,700 per family | | \$3,850 per member \$7,700 per family | |
| Total Calendar Year Out-of-Pocket (Deductible + Coinsurance + Copayment Maximum) | \$6,850 per member \$13,700 per family | \$8,550 per member \$17,100 per family | \$6,850 per member \$13,700 per family | | \$6,850 per member \$13,700 per family | | \$6,850 per member \$13,700 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 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 |

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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 |
| 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 100 days per member per calendar year | 65% after deductible | 85% after deductible No Annual Limit | 65% after deductible No Annual Limit | 80% after deductible No Annual Limit | 60% after deductible No Annual Limit | 80% after deductible No Annual Limit | 60% after deductible No Annual Limit |
| 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 | 85% after deductible | 65% after deductible | 85% after deductible | 65% after deductible | 80% after deductible | 60% after deductible | 80% after deductible | 60% after deductible |
| MENTAL HEALTH | Primary Care Physician referral is not required. | | | | | | | |
| 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 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 |



In Maine, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans of Maine, Inc., an independent licensee of the Blue Cross and Blue Shield Association.
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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.