

Benefit Comparison – Plans Effective July 1, 2011

| SERVICE | MEA STANDARD PLAN | | MEA CHOICE PLUS | |
|--|---|---|---|--|
| | <i>In-Network</i> | <i>Out-of-Network</i> | <i>Higher Benefit Level</i> | <i>Self-referred Benefit Level</i> |
| 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 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 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 Outpatient Emergency Care in ER (Copayment is waived if you are admitted) | 85% after deductible 85% after deductible 100% after \$100 copayment | 65% after deductible 65% after deductible 100% after \$100 copayment | 85% after deductible 85% after deductible 100% after \$100 copayment | 65% after deductible 65% after deductible 100% after \$100 copayment |
| 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 |
| 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 <i>60 visits per member per calendar year for all therapies combined</i> | 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 | 65% after deductible <i>No annual limit</i> |
| Chiropractic Care – Physical Manipulations | 85% after deductible <i>Up to 40 visits per member calendar year</i> | 65% after deductible | 85% after deductible | 85% if network provider 65% non-network provider <i>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</i> |
| Nutritional Counseling <i>(Benefit differs for retired MEA members)</i> | 100% <i>No annual limit</i> | 80% no deductible | 100% <i>No annual limit</i> | 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 <i>No annual limit</i> | 65% after deductible | 85% after deductible <i>Up to 100 days per member per calendar year</i> | 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 <i>No annual limit</i> | 65% after deductible | 85% <i>No annual limit</i> | 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 Residential Treatment Facilities Outpatient Office | 85% after deductible 85% after deductible 85% (no deductible) 85% (no deductible) | 65% after deductible 65% after deductible 65% (no deductible) 65% (no deductible) | 85% after deductible 85% after deductible 85% (no deductible) 85% (no deductible) | 65% after deductible 65% after deductible 65% after deductible 65% after deductible |

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| Prescription Drug Coverage For each 30-day supply Mail Order and Select Retail Pharmacies for up to a 90-day supply (please ask your pharmacy if they offer this benefit) | Tier 1: \$10 copayment Tier 2: \$30 copayment Tier 3: \$45 copayment Impotency Drugs \$50 Tier 1: \$20 copayment Tier 2: \$60 copayment Tier 3: \$90 copayment Impotency Drugs \$100 | Tier 1: \$10 copayment Tier 2: \$30 copayment Tier 3: \$45 copayment Impotency Drugs \$50 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.