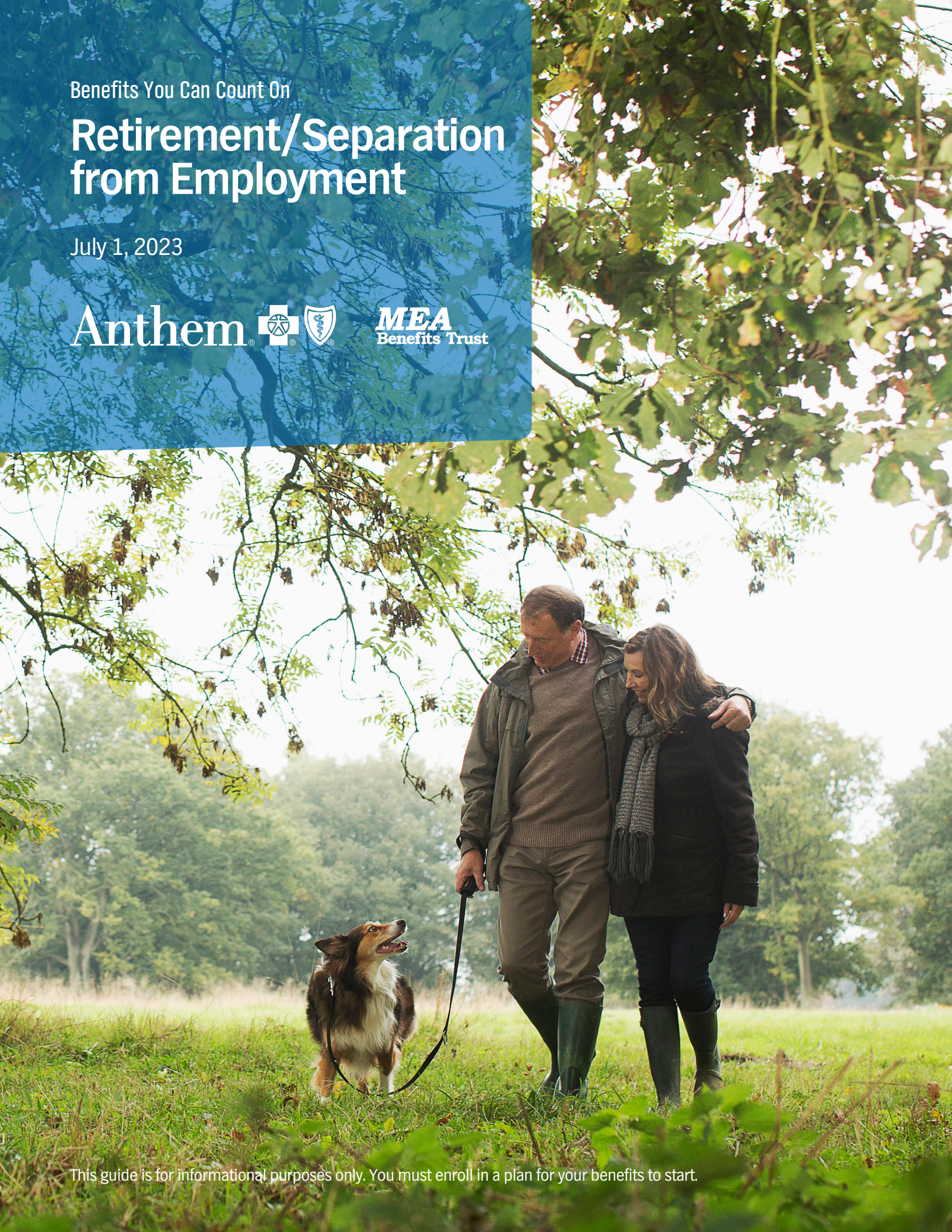
Benefits You Can Count On

Retirement/Separation from Employment

July 1, 2023

Anthem

MEA Benefits Trust



This guide is for informational purposes only. You must enroll in a plan for your benefits to start.

Explore your plan options

MEA Choice Plus 

With the Point of Service (POS) plan, you can see doctors in your plan and outside of your plan, giving you more flexibility and choices. The POS offers three different ways to get care:

- You'll pay less for care if you choose a primary care doctor (PCP) from the plan for preventive care like checkups and screenings.
- If you need care from a specialist, you'll want to go through your PCP to get a referral. If you don't get a referral, you'll pay a bit more to see specialists.
- You'll pay a bit more to see specialists or doctors in the plan without a referral.
- You'll pay even more when you go to the doctors who aren't in your plan.

MEA Standard Plans 

With a Preferred Provider Organization, you can go to almost any doctor or hospital and you're covered-giving you more choices and flexibility. You can get special rates for doctors in your plan, which lowers your out-of-pocket costs.

- You can choose a primary care physician (PCP) from the plan for preventive care, like checkups and screenings.
- You don't need a PCP to see a specialist.
- When you see a specialist, like an orthopedic doctor, you don't need to visit your PCP first to get a referral. This can save you time and a copayment.
- You'll pay less if you use doctors who are part of the PPO.
- You can see providers who aren't part of the PPO, but you'll pay more.

Your Medicare Advantage plan Anthem Medicare Preferred (PPO) with Senior Rx Plus Plan (after age 65)

You have coverage for services such as doctor office visits, preventive care services, prescription drug benefits, inpatient and outpatient hospital services, emergency care services, foreign travel emergency, and vision/hearing services.

You also have access to a wide variety of programs and tools to support and guide you in your wellness journey, including:

- $0 copay for an Annual Wellness Visit when you see a doctor in your plan
- Freedom to choose providers who participate in Medicare and are willing to accept the plan, without a referral
- Coverage for emergency care both inside and outside of the U.S.
- 24/7 NurseLine for access to a registered nurse, day or night
- LiveHealth Online virtual visit with a doctor or therapist anytime, anywhere, for a $0 copay
- SilverSneakers® fitness program for support with exercise and activity
- Access to SpecialOffers from our partners to help you stay well and spend less

MEABT Anthem Blue Cross and Blue Shield Health Plans

IMPORTANT RETIREMENT INFORMATION

Rules and Regulations for MEABT Anthem Blue Cross and Blue Shield Health Plans only

For questions regarding MEA Choice Plus
or Standard plans, please call Member Services at 1-833-772-4121

For questions regarding the Medicare Advantage Plan, please call the First Impressions Team at 1-844-951-0624

Patty Whitcomb
Account Service Representative
Anthem Blue Cross and Blue Shield
207-822-7556
patty.whitcomb@anthem.com

Sharon Beaulieu
Benefits Manager
MEA Benefits Trust
207-622-4418, ext. 2207
sbeaulieu@meabt.org

BARGAINING ISSUES

Your health coverage as a retiree is determined by the Health Plan bargained by your local bargaining unit. If your local unit bargains in new health benefit options (i.e. MEA Choice Plus), they will be made available to all non-Medicare eligible retirees annually at the Selection/Annual Enrollment Period.

If your local Association changes their health insurance carrier, then *ALL* retirees under or over 65 will have to go with the new insurance company or plan. You may not stay with the MEA Anthem Blue Cross Blue and Shield health plan.

This is in compliance with Maine State law.

Basic Eligibility Rules

A participant is eligible to continue coverage under the MEABT Health Plan after terminating employment and to receive a direct bill or pension deduction from Anthem Blue Cross and Blue Shield for continued coverage if he or she meets one of the rules below:

- *under age 50*: 10 years of continuous active service and MEABT Health Plan coverage; and active participation and coverage in the MEABT Health Plan for the immediate 12 months prior to termination of employment.

- *age 50 and over*: 5 years of continuous active service and MEABT Health Plan coverage; and active participation and coverage in the MEABT Health Plan for the immediate 12 months prior to termination of employment.

- Dependents must be added to employee's policy no later than the date of transition from the active plan to the retiree plan. Once an employee is retired, they cannot add anyone to their policy unless it is within 60 days of marriage or the birth/adoption of a child.

In order to take advantage of these rules, the participant's employer must be in the MEABT Health Plan on the participant's date of retirement/termination of employment.

(Special provisions apply to schools coming from another carrier.)

Retirement Information

Beginning the Process

Begin the paperwork for Anthem Blue Cross and Blue Shield retirement a minimum of 3 months prior to retirement. This is not done for you. Most times you must initiate the request for paperwork.

Your Pay Deduction

Most teacher contracts provide that your health insurance be paid for by the school during the summer months of July and August; therefore, if you retire July 1st and start to receive your MainePERS check immediately, there would be no deduction out of the July 31st check. There would be a deduction out of your August 31st check because MainePERS deducts in advance for the September premium.

State of Maine Contribution

The State of Maine contribution is only for certain staff members defined by the Maine Department of Education. Retirees must have reached their normal retirement age as defined by MainePERS in order to be eligible for the State contribution to their retirement plan premium. The State does not contribute to the cost of coverage for dependents.

The only way for eligible staff to get the State's contribution is if you have reached your normal retirement age ***and*** the health insurance premium is deducted from your MainePERS check.

If you are an educator/staff member retiring before you have reached your normal retirement age and are not receiving a MainePERS check, you will be direct billed at your home address for your MEA Anthem Blue Cross Blue Shield health plan.

If you are an educator/staff member retiring before you have reached your normal retirement age and are receiving a MainePERS check, you can choose to be direct billed or to have the premium deducted from your check.

If there is a delay in getting your MainePERS check, Anthem Blue Cross Blue Shield will direct bill you at home for your share of the cost and bill the State for their contribution for eligible employees.

Support staff eligible for a MainePERS check can have their premium deducted out of their MainePERS check. If you are not eligible for a MainePERS check, you will be direct billed at your home address for your MEA Anthem Blue Cross Blue Shield health plan.

MEABT BREAK PROVISION

- If a participant is eligible to continue coverage under the Basic Rules, he or she shall be entitled to one (and only one) break in coverage, which may last no longer than 5 years, after which he or she can return to the MEABT Health Plan. For example, if a person takes a 1-year break and then returns, he or she cannot take another break and thereafter return to the Plan.

- During the break, the participant must be covered by comprehensive health insurance similar to the MEABT Health Plan. This requirement is not met by very high deductible plans, very limited policies paying small amounts only for hospital stays, or single disease policies (such as cancer policies). Subscriber must submit proof of coverage when returning to the MEABT Anthem Blue Cross Blue Shield plan.

- The break must cease within five years or when a participant attains age 62, ***whichever comes first***.

- Breaks cannot commence after an employer decides to leave the MEA Health Plan to move to a competitor.

- A participant is not considered to on a "break" if he or she is covered as a dependent of another participant under the MEA Health Plan.

- A participant who terminates employment, meets one of the Retirement Basic Eligibility Rules, has twenty-five years of MainePERS credible service and does not retire through MainePERS will have a **one-time** election to re-enroll at the time of their retirement if they choose not to continue their health insurance at the time of employment termination. There is no time limitation to the break other than returning at the time of their retirement through MainePERS.

Please note: It is ***your responsibility*** to monitor your break time; neither Anthem Blue Cross Blue Shield nor the MEABT will notify you at the end of your break time. You should notify us 60 days in advance of your return for paperwork to complete the transaction. Failure to do so could jeopardize your participation in the retirement health plan.

Miscellaneous Information

Children: Children can remain on the parent's policy until the first of the month following their 26th birthday.

Plan Additions: Retirement group does not allow additions unless it is due to marriage or birth/adoption of a child. Plan changes are permitted when transferring from active status to retirement.

Annual Enrollment: Annual enrollment under the retiree plan only allows you to change your health plan option – it does not allow you to add dependents (exception being new marriage or birth/adoption of a child).

Survivor Spouse Provisions: If the employee dies while insured under the health plan, their spouse and dependents that were covered at the time of their death will be eligible to continue the Anthem Blue Cross Blue Shield coverage. The premium will be deducted from the MainePERS check if applicable, or they will be direct billed. If the surviving spouse remarries, the group MEA Anthem Blue Cross Blue Shield coverage will end the first of the month following the remarriage date.

Active/Retirement: Any teacher who has reached normal retirement age may be restored to service for up to 5 years. You may not return to employment after retirement with the same employer for at least 30 calendar days after the termination of employment and may not return to employment before the effective date of the person's retirement.

Spouses/Domestic Partners Employed by MEA Covered School Departments: As long as both spouses/domestic partners are employed by or retired from MEA covered school departments, you can go from a single policy to a 2-person/family, or vice versa, plan at any time. i.e. if one of you retires and it is less expensive to go onto your actively working spouse/domestic partner's MEA plan, and your spouse/domestic partner's school department allows it, you should do whatever is financially beneficial for you. Keep in mind that you need to be of normal retirement age in order to receive the state's contribution when you move to the MEA retirement group plan.

MEA Benefits Trust
Application for Transfer of the Health Plan to Retirement Status

Please return this form to your employer – If you are now retired, please mail this form to:

Anthem Blue Cross and Blue Shield
Enrollment and Billing
2 Gannett Drive
South Portland, ME 04106

If you have any questions about this form, call Anthem Blue Cross and Blue Shield (Anthem) at: 888-399-8706

Please complete electronically or print legibly using black ink.

Section 1: Applicant information

Check plan: ☐ Single ☐ 2 person ☐ Family ☐ Adult with child or children					Group no.
Employee Information – If Rehired Retiree, use original school you retired from.					
School department			Occupation		Identification no.
Current email address (**other than your school email**)					
Retiree Information					
Last name	First name	M.I.	Birthdate (MMDDYYYY)		Social Security no.
Phone no.	Street address		City	State	ZIP code
Complete only if legal spouse, domestic partner, or dependent is eligible for coverage.					
Last name	First name	M.I.	Birthdate (MMDDYYYY)		Social Security no.

Section 2: Delete dependents – Deleted dependents will not be eligible to re-enroll.

Name	Birthdate (MMDDYYYY)	Social Security no.	Reason	Effective date (MMDDYY)
Spouse or domestic partner				
Dependent – oldest first				
Dependent				
Dependent				

Section 3: Medicare eligible – To be eligible for Medicare Advantage coverage you must have both Medicare Parts A and B. If you are age 65 or older and not eligible for premium-free Medicare, include a copy of your Social Security ineligibility letter.

Name(s) of Medicare covered person(s)			Medicare number	Medicare Part A effective date (MMDDYY)	Medicare Part B effective date (MMDDYY)	Check all reasons you qualified for Medicare		
Last name	First name	M.I.				Age 65	Disability	ESRD*
						☐	☐	☐
						☐	☐	☐
						☐	☐	☐

* End Stage Renal Disease

Required information prior to sending to Anthem

For school use only	MainePERS employer code	Position class code	Termination from active group	Date health insurance ends	Signature of school official

Section 4: MainePERS retirees

If you retired through the Maine Public Employees Retirement Systems (MainePERS) after July 1, 2012, Maine law generally requires you to reach "normal retirement age" before you can begin to receive the State of Maine contribution toward your health insurance. Your "normal retirement age" will be determined by your dates of service. To ensure that you receive the State of Maine contribution to which you may be entitled, you are required to notify Anthem on reaching "normal retirement age" as it applies to you. Please contact MainePERS with any questions pertaining to "normal retirement age."

If you are eligible for the State of Maine contribution toward retired teachers' health insurance premium, your health insurance premium must be deducted from your MainePERS pension check.

☐ I hereby authorize the MainePERS to deduct the proper amount to cover the cost(s) of my Anthem health coverage.

Please check one of the following:

- ☐ I have reached my "normal retirement age" as of: ____ ____ ____ ____ (MMDDYYYY)
- ☐ I have not reached my "normal retirement age."

☐ I have elected not to transfer the Anthem health coverage.

☐ I am applying for Disability Retirement: ☐ I have been approved for Disability Retirement as of: ____ ____ ____ ____ (MMDDYYYY)

- ☐ Bill me directly
- ☐ Deduct the Anthem health premium out of my MainePERS pension check

☐ Please bill me directly for Anthem health coverage.

☐ Please continue my coverage as a surviving spouse/domestic partner/dependent:

- ☐ Bill me directly
- ☐ Deduct the Anthem health premium out of my survivor MainePERS pension check

☐ I have 25 years of creditable service, was not in service immediately prior to retirement, and am now making a one-time election to rejoin the plan at the time of my retirement, as allowed by 20-A Me. Rev. Stat § 13451(2-C).

MEA Benefits Trust Break Provision: If a participant is eligible to continue coverage, he or she shall be entitled to one break in coverage, lasting no longer than five (5) years or until reaching age 62, whichever occurs first. Other restrictions apply. For more information, please contact the MEA Benefits Trust at 888-622-4418, ext. 2207 or Anthem at 888-399-8706.

☐ Applying for the MEA Benefits Trust break provision effective: ____ ____ ____ ____ (MMDDYYYY)

☐ Returning from the MEA Benefits Trust break provision effective: ____ ____ ____ ____ (MMDDYYYY)

Section 5: Signature required

I have been advised that **if at the time of retirement I am covered by the MEA Benefits Trust group health plan and meet the applicable requirements**, I may request transfer of my health coverage to retirement status. That part of the monthly premium for which I am responsible will be deducted from my retirement benefit check (if applicable). If retiring on a disability retirement, I authorize the MainePERS to withhold the amount of any health insurance premium which the MEA Benefits Trust/Anthem certifies to the System is owed by me as of the date on which my disability retirement is approved (if applicable). **I understand that in so doing, the MainePERS is acting as the agent of the MEA Benefits Trust**; any dispute as to this withholding is to be addressed to the MEA Benefits Trust/Anthem (if applicable). ***I also acknowledge that if I elected to delete dependents on this form, I will not be eligible to re-add them at a later date under the retiree group.***

I have been advised that the portion of the monthly premium for which I am responsible will be deducted from my retirement benefit check (if applicable). All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

My signature on this application constitutes my approval and authorization for Anthem to enforce its subrogation rights for my claims on a just and equitable basis.

In signing this application I certify that I have read and understand all the information on **both** sides of this form.

Applicant signature	Date (MMDDYYYY)
X	____ ____ ____ ____

Maine Education Association Benefits Trust

PLAN YEAR 2023-2024

		RETIREMENT RATE WITHOUT 55% STATE OF MAINE CONTRIBUTION			
	PLAN	SINGLE	2 ADULTS	ADULT W/ CHILD	FAMILY
	CHOICE PLUS	$852.67	$1,921.71	$1,509.02	$2,339.01
	STANDARD PLAN	$920.75	$2,075.48	$1,629.72	$2,526.12
	STANDARD PLAN 500	$810.01	$1,825.64	$1,433.57	$2,222.05
	STANDARD PLAN 1000	$772.52	$1,741.10	$1,367.17	$2,119.13
		RETIREMENT RATE INCLUDING THE STATE OF MAINE 55% CONTRIBUTION			
CHOICE PLUS	*55 % STATE SHARE*	$468.97	$528.47	$468.97	$528.47
	MEPERS CHECK DEDUCTION	$383.70	$1,393.24	$1,040.05	$1,810.54
STANDARD	*55% STATE SHARE*	$506.41	$570.76	$506.41	$570.76
	MEPERS CHECK DEDUCTION	$414.34	$1,504.72	$1,123.31	$1,955.36
STANDARD 500	*55% STATE SHARE*	$445.51	$502.05	$445.51	$502.05
	MEPERS CHECK DEDUCTION	$364.50	$1,323.59	$988.06	$1,720.00
STANDARD 1000	*55% STATE SHARE*	$424.89	$478.80	$424.89	$478.80
	MEPERS CHECK DEDUCTION	$347.63	$1,262.30	$942.28	$1,640.33

RETIREMENT MEDICARE ADVANTAGE RATES		
	SINGLE	2 ADULTS
NO STATE OF MAINE CONTRIBUTION	$393.32	$786.64
55% STATE SHARE	$216.33	$216.33
MEPERS CHECK DEDUCTION	$176.99	$570.31

Anthem® MEA Benefits Trust

Anthem Blue Cross and Blue Shield Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*

Group sponsor name: **Maine Education Association Benefits Trust (MEABT)**	Group #: **MEEGR001**
Plan you will join: ☑ **Anthem Medicare Preferred (PPO) with Senior Rx Plus**	Requested effective date of coverage: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.

FIRST name:	LAST name:	MIDDLE initial:

Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other

Permanent residence street address (Do not enter a P.O. Box):

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address: City: State: ZIP code:

Email address:_____

Your email address will be used for communications only from Anthem Blue Cross and Blue Shield. We will not share your email address. Thank you for providing your email address and phone number. We will only use this information to occasionally contact you by email, phone call or text with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by ☐ email and/or ☐ text? Messaging and data rates may apply.

Please know you can change your preference at any time by visiting www.anthem.com or contacting customer service.

Race*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander
- ☐ I choose not to answer

Ethnicity*

- ☐ Not of Hispanic, Latino/a, or Spanish Origin
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish Origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

Your Medicare information:

Medicare Number: _____

Note: The Medicare Number is required to complete your enrollment. If you do not provide your Medicare Beneficiary ID from your plan membership card, your enrollment into the plan may be delayed.

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If "yes," retirement date (month/date/year): _____

If "no," name of retiree:_____ Retiree Medicare ID #:_____

2. Do you have other medical insurance? ☐ Yes ☐ No

If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____

What are the effective dates of coverage? _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of institution:_____

Address (number and street) and phone number of institution:_____

_____

4. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-833-848-8729**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this Medicare Advantage Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Anthem Blue Cross and Blue Shield will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Anthem Medicare Preferred (PPO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Anthem Blue Cross and Blue Shield. Benefits and services authorized by Anthem Blue Cross and Blue Shield and contained in my Anthem Medicare Preferred (PPO) with Senior Rx Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem Blue Cross and Blue Shield will pay for benefits or services.**

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment election form, and
    2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

HIPAA authorization

If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form on the next page, and **sign and return it with this form**. This form is valid for one year from the signature date.

- If you don't complete the HIPAA form at this time, a future request for this form can be made by contacting Member Services at the telephone number on the back of your membership card.
- If you wish to continue having the authorized representative on your account, a new form is required annually.
- If you have a durable health care power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:
Anthem Blue Cross and Blue Shield
P.O. Box 173605
Denver, CO 80217-3605

Please refer to the Anthem Blue Cross and Blue Shield *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

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Instructions for completing the *Member Authorization Form*

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company.

1. Print your last name, first name, and middle initial.
2. Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number (including area code.)
5. Write your cell/mobile number (including area code).
6. **Identification number**
   You will find this number on your member identification card.
7. **Group number**
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

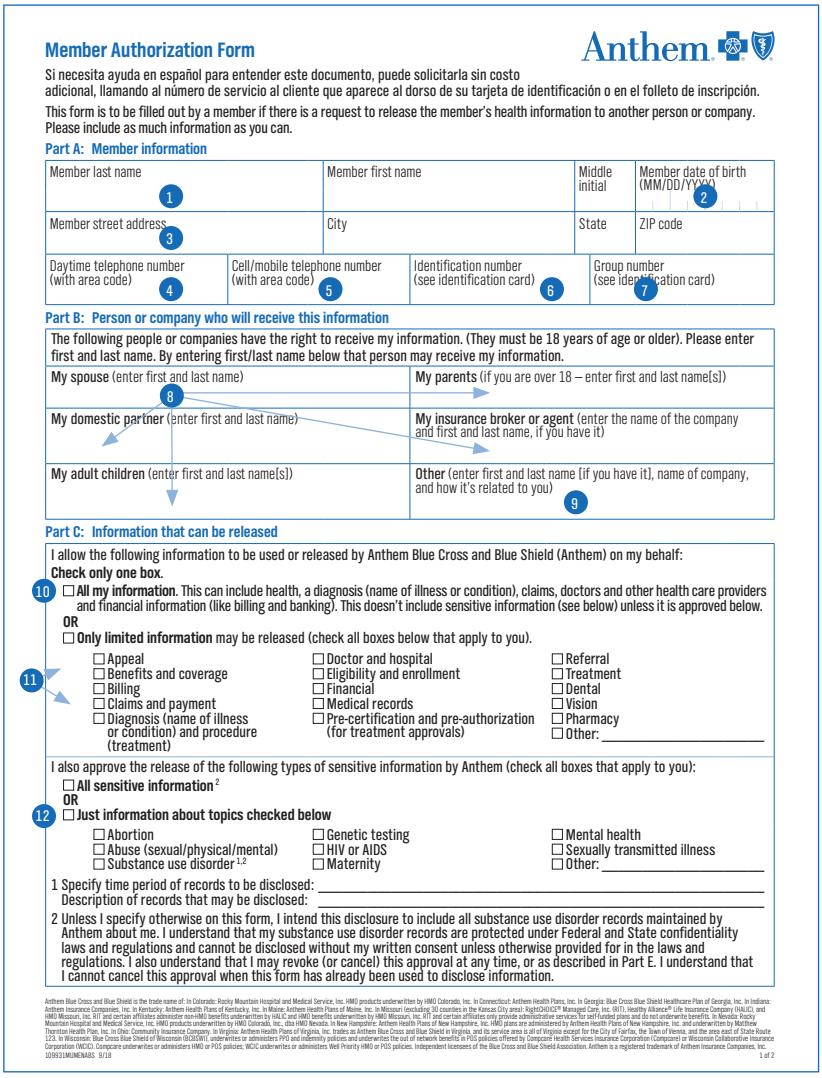
Part B: Person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like “my daughter” or “my son” as it will not be accepted. You need to be specific.
9. If you check “Other,” give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

10. For “all of your information,” check the first box.
11. For “limited information,” check the second box and the boxes that apply to you.
12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.



Member Authorization Form

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name 1	Member first name	Middle initial	Member date of birth (MM/DD/YYYY) 2
Member street address 3	City	State	ZIP code
Daytime telephone number (with area code) 4	Cell/mobile telephone number (with area code) 5	Identification number (see identification card) 6	Group number (see identification card) 7

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name) 8	**My parents** (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	**Other** (enter first and last name [if you have it], name of company, and how it's related to you) 9

Part C: Information that can be released

I allow the following information to be used or released by Anthem Blue Cross and Blue Shield (Anthem) on my behalf:

Check only one box.

10 ☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

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☐ Appeal	☐ Doctor and hospital	☐ Referral
☐ Benefits and coverage	☐ Eligibility and enrollment	☐ Treatment
☐ Billing	☐ Financial	☐ Dental
☐ Claims and payment	☐ Medical records	☐ Vision
☐ Diagnosis (name of illness or condition) and procedure (treatment)	☐ Pre-certification and pre-authorization (for treatment approvals)	☐ Pharmacy
		☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

☐ **All sensitive information**[2]

OR

12 ☐ **Just information about topics checked below**

☐ Abortion	☐ Genetic testing	☐ Mental health
☐ Abuse (sexual/physical/mental)	☐ HIV or AIDS	☐ Sexually transmitted illness
☐ Substance use disorder[1,2]	☐ Maternity	☐ Other: _____

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightChoice® Managed Care, Inc. (RIT); Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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1 of 2

Please read the following for help completing page two of the form.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know to give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: Date your approval expires

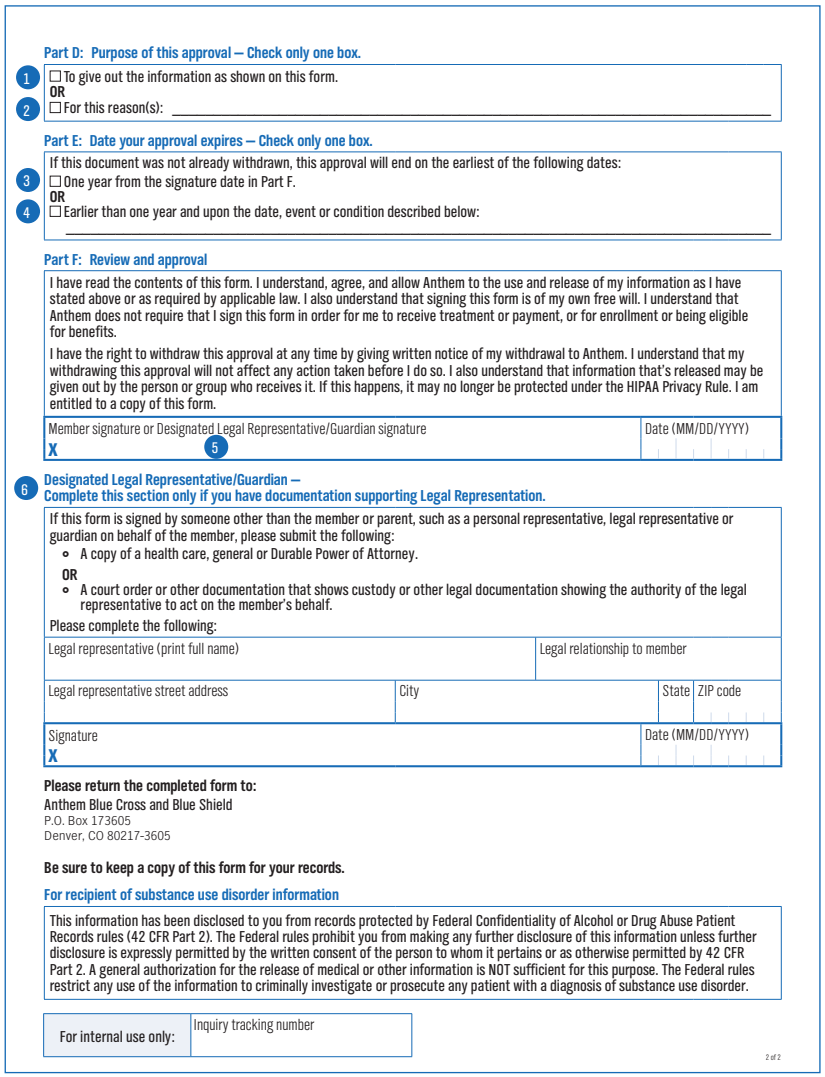
You have two choices of when you would like this approval to end.

3. Check the first box for the standard one year that it will end.
4. Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

Part F: Review and approval

5. **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.
6. **If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:**
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: Purpose of this approval — Check only one box.

1 ☐ To give out the information as shown on this form.
OR
2 ☐ For this reason(s): _____

Part E: Date your approval expires — Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
3 ☐ One year from the signature date in Part F.
OR
4 ☐ Earlier than one year and upon the date, event or condition described below:
_____

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Anthem to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature (5)	Date (MM/DD/YYYY)
X	

6 **Designated Legal Representative/Guardian — Complete this section only if you have documentation supporting Legal Representation.**

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:
- A copy of a health care, general or Durable Power of Attorney.

OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member		
Legal representative street address	City	State	ZIP code

Signature	Date (MM/DD/YYYY)
X	

Please return the completed form to:
Anthem Blue Cross and Blue Shield
P.O. Box 173605
Denver, CO 80217-3605

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

For internal use only:	Inquiry tracking number

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Examples of legal documents:

- **Health Care, General or Durable Power of Attorney**. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship**. This is when the court appoints someone to care for another person.
- **Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate**. This type of document would be used when the person who is being represented has died.

Member Authorization Form

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name	Member first name	Middle initial	Member date of birth (MM/DD/YYYY)
Member street address	City	State	ZIP code

Daytime telephone number (with area code)	Cell/mobile telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name)	**My parents** (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	**Other** (enter first and last name [if you have it], name of company, and how it's related to you)

Part C: Information that can be released

I allow the following information to be used or released by Anthem Blue Cross and Blue Shield (Anthem) on my behalf:

Check only one box.

☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

☐ **All sensitive information** [2]

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder [1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Part D: Purpose of this approval – Check only one box.

☐ To give out the information as shown on this form.
OR
☐ For this reason(s): _____

Part E: Date your approval expires – Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
☐ One year from the signature date in Part F.
OR
☐ Earlier than one year and upon the date, event or condition described below:

_____

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Anthem to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date (MM/DD/YYYY)
X	

Designated Legal Representative/Guardian – Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature	Date (MM/DD/YYYY)
X	

Please return the completed form to:

Anthem Blue Cross and Blue Shield
P.O. Box 173605
Denver, CO 80217-3605

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

For internal use only:	Inquiry tracking number

MEA Benefits Trust Retiree – Vision Application/Change Form

Anthem

All sections need to be completed before this application can be processed.

Group no.	Firm division
008999000	008500065

Section 1: Applicant information

Last name	First name	M.I.

Home street address	City	State	ZIP code

Date of birth (MMDDYYYY)	Social Security no.	Home phone no.	Gender	Anthem Blue View Vision ID no. (if applicable)
			☐ Male ☐ Female	

Section 2: Reason for application – Please check one

☐ New enrollment application Effective date: (MMDDYYYY)

☐ Cancel coverage Effective date: (MMDDYYYY)

☐ Change of coverage (e.g. add or delete spouse/dependents/domestic partner) Effective date: (MMDDYYYY)

Section 3: Applicant and family information

Add/ Remove	Last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no.	Gender
☐ Add ☐ Remove	Self					☐ Male ☐ Female
☐ Add ☐ Remove	☐ Spouse ☐ Domestic partner					☐ Male ☐ Female
☐ Add ☐ Remove	Dependent					☐ Male ☐ Female

Section 4: Applicant signature *(if you are **enrolling or making changes**).* Please sign below in either section 4 or 5.

The certificate provides vision benefits only. Review your certificate carefully.

I am requesting coverage for myself and all dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

Applicant signature	Date (MMDDYYYY)
X	

Section 5: Applicant signature *(if you are **cancelling the entire policy**)*

Applicant signature	Date (MMDDYYYY)
X	

Please call 800-322-9808 with questions regarding enrollment.

Send completed form to: Anthem Blue Cross Blue Shield
Enrollment and Billing Department
2 Gannett Drive
South Portland, ME 04106

OR Fax to **801-252-4292**
(Do not send the original if sending by fax.)

MEA Benefits Trust

Anthem

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	

MEA Benefits Trust

Anthem

	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**
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

MEA Benefits Trust

Anthem

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
	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 Limited to 20 visits per year	65% after deductible	80% after deductible Limited to 20 visits per year	60% after deductible	80% after deductible Limited to 20 visits per year	60% after deductible
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

MEA Benefits Trust

Anthem

	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**
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 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**	 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)

	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**
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.

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