Anthem. MEA Benefits Trust

July 1, 2024

Retirement or separation from employment

Choose benefits you can count on

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

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anthem.com meabt.org

Choose your plan with confidence

You deserve peace of mind when it comes to your healthcare. An Anthem health plan gives you that and more, supporting you every step of the way — from employment through retirement — with coverage that fits your needs and your budget.

Review the health plans before making your selection. You'll want to check to see if your doctors are in the plan's network, which will help you make the most of your benefits and save money.

MEA Choice Plus

Planning for expense is not only about money. It's about you, your health, and your financial security. That's why choosing a primary care doctor (also called a primary care physician, or PCP) is important. You will receive a referral from them when you go to specialists. The plan covers you when you see a doctor outside the plan's network, but your out-of-pocket costs may be higher.

MEA Standard Plans

With a preferred provider organization PPO plan, you can go to almost any doctor or hospital — giving you more choices and flexibility. You can get special rates for doctors in your plan, which lowers your out-of-pocket costs.

- Choose a primary care doctor in the plan's network to save money on preventive care, such as checkups and screenings.
- No referral is needed from your primary care doctor to see a specialist, such as an orthopedic doctor or a cardiologist — saving you time and money.
- You'll pay less if you choose doctors and facilities in your plan's network.
- 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)

This plan provides 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 and hearing services.

This plan gives you more flexibility, can help save you money, and offers tools and programs to support your whole health. Some of the highlights include:

- A **$0 copay** for all covered provider benefits
- **Freedom to choose** from any doctor, provider, or specialist who participates in Medicare anywhere in the United States, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and Northern Mariana Islands. You do not need referrals for care.
- Coverage for **emergency care** both inside and outside the U.S.
- **24/7 NurseLine** for access to a registered nurse, day or night.
- **LiveHealth Online** virtual visits 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 be your healthiest and get discounts.

Rules and regulations for MEABT Anthem health plans

Help and support

For questions about the MEA Choice Plus or Standard plans, call Member Services at **833-772-4121**.

For help with the Medicare Advantage plan, call the First Impressions Team at **844-951-0624**.

Patty Whitcomb
Anthem account service representative
207-822-7556
patty.whitcomb@anthem.com

Sharon Beaulieu
MEA Benefits Trust benefit manager
207-622-4418 x2207
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, such as MEA Choice Plus, they'll be made available to all non-Medicare eligible retirees every year during the selection or annual enrollment period.

If your local association changes their health insurance carrier, then all retirees, including retirees on the group Medicare Advantage plan will need to choose a health plan from that insurance company or plan. You won't be able to stay with the MEABT Anthem health plan. This is in compliance with Maine State law.

Basic eligibility rules

If you have terminated employment, you may be eligible to continue coverage under the MEABT Anthem health plan:

- If you're **younger than 50** years of age, you must have:
  - 10 years of continuous active service and MEABT Anthem health plan coverage.
  - Active participation and coverage in the MEABT Anthem health plan for 12 months immediately before retirement or employment ends.
- If you're **age 50 or older**, you must have:
  - Five years of continuous active service and MEABT Anthem health plan coverage.
  - Active participation and coverage in the MEABT Anthem health plan for 12 months immediately before retirement or employment ends.

Your employer must be in the MEABT Anthem health plan on your date of retirement or end of employment. Dependents must be added to the employee's policy no later than the date of transition from the active plan to the retiree plan. After retirement, you can only add new dependents to your plan within 60 days of marriage, a new domestic partnership, or the birth or adoption of a child.

You'll receive a direct bill or pension deduction for the MEABT Anthem health plan.

Understanding your retirement

Beginning the retirement process

You're required to request the proper paperwork when you plan to retire, as it's not an automatic process. It's recommended to start this process a minimum of three months before your retirement date.

Your premium deductions during the summer

Most teacher contracts provide health insurance during July and August. If you retire on July 1 and immediately start to receive your MainePERS direct deposit:

- No deduction will occur from your July MainePERS direct deposit.
- A deduction will occur from the August MainePERS direct deposit. Premiums are deducted one month in advance.

You may be eligible for contributions from the State of Maine

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 and authorize MainePERS to deduct the proper amount to cover the cost of my Anthem health insurance.

You'll only be eligible for contributions from the State of Maine if you have:

- Reached your normal retirement age.
- Authorized premiums to be deducted from your MainePERS direct deposit.
- Your position classification code must start with a "Y". If you don't know what your code is, please verify it with your Human Resources person at your Central Office.

Paying for your health plan premiums

If you're not receiving a MainePERS direct deposit, you'll receive a bill at your home address. This includes:

- Educators or staff members retiring before their normal retirement age.
- Support staff not eligible for a MainePERS check.

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

If you receive a MainePERS direct deposit prior to reaching your normal retirement age, you will not be entitled to the State of Maine's contribution. Once you have reached your normal retirement age, you will need to contact Anthem to complete a form to receive the State of Maine contribution.

MEA Benefits Trust break provision

If you're eligible to continue health plan coverage under the Basic Rules, you're entitled to one break in coverage, which may last no longer than five years, or reaching the age of 62, whichever comes first. After which you can return to the MEABT Anthem health plan.

- During the break, you must be covered by comprehensive health insurance similar to the MEABT Anthem health plan. You must submit proof of coverage when returning to the MEABT Anthem health plan. This requirement is not met by:
  - Very high deductible plans.
  - Very limited policies paying small amounts only for hospital stays.
  - Single disease policies (such as cancer policies).
- The break must end within five years or when a you reach age 62, whichever comes first.
- Breaks cannot begin after you decide to leave the MEABT Anthem health plan to move to a competitor.
- You're not considered to on be on a break if you're covered as a dependent of another participant under the MEABT Anthem health plan.

If you terminate your employment and choose not to continue your health insurance coverage at that time, you may have a one-time opportunity to re-enroll at the time of your retirement (pension through MainePERS) if you:

- Meet one of the Retirement Basic Eligibility Rules.
- Have 25 years of MainePERS credible service.
- Haven't retired through MainePERS.
- There is no time limitation to this rule other than returning at the time of their retirement through MainePERS.

Remember, it's your responsibility to monitor your break time. Neither Anthem nor the MEABT will notify you at the end of your break time. Please notify us 60 days in advance of your return for paperwork to complete the process. Failure to do this could jeopardize your participation in the retirement health plan.

Additional plan details

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

Plan additions: Retirement group doesn't allow additions unless they're due to marriage, new domestic partnership, or birth or adoption of a child. Plan changes are permitted when transferring from active status to retirement status.

Changes during annual enrollment: Annual enrollment under the retiree plan only allows you to change your health plan option — it doesn't allow you to add dependents (exception being new marriage, new domestic partnership, or birth/adoption of a child).

Survivor spouse provisions: If an employee dies while insured under the health plan, their spouse and dependents who were covered at the time of their death will be eligible to continue MEABT Anthem health plan coverage. The premium will be deducted from the MainePERS check if applicable, or they'll be direct billed. If the surviving spouse remarries, the group MEABT Anthem health plan coverage will end the first of the month following the remarriage date.

Active/retirement: Any teacher who has reached normal retirement age may return to service. 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 your retirement.

Spouses or 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 change from a single policy to a two-person/family (or vice versa) plan at any time. For example, if one of you retires and it's less expensive to go onto your actively working partner's MEA plan, and your partner's school department allows it, you should do whatever is financially better for you.

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 — Dependent coverage is only available to those members now covered on your policy.

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	Anthem member ID 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

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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 2024-2025

		RATE WITHOUT STATE OF MAINE'S 60% CONTRIBUTION			
		Single	Two Person	Adult w/Child/ren	Family
	CHOICE PLUS	$972.75	$2,192.35	$1,721.53	$2,668.41
	STANDARD PLAN	$1,050.42	$2,367.77	$1,859.23	$2,881.86
	STANDARD PLAN 500	$924.08	$2,082.75	$1,635.46	$2,534.98
	STANDARD PLAN 1000	$881.31	$1,986.29	$1,559.71	$2,417.57
		RATE WITH STATE OF MAINE'S 60% CONTRIBUTION			
Choice Plus	State Share 60%	$583.65	$657.71	$583.65	$657.71
	MEPERS CHECK DEDUCTION	$389.10	$1,534.64	$1,137.88	$2,010.70
Standard	State Share 60%	$630.25	$710.33	$630.25	$710.33
	MEPERS CHECK DEDUCTION	$420.17	$1,657.44	$1,228.98	$2,171.53
Standard 500	State Share 60%	$554.45	$624.83	$554.45	$624.83
	MEPERS CHECK DEDUCTION	$369.63	$1,457.92	$1,081.01	$1,910.15
Standard 1000	State Share 60%	$528.79	$595.89	$528.79	$595.89
	MEPERS CHECK DEDUCTION	$352.52	$1,390.40	$1,030.92	$1,821.68

MEDICARE ADVANTAGE PPO GROUP PLAN RATES		
	SINGLE	TWO PERSON
RATE WITHOUT STATE OF MAINE CONTRIBUTION	$356.17	$712.34
60% STATE OF MAINE CONTRIBUTION	$213.70	$213.70
MEPERS CHECK DEDUCTION	$142.47	$498.64

SAMPLE ONLY

Community Rates Worksheet

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 **anthem.com** or contacting customer service.

Race*		Ethnicity*
☐ White	☐ Vietnamese	☐ Not of Hispanic, Latino/a, or Spanish Origin
☐ Black or African American	☐ Other Asian	☐ Puerto Rican
☐ American Indian or Alaska Native	☐ Native Hawaiian	☐ Another Hispanic, Latino/a, or Spanish Origin
☐ Asian Indian	☐ Samoan	☐ Mexican, Mexican American, Chicano/a
☐ Chinese	☐ Guamanian or Chamorro	☐ Cuban
☐ Filipino	☐ Other Pacific Islander	☐ I choose not to answer
☐ Japanese	☐ I choose not to answer	
☐ Korean		

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 plan 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 healthcare 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.

Anthem Blue Cross and Blue Shield is an LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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Instructions for completing the *Member Authorization Form*

Anthem

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: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)
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 (MMDDYYYY) (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

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

☐ Appeal	☐ Eligibility and enrollment	☐ Referral
☐ Benefits and coverage	☐ Financial	☐ Treatment
☐ Billing	☐ Medical records	☐ Dental
☐ Claims and payment	☐ Pre-certification and pre-authorization (for treatment approvals)	☐ Vision
☐ Doctor and hospital		☐ Pharmacy

☐ Diagnosis (name of illness or condition) and procedure (treatment): ______

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

(12) ☐ **All sensitive information** [2]

OR

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

☐ Abuse (sexual/physical/mental)	☐ HIV or AIDS	☐ Reproductive health [3] (including abortion, maternity, etc.)
☐ Substance use disorder [1,2]	☐ Mental health	
☐ Genetic testing	☐ Sexually transmitted illness	

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.

3 Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

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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	Date (MMDDYYYY)
X 5	

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 X			Date (MMDDYYYY)

Please return the completed form to:
Anthem Blue Cross and Blue Shield

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

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 (MMDDYYYY)
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
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Diagnosis (name of illness or condition) and procedure (treatment): ______________________

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 sensitive information about topics checked below**

- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder [1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Reproductive health [3] (including abortion, maternity, etc.)

1 Specify time period of records to be disclosed: ______________________
Description of records that may be disclosed: ______________________

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OR
☐ For this reason(s):

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Member signature or Designated Legal Representative/Guardian signature	Date (MMDDYYYY)
X	

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Notes:

Notes:

Anthem

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