Ready to choose your benefits?
We can point you in the right direction.

RETIREMENT / SEPARATION FROM EMPLOYMENT
MAINE EDUCATION ASSOCIATION BENEFITS TRUST
Effective July 1, 2018

This guide is for information purposes only. You must enroll in a plan for your benefits to start.
Let's take a look

We know picking a health plan is a big deal, so this guide makes it easier for you to understand your benefit options. We’ll explain how the plans work and give you other important details. That way you can enroll with confidence!

In this guide, you'll find:
- The plans at a glance
- Your health care basics
- How to use your health plan
- Health and wellness programs
- Your privacy and rights

Pay a visit to anthem.com to get an idea of what you can do once you’re a member. Find a doctor, estimate care costs, sign up to get emails instead of mail and much more!
The plans at a glance
Here’s a quick overview of the plans your employer is offering. To learn more plan basics visit anthem.com/basics.

MEABT CHOICE PLUS
- You choose your own doctors.
- You can save more money when you see doctors who are part of the Point of Service (POS) plan.
- You need to choose a main doctor, also called a primary care doctor.
- If you need a specialist, you’ll most likely have to go through your main doctor and get a referral.

MEABT STANDARD PLANS
- This plan covers services from almost any doctor or hospital.
- You pay less if you use a doctor from the Preferred Provider Organization (PPO) plan.
- You pay more if you go to a doctor who’s not part of the PPO plan.
- You don’t usually need a referral from your main doctor, also called a primary care doctor, to see a specialist.

It’s easy to get care in your plan
You can find doctors, hospitals and other health care professionals in our plans on anthem.com — and they charge our members lower rates.

1 Each of our plans may have different rules, so always check your plan details for more specific information.
Know your health care basics
Learn about the kinds of costs you’ll share with your plan

You pay your deductible.
This is a set amount that you pay before we start sharing in the cost of the covered health care you receive. If your plan has copays (flat fees like $30 for each visit) along with a deductible, you only need to pay the copay for most doctor visits.

What happens after I pay my deductible?
You pay a copay or a percentage of the cost, also called coinsurance, each time you receive care for covered services, and then your plan covers the rest.

What’s an out-of-pocket limit?
Each year, there’s a maximum amount you can pay out of your own pocket for covered services — that’s your out-of-pocket limit. Once you’ve reached that limit — it varies by plan — we cover the rest for covered services. If you visit doctors or hospitals that aren’t in your plan, you’ll still have out-of-pocket costs. With some plans, you still have copays even after you reach your out-of-pocket limit.

What about the money for the plan that gets taken out of my paycheck?
That’s what you pay for the plan. Think of it like a membership fee. It’s separate from what you pay when you get care.

This chart is only an example. Your actual cost share will depend on your plan, the service you get and the doctor you choose. For your actual cost share, see your plan details.
Using your health plan

It’s easy to get started with your plan and make the best of your benefits.

Choose a doctor in your plan

Avoid getting care from doctors outside of your plan; it will cost you more or your plan may not cover it at all. We’ve made it easy for you to find doctors in your plan. Visit anthem.com to look for a primary care doctor, hospitals, labs and other health care professionals in your plan.

Use your ID card

You’ll be a member after you complete enrollment and your benefits begin. Then, you’ll be able to use your ID card. Don’t forget, it’s always available and easy to use on the Anthem Anywhere mobile app. It’s like your passport to care since you’ll need to show it whenever you go to the doctor.

Anthem.com

Once your benefits begin and you access your ID card, register on anthem.com or on the Anthem Anywhere mobile app to get personalized information about your wellness programs and health plan.

- Find a doctor.
- Estimate your costs, before you step into the doctor’s office.

Learn more at anthem.com/guidedtour.

Preventive care is covered at no extra cost

Preventive care from a doctor in your plan is covered at 100%. Getting these regular checkups, screenings and shots can help you stay healthy and catch problems early – when they’re easier to treat. So, talk to your doctor about what preventive care you may need to protect your health.

Save emergency room visits for emergencies only

Knowing where to go for care saves you time and money. So if you have a real emergency, head straight to the ER or call 911. Otherwise, visit your regular doctor or an urgent care center for minor medical issues.

We’re here for you

When you become a member, we make it easy for you to get your questions answered in the way that works best for you.

- By phone: Call the Member Services number on your mobile ID card.
- Online: Register at anthem.com or download the Anthem Anywhere mobile app to chat with a team member.

Done driving to the doctor? Hey there, Live Health Online!

You can visit a board-certified doctor 24/7 for simple things like the cold, flu, allergies and more with no appointments and no waiting room. All you need is the LiveHealth Online mobile app or a computer with a webcam to have a video visit with a doctor.** LiveHealth Online costs as little as an office visit or at most $49. Learn more at livehealthonline.com.

**Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to expand in the near future. Visit livehealthonline.com to view the service map by state.
Health and wellness programs support you along the way

Your plan goes way beyond covering doctor visits

We can help you reach your health goals and save money on healthy products and services. After your benefits begin, you have easy access to these programs and tools on anthem.com or by calling the Member Services number on your mobile ID card.

24/7 NurseLine — Our registered nurses can answer your health questions wherever you are — any time, day or night. All you have to do is call.

Case Management — If you’re in the hospital or have a serious health problem and need extra care, a nurse care manager can help. Your nurse care manager will answer your questions, set up your care with different doctors and help you use your health benefits.

ConditionCare — Get support from a dedicated nurse team if you have asthma, diabetes, heart disease or heart failure. You work with dietitians, health educators and pharmacists to help you reach your goals and feel your best.

Enhanced Personal Health Care — This program supports you with main doctors, also called primary care doctors, who are real partners in your care. They get to know you and your history, and connect you to the specialists and services you need when you need them – even after hours.

LiveHealth Online — Using LiveHealth Online, you can have a video visit with a board-certified doctor or therapist on your smartphone, tablet or computer with a webcam. It’s easy to use and there when you need it. All you have to do is sign up at livehealthonline.com or download the app.

MyHealth Coach — You and your family can get one-on-one professional advice from an experienced health coach. Topics range from general wellness information to more serious issues like coping with an ongoing illness or help with medicines.

Staying Healthy Reminders — This yearly reminder is sent to your home or through email to tell you about important preventive health screenings or treatments you may need, based on your age and gender. Once you’re a member, you can choose how to get the reminder on anthem.com.

Online Wellness Toolkit — The Online Wellness Toolkit gives you tools to set and achieve your unique health goals. It includes a Health Assessment for identifying health risks, guidance for lowering those risks, personalized trackers to monitor progress and fun activities that promote healthier decision-making.

MyHealth Advantage — Avoid health problems, stay healthy and save money. This program tracks your health information to see if there’s anything you can do to improve your health. If so, you’ll get a personalized and confidential MyHealth Note in the mail. Download the Anthem Anywhere app to receive your personalized, secure health messages on-the-go via the Mobile Inbox.
Your plan details

In this next section, you’ll find more information about your plan.
IMPORTANT
RETIREMENT
INFORMATION

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

Becky DuVal
Anthem Blue Cross and Blue Shield
207-430-3533
becky.duval@anthem.com

Sharon Beaulieu
MEA Benefits Trust
35 Community Drive
Augusta, ME 04330
207-622-4418, ext. 2207
sbeaulieu@meabt.org

Retirement Info 7/2018
**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 will 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.

Again, the state will not contribute to your premium until you reach your normal retirement age and are receiving your MainePERS check. It is your responsibility to notify Anthem Blue Cross Blue Shield at that time so we change your billing amount.
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 be on a “break” if he or she is covered as a dependent of another participant under the MEA Health Plan.

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.

During the period of reemployment, the retired teacher is not entitled to health insurance, dental insurance or life insurance benefits through the school department. Health insurance benefits must be provided under the provisions of Maine Statute Title 20-A, Section 13451, for retired teachers.

This information can be found at [http://www.mainelegislature.org/legis/statutes/5/title5sec17859.html](http://www.mainelegislature.org/legis/statutes/5/title5sec17859.html)

**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.
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 1-888-399-8706, ext. 1.

Please print.

### Section 1: Applicant information — Dependent coverage is only available to those members now covered on your policy

<table>
<thead>
<tr>
<th>Check plan</th>
<th>Group no.</th>
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<tbody>
<tr>
<td>Single</td>
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<tr>
<td>2 person</td>
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<tr>
<td>Family</td>
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<tr>
<td>Adult with child or children</td>
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#### Employee Information

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<thead>
<tr>
<th>School department</th>
<th>Occupation</th>
<th>Identification no.</th>
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#### Retiree Information

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>M.I.</th>
<th>Birthdate</th>
<th>Social Security no.</th>
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#### Legal spouse or domestic partner information — Complete only if legal spouse or domestic partner is eligible for coverage

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>M.I.</th>
<th>Birthdate</th>
<th>Social Security no.</th>
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### Section 2: Delete dependents — Deleted dependents will not be eligible to re-enroll

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
<th>Social Security no.</th>
<th>Reason</th>
<th>Effective date</th>
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<tr>
<td>Spouse or domestic partner</td>
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<tr>
<td>Dependent — oldest first</td>
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<tr>
<td>Dependent</td>
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1 Reason:  
A. Marriage  
B. Divorce  
C. Separation  
D. Death  
E. Entered military service  
F. Medicaid or state assistance  
G. Has own Anthem contract  
H. Other insurance: __________________________  
I. Other: __________________________

### Section 3: Medicare eligible — To be eligible for Medicare supplemental 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.

<table>
<thead>
<tr>
<th>Name(s) of Medicare covered person(s)</th>
<th>Medicare claim no.</th>
<th>Medicare Part A effective date</th>
<th>Medicare Part B effective date</th>
<th>Check all reasons you qualified for Medicare</th>
<th>Age 65</th>
<th>Disability</th>
<th>ESRD</th>
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<tr>
<td>Last name</td>
<td>First name</td>
<td>M.I.</td>
<td>month/day/year</td>
<td>month/day/year</td>
<td>Age 65</td>
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If you are currently eligible for Medicare and Group Companion Plan coverage, the Blue View Vision Plan will no longer be included in your health plan benefit. There is the option of enrolling in the vision plan at the current monthly rate for retiree only benefits and retiree and spouse benefits.

Check the appropriate box to enroll for Blue View Vision Plan benefits: Retiree only Retiree and spouse

Please check with your central office for rate information.

2 End Stage Renal Disease

### For school use only

<table>
<thead>
<tr>
<th>MainePERS employer code</th>
<th>Position class code</th>
<th>Termination from active group</th>
<th>Date health insurance ends</th>
<th>Signature of school official</th>
</tr>
</thead>
</table>
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.”
☐ I have not reached my “normal retirement age.”
☐ I have elected not to transfer the Anthem health coverage.

☐ I am applying for Disability Retirement:

☐ 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 § 1345112-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 1-888-622-4418, ext. 2207 or Anthem at 1-888-399-8706, ext. 1.

☐ Applying for the MEA Benefits Trust break provision effective: _______ _______ _______ _______ _______

☐ Returning from the MEA Benefits Trust break provision effective: _______ _______ _______ _______ _______

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.

If MEA Choice Plus is chosen, I understand that each family member’s care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my 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

X

Date
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<td><strong>Important Information</strong></td>
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<td>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 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 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 who are not in the Blue Choice network.</td>
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<td><strong>Primary Care Physician Required</strong></td>
<td>YES</td>
<td>NO</td>
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<td><strong>Physician Office Visits</strong></td>
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<tr>
<td>Sick Care</td>
<td>100% after $15 PCP copay</td>
<td>65% after deductible</td>
<td>100% after $15 PCP copay</td>
<td>80% after $15 PCP copay</td>
<td>100% after $20 PCP copay</td>
<td>80% after $15 PCP copay</td>
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<tr>
<td>Preventive &amp; Well Care Services</td>
<td>100% after $25 Specialist copay</td>
<td>Not Covered (members can self-refer to a participating Ob/Gyn for their annual Well Woman exam)</td>
<td>100% after $25 Specialist copay</td>
<td>80% after $25 Specialist copay</td>
<td>100% after $30 Specialist copay</td>
<td>80% after $30 Specialist copay</td>
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<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$200 per member $400 per family</td>
<td>$250 per member $500 per family</td>
<td>$200 per member $400 per family</td>
<td>$500 per member $1,000 per family</td>
<td>$1,000 per member $2,000 per family</td>
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<tr>
<td><strong>Coinsurance Limit</strong></td>
<td>$1,000 per member $2,000 per family</td>
<td>$2,250 per member $4,500 per family</td>
<td>$1,000 per member $2,000 per family</td>
<td>$2,000 per member $4,000 per family</td>
<td>$2,000 per member $4,000 per family</td>
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<tr>
<td><strong>Total Calendar Year Out-of Pocket (Deductible &amp; Coinsurance)</strong></td>
<td>$1,200 per member $2,400 per family</td>
<td>$2,500 per member $5,000 per family</td>
<td>$1,200 per member $2,400 per family</td>
<td>$2,500 per member $5,000 per family</td>
<td>$3,000 per member $6,000 per family</td>
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</tr>
<tr>
<td><strong>Calendar Year Copayment Maximum (office visit, emergency room, &amp; pharmacy copays apply)</strong></td>
<td>$6,150 per member $12,300 per family</td>
<td>$6,150 per member $12,300 per family</td>
<td>$6,150 per member $12,300 per family</td>
<td>$4,850 per member $9,700 per family</td>
<td>$4,350 per member $8,700 per family</td>
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<tr>
<td>SERVICE</td>
<td>MEA CHOICE PLUS</td>
<td>MEA STANDARD PLAN</td>
<td>MEA STANDARD PLAN</td>
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<tr>
<td></td>
<td>Higher Benefit Level</td>
<td>Self-referred Benefit Level</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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</tr>
<tr>
<td><strong>Utilization Management</strong></td>
<td></td>
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</tr>
<tr>
<td>All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization by your Primary Care Physician.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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</tr>
<tr>
<td><strong>Hospital Services Inpatient</strong></td>
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</tr>
<tr>
<td>Emergency Care in ER (Copay is waived if you're admitted)</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td></td>
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</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Professional Services Inpatient Diagnostic Tests Outpatient Surgery</strong></td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
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<td></td>
</tr>
<tr>
<td><strong>High Tech Diagnostic Radiology (including but not limited to, CT Scans, MRI/MRA’s, Nuclear Cardiology, PET Scans)</strong></td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
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</tr>
<tr>
<td><strong>Occupational Therapy, Physical Therapy, and Speech Therapy</strong></td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit copay will apply to OT/PT evaluation or re-evaluation</td>
<td>Office visit copay will apply to OT/PT evaluation or re-evaluation</td>
<td>Office visit copay will apply to OT/PT evaluation or re-evaluation</td>
<td>Office visit copay will apply to OT/PT evaluation or re-evaluation</td>
<td>Office visit copay will apply to OT/PT evaluation or re-evaluation</td>
<td></td>
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</tr>
<tr>
<td>No Annual Limit</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td>60 visits per member per calendar year for all therapies combined</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

*Registered marks of the Blue Cross and Blue Shield Association.*
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>MEA CHOICE PLUS</th>
<th>MEA STANDARD PLAN</th>
<th>MEA STANDARD PLAN $500 DEDUCTIBLE</th>
<th>MEA STANDARD PLAN $1,000 DEDUCTIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Higher Benefit Level</td>
<td>Self-referred Benefit Level</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Chiropractic Care – Physical Manipulations</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>In-Network Provider 65% after deductible</td>
<td>Out-of-Network Provider 65% after deductible</td>
<td>Up to 40 visits per member per calendar year</td>
<td>Up to 40 visits per member per calendar year</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>100%</td>
<td>65% after deductible</td>
<td>100%</td>
<td>80% no deductible</td>
</tr>
<tr>
<td>Smoking Cessation Education Programs</td>
<td>100%</td>
<td>65% after deductible</td>
<td>100%</td>
<td>80% no deductible</td>
</tr>
<tr>
<td>Physician Follow-up Visits</td>
<td>100%</td>
<td>65% after deductible</td>
<td>100%</td>
<td>80% no deductible</td>
</tr>
<tr>
<td>Prescribed Medications (see list of select medications)</td>
<td>100%</td>
<td>Prescription drug copay applies</td>
<td>100%</td>
<td>Prescription drug copay applies</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
</tr>
<tr>
<td></td>
<td>Up to 150 days per member per calendar year</td>
<td>Up to 150 days per member per calendar year</td>
<td>Up to 150 days per member per calendar year</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>100%</td>
<td>65% after deductible</td>
<td>100%</td>
<td>80% no deductible</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>85% after deductible</td>
<td>85% after deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
</tr>
<tr>
<td>Pediatric Dental Varnish</td>
<td>100% up to age 5</td>
<td>Not Covered</td>
<td>100% up to age 5</td>
<td>80% no deductible, up to age 5</td>
</tr>
<tr>
<td>(not covered under the retiree plans)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Early Intervention Services</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
</tr>
<tr>
<td>(Limited for children up to age 36 months of age)</td>
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</tr>
<tr>
<td>SERVICE</td>
<td>MEA CHOICE PLUS</td>
<td>MEA STANDARD PLAN</td>
<td>MEA STANDARD PLAN $500 DEDUCTIBLE</td>
<td>MEA STANDARD PLAN $1,000 DEDUCTIBLE</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Autism Spectrum Disorders: Applied Behavior Analysis</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>65% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Primary Care Physician referral is not required.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Managed by Anthem Behavioral Health and all services require preauthorization. Failure to comply with the requirements outlined in your Certificate of Coverage may result in a penalty up to $300</td>
<td>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. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)</td>
<td>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. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)</td>
<td>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. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)</td>
<td>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. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>85% after deductible</td>
<td>65% after deductible</td>
<td>85% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient Office Visits</td>
<td>100% after $15 PCP copay</td>
<td>100% after $15 copay</td>
<td>80% after $20 copay</td>
<td>100% after $20 copay</td>
</tr>
</tbody>
</table>
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.
Maine Education Association Benefits Trust
Effective Date: July 1, 2018

Blue View Vision℠

Your Blue View Vision network
Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision’s network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts.

Out-of-network: If you choose to, you may receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

**YOUR BLUE VIEW VISION PLAN AT-A-GLANCE**

**VISION PLAN BENEFITS**

**IN-NETWORK**

**ROUTINE EYE EXAM**
- $0 copay, then covered in full

**EYEGlass Frames**
- $150 allowance, then 20% off any remaining balance

**EYEGlass Lenses (Standard)**
- $25 copay, then covered in full

**EYEGlass Lense enhancements**
- Standard plastic single vision lenses (1 pair)
- Standard plastic bifocal lenses (1 pair)
- Standard plastic trifocal lenses (1 pair)

**Contact lenses**
- $150 allowance, then 15% off any remaining balance

EXCLUSIONS & LIMITATIONS (not a complete list)

Combined Offers. Not combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Sunglasses. Sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Not Specifically Listed. Services not specifically listed in this plan as covered services.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Orthoptics. Orthoptics or vision training and any associated supplemental testing.
### Optional Savings Available from In-Network Providers Only

<table>
<thead>
<tr>
<th>Retinal Imaging - at member’s option can be performed at time of eye exam</th>
<th>In-network Member Cost (after any applicable copay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyeglass Lens Upgrades</strong>&lt;br&gt;When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.</td>
<td><strong>Not more than $39</strong></td>
</tr>
<tr>
<td>- Transitions® lenses (Adults)</td>
<td>$25</td>
</tr>
<tr>
<td>- Standard Polycarbonate (Adults)</td>
<td>$40</td>
</tr>
<tr>
<td>- Tint (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>- UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td>- Progressive Lenses&lt;sup&gt;1&lt;/sup&gt;&lt;br&gt;- Standard</td>
<td>$65</td>
</tr>
<tr>
<td>- Premium Tier 1</td>
<td>$85</td>
</tr>
<tr>
<td>- Premium Tier 2</td>
<td>$95</td>
</tr>
<tr>
<td>- Premium Tier 3</td>
<td>$110</td>
</tr>
<tr>
<td>- Anti-Reflective Coating&lt;sup&gt;2&lt;/sup&gt;&lt;br&gt;- Standard</td>
<td>$45</td>
</tr>
<tr>
<td>- Premium Tier 1</td>
<td>$57</td>
</tr>
<tr>
<td>- Premium Tier 2</td>
<td>$88</td>
</tr>
<tr>
<td>- Other Add-ons and Services</td>
<td>20% off retail price</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Additional Pairs of Eyeglasses</strong>&lt;br&gt;Anytime from any Blue View Vision network</th>
<th><strong>40% off retail price</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Complete Pair</td>
<td>20% off retail price</td>
</tr>
<tr>
<td>- Eyeglass materials purchased separately</td>
<td>20% off retail price</td>
</tr>
</tbody>
</table>

| **Eyewear Accessories**<br>Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. | **20% off retail price** |

<table>
<thead>
<tr>
<th><strong>Contact Lens Fit and Follow-up</strong>&lt;br&gt;A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.</th>
<th><strong>Up to $55</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Standard contact lens fitting&lt;sup&gt;3&lt;/sup&gt;</td>
<td>10% off retail price</td>
</tr>
<tr>
<td>- Premium contact lens fitting&lt;sup&gt;4&lt;/sup&gt;</td>
<td>10% off retail price</td>
</tr>
</tbody>
</table>

| **Conventional Contact Lenses**<br>Discount applies to materials only | **15% off retail price** |

### Additional Savings Available through Our Special Offers Program

Members can take advantage of savings opportunities from dozens of vendors on a variety of products and services, including LASIK vision surgery, hearing services and aids, wellness products, weight loss programs, fitness memberships, elder care services, and much more.

1 Please ask your provider for his/her recommendation as well as the progressive brands by tier.
2 Please ask your provider for his/her recommendation as well as the coating brands by tier.
3 A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.
4 A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

### Out-of-Network

If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment of services and/or eyewear materials at the time of service.

**To Fax:** 866-293-7373  
**To Email:** oonclaims@eyewearspecialoffers.com  
**To Mail:** Blue View Vision  
Attn: OON Claims  
P.O. Box 8504  
Mason, OH 45040-7111

Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at 1-866-723-0515.

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and insured person’s coverage is in force.

This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member’s policy, which shall control in the event of a conflict with this overview. Discounts referenced are not covered benefits under this vision plan and therefore are not included in the member’s policy. Frame discounts may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice. This benefit overview is only one piece of your entire enrollment package.
Benefit Overview
MEA Group Companion Plan
July 1, 2018

- All Medicare deductible and coinsurance costs listed are in effect January 1, 2018
- Benefits described in shaded areas are subject to the plan deductible before being paid at 80%. MEA Group Companion Plan has a $100 individual deductible and a $600 individual coinsurance limit per calendar year.
- To have Medicare send information on claims it has paid directly to Anthem Blue Cross and Blue Shield, your doctor must include your MEA Group Companion Plan certificate number with the claim information sent to Medicare. Please keep your Explanation of Medicare Benefits (EOMB). Group Companion Plan will need the EOMB to process some claims. Your MEA Group Companion Plan EOB will ask you to send Anthem Blue Cross and Blue Shield your EOMB when it is needed.
- Services initially covered by Medicare are paid based upon Medicare approved amounts. Services paid by Group Companion Plan only are paid based upon Anthem Blue Cross and Blue Shield maximum allowances. Participating Anthem Blue Cross and Blue Shield professionals will not balance bill members if their charge is greater than the Anthem Blue Cross and Blue Shield maximum allowance.
- Lifetime Maximum Benefit $5,000,000

Who Pays What?

<table>
<thead>
<tr>
<th>Services</th>
<th>Medicare</th>
<th>Group Companion Plan</th>
<th>You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>Medicare hospital benefits are based on “benefit periods”. A benefit period begins on the first day inpatient services are received and ends after the beneficiary has been out of the hospital and/or skilled care facility for 60 consecutive days. Semiprivate room and board, general nursing, and miscellaneous services and supplies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First 60 days of admission</td>
<td>All but $1,340</td>
<td>$1,340 (Medicare Part A Deductible)</td>
<td>$0</td>
</tr>
<tr>
<td>Day 61-90</td>
<td>All but $335 per day</td>
<td>$335 per day</td>
<td>$0</td>
</tr>
<tr>
<td>Day 91 and after:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- while using 60 lifetime reserve days</td>
<td>All but $670 per day</td>
<td>$670 per day</td>
<td>$0</td>
</tr>
<tr>
<td>- once lifetime reserve days are gone:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- additional 365 days</td>
<td>$0</td>
<td>100 % of maximum allowance</td>
<td>$0</td>
</tr>
<tr>
<td>- beyond additional 365 days</td>
<td>$0</td>
<td>$0</td>
<td>All Costs</td>
</tr>
</tbody>
</table>
## Who Pays What?

<table>
<thead>
<tr>
<th>Services</th>
<th>Medicare</th>
<th>Group Companion Plan</th>
<th>You</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td>Must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First 20 days of admission</td>
<td>All approved amounts $0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Day 21-100</td>
<td>All but $167.50 per day $167.50 per day</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Day 101 and after</td>
<td>$0</td>
<td>$0</td>
<td>All Costs</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First 3 pints</td>
<td>$0</td>
<td>3 pints $0</td>
<td></td>
</tr>
<tr>
<td>Additional amounts</td>
<td>80%</td>
<td>20%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>Available as long as your doctor certifies terminal illness and member elects to receive these services</td>
<td>All but very limited coinsurance for outpatient drugs and inpatient respite care</td>
<td>The lesser of 5% or $5 per prescription and 5% respite care billed by hospice $0</td>
</tr>
<tr>
<td><strong>Medical Expenses</strong></td>
<td>In or out of the hospital and outpatient hospital treatment, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, diagnostic tests, ambulance services, physical, speech and occupational therapy, durable medical equipment, office visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First $183 of Medicare-approved amounts</td>
<td>$0</td>
<td>$183 for all Medicare Part B eligible services</td>
<td>$0</td>
</tr>
<tr>
<td>Remainder of Medicare-approved amounts</td>
<td>80%</td>
<td>20% for all Medicare Part B eligible services</td>
<td>$0</td>
</tr>
<tr>
<td>Part B Excess Charges (up to 15% above Medicare-approved amounts for physicians who do not accept Medicare assignments)</td>
<td>$0</td>
<td>100% of legal excess charge</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Benefits beyond Medicare-approved amounts</strong></td>
<td>$0</td>
<td>80% subject to medical necessity</td>
<td>20% as long as treatment meets medical necessity requirement</td>
</tr>
<tr>
<td>Physical or occupational therapy, durable medical equipment, and prosthetics</td>
<td>$0</td>
<td>80% (40 visits per year)</td>
<td>20% for 40 visits</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>$0</td>
<td>80% (25 visits per year)</td>
<td>20% for 25 visits</td>
</tr>
<tr>
<td>Physical manipulations</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Who Pays What?

<table>
<thead>
<tr>
<th>Services</th>
<th>Medicare</th>
<th>Group Companion Plan</th>
<th>You</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OTHER BENEFITS – NOT COVERED BY MEDICARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign Travel-Care Received Outside the USA</td>
<td>$0, except in limited instances in Canada &amp; Mexico (emergencies &amp; borders)</td>
<td>Balances on Medicare approved days. In emergencies, 100% of reasonable charges for semi-private room up to 121 days for non-Medicare approved days; then 80%</td>
<td>In emergencies $0 for 121 days; 20% for days over 121 for non-Medicare approved days</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>$0</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s GYN Exam &amp; PAP Test</td>
<td>100% GYN/PAP Test every 2 years; Once every 12 months for high risk women</td>
<td>$0 in years Medicare pays benefits; 80% in other years</td>
<td>$0 in years Medicare provides benefits; 20% in other years</td>
</tr>
<tr>
<td>Women’s Mammography Exam</td>
<td>100% every 12 months – age 40 and over</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Men’s Prostate Specific Antigen Testing</td>
<td>100% of Medicare’s approved allowance every 12 mos. for age 50 and over</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
### Who Pays What?

<table>
<thead>
<tr>
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<th>You</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health and Substance Abuse</strong></td>
<td>Treated like any other illness. **</td>
<td>Medicare balances,</td>
<td>See Summary Schedule of Benefits for deductible, coinsurance and</td>
</tr>
<tr>
<td>Inpatient and Outpatient treatment</td>
<td></td>
<td>then Maine State Mandates</td>
<td>benefit maximums under Maine State Mandates and Federal Mandates</td>
</tr>
<tr>
<td><strong>MEDICARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong><em>(See Summary Schedule of Benefits for deductible, coinsurance and benefit maximums under Maine State Mandates and Federal Mandates</em>)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prescription Drug Program**

*Through Mail Order and retail pharmacies you can purchase your prescriptions for up to a 90 day supply for 2 copayments. (check with your pharmacy to confirm they offer this benefit)*

<table>
<thead>
<tr>
<th>Tier 1: Speciality Drugs: $85</th>
<th>Tier 2: $35 copayment</th>
<th>Tier 3: $60 copayment</th>
<th>Tier 4: $120 copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail Order and Select Retail Pharmacies for up to a 90-day supply</td>
<td>Tier 1: $20 copayment</td>
<td>Tier 2: $70 copayment</td>
<td>Tier 3: Specialty Drugs: Not eligible for 90 day supplies</td>
</tr>
</tbody>
</table>

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THIS IS NOT A CONTRACT. It is an overview of your benefits. For more detailed information, please contact your benefits administrator or us for a copy of the certificate of coverage for this health plan. If there are discrepancies between this benefit overview and the certificate of coverage, the certificate will govern.

Please call our Companion Plan Customer Service Department if you have questions. The number is 1-800-422-4304.

Please Note: The Blue View Vision Plan is not included in the benefits of the MEA Group Companion Plan, but is available to be purchased. The rate for a single enrollee is $7.38 per month / $12.92 for retiree and spouse.
Take care of yourself
Use your preventive care benefits

Getting regular checkups and exams can help you stay healthy and catch problems early — when they’re easier to treat.

That’s why our health plans offer all the preventive care services and immunizations below — at no cost to you. As long as you see a doctor or use a pharmacy or lab in the plan, you won’t have to pay anything for these services and immunizations. If you want to visit a doctor or pharmacy outside the plan, you may have to pay out of pocket.

Not sure which services make sense for you? Talk to your doctor. He or she can help you figure out what you need.

Preventive vs. diagnostic care

What’s the difference? Preventive care helps protect you from getting sick. If your doctor recommends you have services even though you have no symptoms, that’s preventive care. Diagnostic care is when you have symptoms and your doctor recommends services to determine what’s causing those symptoms.

Adult preventive care

Preventive physical exams

Screening tests:
- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision

Immunizations:
- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)

Women’s preventive care:
- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression
- Pelvic exam and Pap test, including screening for cervical cancer

These preventive care services are recommendations of the Affordable Care Act (ACA or health care reform law). They may not be right for every person, so ask your doctor what’s right for you.

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will rule. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for exclusions and limitations.

* CDC-recognized Diabetes Prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

43199MUMENABS V030 Rev. 10/17
Child preventive care

Preventive physical exams

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and BMI
- Hemoglobin or hematocrit (blood count)

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type b (Hib)
- Hepatitis A and hepatitis B
- HPV
- Meningitis
- MMR
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

A word about pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules.
- Get prescriptions from plan providers and fill them at plan pharmacies.
- Have prescriptions, even for OTC items.

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease, preeclampsia and colorectal cancer by adults less than 70 years old.
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening.
- Generic low to moderate dose statins for members that are 40-75 years and have 1 or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking).
- Tobacco-cessation products, including all FDA-approved brand and generic OTC and prescription products, for those ages 18 and older.
- Vitamin D for adults over age 65

- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10-24 with fair skin about lowering their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening when done as part of a preventive care visit

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent the tooth decay of primary teeth for children ages 0-5.
- Fluoride supplements for children ages 0-6.

Women’s preventive drugs and other pharmacy items — age appropriate:

- Contraceptives, including generic prescription drugs, brand-name drugs with no generic equivalent and OTC items like female condoms and spermicides.
- Low-dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia.
- Folic acid for women ages 55 or younger who are planning and able to get pregnant.

Breast cancer risk-reducing medications, such as tamoxifen and raloxifene, that follow the U.S. Preventive Services Task Force criteria.

1 The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 You may be required to get prior approval for these services.

4 Check your medical policy for details.

5 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

6 This benefit applies to those younger than age 18.

7 Counseling services for breastfeeding (lactation) can be provided or supported by a plan doctor or hospital provider, such as a pediatrician, obstetrician/gynecologist or family medicine doctor, and hospitals with no member cost share (deductible, copay, coinsurance).

8 Contact the provider to see if such services are available.

9 A cost share may apply for other prescription contraceptives, based on your drug benefits.

10 Your cost share may be waived if your doctor decides that using the multisource brand is medically necessary.

11 The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

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27 A cost share may apply for other prescription contraceptives, based on your drug benefits.

28 Your cost share may be waived if your doctor decides that using the multisource brand is medically necessary.
Skip the drugstore – have your medicine delivered to your home!

Why wait in line at the drugstore if you don’t have to? If you take prescribed medicine on a regular basis, you can get up to a 90-day supply delivered to your door.¹ And depending on your plan, you may save on copays because the cost of a 90-day supply of many drugs is usually less than three 30-day refills. On average, members save up to 25% on their copay when they use home delivery.² Standard shipping is free, and you can even set up automatic refills.

Getting started with home delivery is easy:

1. Go online to get a prescription order form.

Visit anthem.com, choose Manage Your Prescriptions from the home page and log in with your username and password. If you haven’t signed up on the site yet, you’ll need to do that first.

On your personal pharmacy page, select Start a New Prescription.

That’ll take you to the site of the company that helps manage our prescription benefits.³ There, you can download and print the physician fax form or, if you already have a new prescription for a 90-day supply of medicine from your doctor, download the home delivery mail form. You’ll use one of these forms to send in your prescription.

2. Get a new prescription from your doctor for home delivery.

You’ll need an up-to-90-day supply prescription. Your doctor can send in your prescription through eprescribe or fax it using the physician fax form from step 1.

Also ask your doctor for a 30-day prescription. Get this filled at your regular pharmacy to make sure you have enough medicine to last until you get your first home delivery prescription.
3. Send in your prescription

Fill out the home delivery order form and mail it to the address on the form. Be sure to include prescription and payment information along with it.

or

Your doctor can fill out the physician fax form and fax or efax it to the number on the form.

4. Pay for your prescription.

You can pay by check, echeck, money order, credit or debit card, flexible spending account or health savings account.

You can sign up for e-payments or have your credit card on file online. To set up your payments, go to anthem.com, choose Manage Your Prescriptions from the home page and log in. Then, select Start a New Prescription. Once you’re on our prescription benefit manager’s site, select My Account to choose how you’d like to pay.

If you want to use our Home Delivery Pharmacy and are enrolled in a program that helps you with your copay or if you use manufacturer coupons to help pay for prescriptions, you’ll need to give the program or manufacturer detailed claim information and a receipt to get paid back. The company that manages our prescription benefits can’t bill us or these third parties for prescriptions you fill through home delivery.

A few important things to know

- If your doctor prescribes a brand-name drug, your pharmacy plan may require the home delivery pharmacy to send a generic version instead.
- All prescriptions and refills, including those sent by your doctor, will be filled as soon as the home delivery pharmacy gets them.
- In most cases, your first order will arrive within two weeks after the home delivery pharmacy gets it. After that, the orders will arrive within one week.
- If you need your medicine sooner, you can call the home delivery pharmacy and ask for overnight delivery. It will still take 3 to 5 days to process the order, plus the shipping time. You’ll be charged extra for the faster shipping.
- Your orders will be delivered by the U.S. Postal Service, UPS or FedEx.
- With some drugs, you may need to sign to accept delivery.

1 Supplies are based on your pharmacy plan design.
2 Express Scripts internal data, 2017.
3 Express Scripts is a separate company that manages pharmacy services for our health plan members.
4 Drugs that are defined as controlled substances are highly regulated, which requires the home delivery pharmacy to follow special rules for filling these prescriptions.
As a member, you have the right to expect us to protect the privacy of your personal health information. We do this according to state and federal laws, and our policies. You also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women’s Health and Cancer Rights Act, go to www.anthem.com/memberrights. To ask for a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we’ll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). Doctors and pharmacists who want to be sure you get the best treatments for certain health conditions make up Anthem’s UM team. They review the information your doctor sends us. These reviews can be done before, during or after your treatment. We also use case managers. They’re licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more detailed information about how we help manage your care, visit www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

The Maine Insurance Information and Privacy Protection Act provides consumers in Maine with these additional rights:

- To obtain access to the consumer’s recorded personal information in the possession or control of a regulated insurance entity.
- To request correction if the consumer believes the information to be inaccurate, and to add a rebuttal statement to the file if there is a dispute.
- To know the reasons for an adverse underwriting decision (previous adverse underwriting decisions may not be used as the basis for subsequent underwriting decisions unless the carrier makes an independent evaluation of the underlying facts).
- With very narrow exceptions, the right not to be subjected to pretext interviews.
We’ve got your back!

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield is the trade name of: In Connecticut: Anthem Health Plans, Inc. In Maine: Anthem Health Plans of Maine, Inc. 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. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.