Auto Retiree VEBA Trust

Medicare Eligible Benefit Enrollment and Change of Status Form

Auto Retiree VEBA Trust

Thank you for your time and attention as you enroll for benefits with the Auto VEBA. Please complete in ink and check the applicable boxes (☐) below.

❒ SECTION 1: Member Information

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /
Address	City	State	Zip
Telephone Number	Social Security Number	Gender ☐ Male ☐ Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: ☐ Part A ☐ Part B	If waiting on Medicare #, Check Here* ☐
Email Address	Retirement Date		
Effective Date / /	Salary / Hourly ☐ Salary ☐ Hourly	If Hourly, Name of Union	

❒ SECTION 2: Spouse/Surviving Spouse Information (If Enrolling)

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /
Retirement Date	Social Security Number	Gender ☐ Male ☐ Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: ☐ Part A ☐ Part B	If waiting on Medicare #, Check Here* ☐

❒ SECTION 3: Important Notes to Help You Correctly Select & Compare Your Coverage Election

1. The effective date of your coverage will be the first of the month following your signature date, but not prior to the month in which you become Medicare Eligible. If you become Medicare Eligible on the 1st day of the month, your coverage is effective on the 1st of the month prior. The exception to this is if you are enrolling through our annual open enrollment period. In this case, the effective date of coverage would be 1/1/2022.
2. Your spouse/domestic partner can elect different medical/prescription coverage as the Retiree.

❒ SECTION 4: Select Your Coverage

To elect Medical coverage, you must complete The Hartford Enrollment Form in addition to this form. The Hartford form is included in the enrollment packet and can also be found on the Auto VEBA website-go to www.MyMedPlans.com and click on Auto Tab '2022 Medicare Rates".

You may select medical ONLY coverage, prescription drug ONLY coverage or medical coverage with prescription drug plans now offered.

Please refer to the 2022 Auto Medicare Brochure for the monthly medical and prescription drug plan premiums.

*If you are enrolling and not the Retiree, include Retiree's Name and Date of Birth and Retirement Date from Auto Industry in the provided fields above.

Please pay special attention to the coverage options. There are two BCBSM Prescription Drug plans, High and Low available for Auto participants with the Hartford Medigap plans, BCBSM Medicare Advantage plans or as "standalone" plans.

Medical Plan Selection -

NEW BCBSM Medicare Advantage is Paired with the BCBSM RX HIGH Plan - BCBSM

☐ DIAMOND	☐ EMERALD	☐ RUBY
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse		

A Prescription Drug Plan is included with all of the Medicare Advantage Plans

The Hartford

☐ Premium	☐ Elite	☐ Choice	☐ Premium Plus
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse			

BCBSM Standalone RX

☐ HIGH RX	☐ LOW RX
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse	

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Dental & Vision - BCBSM

☐ High Dental	☐ Low Dental	☐ Vision
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse	TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse	TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse

❒ SECTION 5: Signature

Retiree Signature: (If Enrolling) _____ **Date:** _____

Spouse/Domestic Partner Signature: (If Enrolling) _____ **Date:** _____

❒ SECTION 5: Release of Information

By joining this plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be dis-enrolled from this plan.

I understand that my signature (or signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by applicable plan vendors or by Medicare.

❒ SECTION 6: Signature

Retiree Signature: (If Enrolling) _____ **Date:** _____

Spouse/Domestic Partner Signature: (If Enrolling) _____ **Date:** _____

If you are the authorized representative, please provide the following information:

Name _____

Address _____

Phone Number _____

Relationship to Retiree _____

Please return your completed enrollment form AND your Hartford form if enrolling in or changing medical plans to Benistar, our plan administrator:

Mail: Benistar Admin Services
10 Tower Lane, Suite 100
Avon, CT 06001

Email: memelig@benistar.com

Fax: 1-860-408-7025

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DENTAL & VISION
Auto VEBA offers dental and vision coverage through Blue Cross Blue Shield of Michigan (BCBSM). Both plans offer comprehensive coverage. If you would like to enroll in dental and vision coverage or change your current elections please contact Benistar at (800)236-4782 or access the Auto VEBA enrollment form on the Auto VEBA website – www.MyMedPlans.com

❒ BCBSM Dental and Vision Standalone Rates – Medicare Eligible

Dental Rates (Standalone or with another option)		
The rates below are priced for eligible plan participants enrolling in the Dental Plan Only.		
	Low Plan Rate	High Plan Rate
Single	$64.75	$68.83
Two-Person	$125.25	$133.41
Administration Fee of $4.25 has been added to the rate.		

2022 Blue Cross Blue Shield Vision Rates (VSP)		
Single	$ 6.07	**Admin Fee is included in the Dental Rate you purchase with Vision Plan**
Two-Person	$ 12.14	
Must be purchased with a Dental plan		

❒ BCBSM Medicare Advantage with High Prescription Drug Plan

OPTIONS	Diamond	Emerald	Ruby
Type of network	Passive	Passive	Passive
Out of pocket maximum		$750	$4,500
Deductible	$0	$0	$0
Coinsurance	0%	20%	20%
Inpatient	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Outpatient	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Office visit	$0	$5	$20
Chiropractic	$0	$5	$20
Specialist	$0	$15	$40
Urgent care	$0	$10	$50
Facility evaluation	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Psych	$0	$5	$25
Surgical services	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Other physician services	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Preventative	No Cost	No Cost	No Cost
Emergency	$0	$75	$90
Ambulance services	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Durable medical equipment	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Monthly MA with High PDP Rate	**$285.99**	**$224.06**	**$109.04**

Admin fee already included (plan administration, billing and claims)

❒ The Hartford with BCBSM Prescription Drug Plans

The total monthly cost for your coverage is per person per month, and based on your age

STANDALONE PLAN RATES Admin fee already included (plan administration, billing and claims)	INSURED'S AGE BANDED RATES			
	65-69	70-74	75-79	80+
Premium Plan (Mirrors Plan G)	$ 172.89	$ 205.13	$ 236.66	$ 246.84
Premium Choice Plan (Mirrors Plan F)	$ 190.66	$ 222.90	$ 254.43	$ 264.61
MEDICAL + RX PLAN RATES				
Premium Plan with LOW RX (Mirrors Plan G)	$ 248.81	$ 281.05	$ 312.58	$ 322.76
Premium Choice Plan with LOW RX (Mirrors Plan F)	$ 266.58	$ 298.82	$ 330.35	$ 340.53
Premium Plan with HIGH RX (Mirrors Plan G)	$ 285.56	$ 317.80	$ 349.33	$ 359.51
Premium Choice Plan with HIGH RX (Mirrors Plan F)	$ 267.79	$ 300.03	$ 331.56	$ 341.74

NOTE REGARDING AGE BANDED RATES: Use the age bracket appropriate for yourself (i.e. the retiree) – and use the age bracket appropriate for your spouse. Your spouse could have a different rate than you if you are in separate age brackets. Please make sure to use your age as of the first of the month of your coverage effective date. Both you and/or your spouse must be Medicare Eligible and enrolled in Medicare Parts A & B in order to participate in this plan.

❒ BCBSM Standalone Prescription Drug Plans

BCBSM (High and Low) Prescription Drug Plan	**Monthly Cost**
High RX	$91.90
Low RX	$72.92
*If Purchased as a Standalone (without a Medical Plan) there will be a $10.00 Admin Fee added to the rate.	

Formulary Option	Comprehensive Enhanced Formulary		Comprehensive Enhanced Formulary	
Prior Authorization/ Step Therapy	Yes		Yes	
Rx Deductible	$0		$0	
	Preferred Rx	**Standard Rx**	**Preferred Rx**	**Standard Rx**
Tier 1 (Preferred Generic)	$2	$10	$5	$10
31-90 Day Supply Mail Order Copay Multiplier				
Tier 2 (Generic)	$2	$10	$5	$10
31-90 Day Supply Mail Order Copay Multiplier				
Tier 3 (Preferred Brand)	$40	$50	$50	$60
31-90 Day Supply Mail Order Copay Multiplier				
Tier 4 (Non-Preferred)	$75	$100	$80	$100
31-90 Day Supply Mail Order Copay Multiplier				
Tier 5 (Specialty)	30% member cost	30% member cost	35% member cost	35% member cost

❒ Terms & Conditions

Please Read the following information. The information on this form and the following conditions are part of my contract with Blue Cross® Blue Shield® of Michigan.

I am applying for coverage for myself and/or my family member identified on this application under my group's or association's contract with Blue Cross. Coverage begins on the date determined by Blue Cross. When Blue Cross accepts my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by Blue Cross Blue Shield of Michigan. **Authorization**: I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Blue Cross® Blue Shield® of Michigan of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize Blue Cross and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with Blue Cross, and for other purposes necessary for Blue Cross to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to Blue Cross for purpose of administering our coverage. Upon my request, Blue Cross will tell me where the information was sent.