Auto Retiree VEBA Trust

Post 65 Benefit Enrollment and Change of Status Form

Auto 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 your turn 65. If you turn 65 on the 1st of the month, your coverage is effective on the 1st of the month prior to your 65th birthday. 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 1/1/2021.
2. Your spouse/domestic partner must have the same medical/prescription coverage as the Retiree.
3. Please review all information and sign and date where necessary.

❒ 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 '2021 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 2021 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.

Auto Retiree VEBA Trust

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

Medical Plan Selection - The Hartford

☐ Premium	☐ Premium Choice
☐ Retiree	☐ Retiree
☐ Spouse	☐ Spouse
☐ Retiree & Spouse	☐ Retiree & Spouse

☐ Terminate Contract — If coverage is terminated (Retiree, spouse/domestic partner, and/or dependent) – regardless of the reason – you CANNOT re-enroll in any of the Post-65 medical/prescription plans at a later date including during a subsequent open enrollment.

Medicare Advantage - AETNA

☐ Aetna $20 PPO w/ High RX (11S3)	☐ Aetna $25 PPO w/ Low RX (1203)
☐ Retiree	☐ Retiree
☐ Spouse	☐ Spouse
☐ Retiree & Spouse	☐ Retiree & Spouse

☐ Terminate Contract — If coverage is terminated (Retiree, spouse/domestic partner, and/or dependent) – regardless of the reason – you CANNOT re-enroll in any of the Post-65 medical/prescription plans at a later date including during a subsequent open enrollment.

Prescription Drug Plan Selection - AETNA

☐ High RX (11S3)	☐ Low RX (1203)
☐ Retiree	☐ Retiree
☐ Spouse	☐ Spouse
☐ Retiree & Spouse	☐ Retiree & Spouse

☐ Terminate Contract — If coverage is terminated (Retiree, spouse/domestic partner, and/or dependent) – regardless of the reason – you CANNOT re-enroll in any of the Post-65 medical/prescription plans at a later date including during a subsequent open enrollment.

Dental & Vision - BCBSM

☐ High Dental	☐ Low Dental	☐ Vision
☐ Retiree	☐ Retiree	☐ Retiree
☐ Spouse	☐ Spouse	☐ Spouse
☐ Retiree & Spouse	☐ Retiree & Spouse	☐ Retiree & Spouse
☐ Terminate Coverage	☐ Terminate Coverage	☐ Terminate Coverage

❒ 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

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

The Hartford with AETNA Prescription Drug Plans

Premiums for 2021 are summarized in the following charts:

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

$ 14.95 admin fee already included (plan administration, billing and claims)	INSURED'S AGE BANDED RATES				
	Under 65	65-69	70-74	75-79	80+
Premium Plan (Mirrors Plan G)	$ 277.29	$ 161.80	$ 192.50	$ 222.53	$ 232.22
Premium Choice Plan (Mirrors Plan F)	$ 294.21	$ 178.73	$ 209.43	$ 239.45	$ 249.15

5 Year Bands - Upon the 1st day of your birthday month

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 your spouse must be age 65 or older in and enrolled in Medicare Parts A & B in order to participate in this plan.

AETNA Medicare Advantage with Prescription Drug Plans

Medicare Advantage Plans	Medical $20 PPO with High RX (11S3)		Medical $25 PPO with LOW RX (1203)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	**$0**	**$0**	**$0**	**$0**
Annual Out-of-Pocket	$6,700	$10.000 for in and out of network services combined	$6,700	$10.000 for in and out of network services combined
Primary Care Physician Selection	Optional	Not Applicable	Optional	Not Applicable
Referral Requirement	There is no requirement for member pre-certification. Your provider will do for you.		There is no requirement for members pre-certification. Your provider will do for you	
PREVENTATIVE CARE				
Annual Wellness Exams	$0	20%	$0	25%
Routine Physical Exams	$0	20%	$0	25%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	$0		$0	
Routine GYN Care)Cervical and Vaginal Cancer Screening	$0	20%	$0	25%
Routine Mammograms (Breast Cancer Screening) one Annual Screening	$0	20%	$0	25%
Routine Prostate Cancer Screening Exam for males over age 50, every 12 months	$0	20%	$0	25%
Routine Colorectal Cancer Screening	$0	20%	$0	25%
Routine Bone Mass Measurements	$0	20%	$0	25%
Additional Medicare Preventative Services	$0	20%	$0	25%
Routine Eye Exams	$0	20%	$0	25%
Routine Hearing Screening	$0	20%	$0	25%
Physician Services				
Primary Doctor Office Visit	$10 copay	20%	$25 copay	25%
Specialist Office Visit (includes mental health & substance abuse)	$20 copay	20%	$25 copay	25%
Outpatient Diagnostic Testing, Imaging, X-ray, Complex Imaging	$20 copay	20%	$25 copay	25%
Emergency/Urgent Care Services				
Emergency Care Worldwide (copay waived, if admitted)	$50 copay	$50 copay	$90 copay	$90 copay
Urgent Care: Worldwide	$35	$35	$25	$25
Ambulance	$0	$100	$25 copay	25%
Hospital Services				
Hospital Admissions member cost sharing applies to covered benefits incurred during member's inpatient stay	Covered 100%	20%	$250 per stay	25%

❒ AETNA Standalone Prescription Drug Plans

AETNA (High and Low) Prescription Drug Plan	**Monthly Cost**
High RX (11S3)	$122.10
LOW RX (1203)	$96.93

❒ BCBSM Dental and Vision Standalone Rates – Post-65

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	$56.59	$60.41
Two-Person	$113.18	$120.82
Family	$169.77	$181.23
When enrolling in Dental Only, an Administration Fee of $4.25 must be added to the rate.		

2021 Blue Cross Blue Shield Vision Rates (VSP)		
Single	$ 5.28	**These Rates do NOT include the admin fee**
Two-Person	$ 10.56	
Family	$ 15.84	
If purchased separately must be bundled with Vision plan and pay admin fee of $4.25		

❒ 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.