2022 BENEFITS GUIDE

Voluntary Benefit Trust for Airline Retirees
Pre-65 Retirees Health Benefit Guide

Providing Coverage for ALL Pre-65 Eligible Retirees

Voluntary Benefit Trust for
AIRLINE RETIREES

Voluntary Benefit Trust for AIRLINE RETIREES

SECTION 1 – Introduction of the Voluntary Benefit Trust for Airline Retirees Trust

Overview

The Board of Directors of the Voluntary Benefit Trust for Airline Retirees (VBTAR) VEBA Trust (the Trust) would like to welcome you to review this Benefits Enrollment Guide that has been created for Retirees of all Airline Industry Companies. Please refer to the Summary Plan Description (SPD) for complete details about your plan. If there is a conflict between this Benefits Guide and a Certificate or Summary Plan Description (SPD), the Certificate or SPD will govern. To receive a copy of the benefit plan materials, please go to www.MyMedPlans.com and download copies of benefit materials. If you would like to have them mailed to you, please contact, Benistar, the plan administrator @ 1-800-236-4782 and they will mail/email you an enrollment packet.

Mission Statement

The goal of the VBTAR Retiree VEBA Trust is to provide and maintain quality, cost effective benefits, including medical, prescription drugs, dental and vision programs and other healthcare benefits for all eligible Airline Retirees that have worked for in the Airline industry and subsidiaries for at least 5 years.

Protecting Your PHI

The Board, Cone Retiree Healthcare the Healthcare Providers understand the importance of protecting your personal health information. We have the ability to communicate with plan participants and protect their PHI.

Coverage Contact Information

Benistar

Phone: 1-800-236-4782

Your Call Center and Plan Administrator

Mailing Address:
Benistar Retiree Service Center
10 Tower Lane, Suite100
Avon, CT 06001

Fax Enrollment Forms:
1(860)408-7025
Make Checks Payable to:
Benistar Retiree Services

Medical Plan Information:	**Blue Cross Blue Shield Medical Plans**	
	Blue Cross Blue Shield of Michigan Post-Enrollment Benefits and Claims Benistar Call Center BCBSM Claims Department	 (800)236-4782 (877)354-2583
Prescription Drug Plan Information:	**Blue Cross Blue Shield Prescription Drug Plans**	
	BCBSM Pre-Enrollment Benefit Inquiries: Post-Enrollment Benefits & Claims Prescription Drug Formulary	(800)236-4782 (877)354-2583
Dental Plan Information:	**Blue Cross Blue Shield Nationwide Plans (Dental)**	
	Blue Cross Blue Shield of Michigan www.Mibluedentist.com Dental Customer Service Find a Doctor	 (888)826-8152
Vision Plan Information:	**Blue Cross Blue Shield Michigan** (Blue Vision VSP with BCBSM)	
	BCBSM Customer Service www.VSP.com or www.BCBSM.com	(800)877-7195

enroll NOW

CALL 1-800-236-4782

Overview

This benefits enrollment guide provides an overview of the benefits offered by the VBTAR VEBA Trust for Retirees. In the event of a conflict between this benefits enrollment guide and a Certificate or Summary Plan Description (SPD), the Certificate or SPD will govern. Please refer to them for additional information. An official detailed description of benefits, exclusions, limitations, eligibility and other terms and conditions is contained in individual benefit Summary Plan Descriptions. Copies of benefit plan materials are available to you via mail or email and may be requested by calling the VBTAR Trust Retiree Service Center at 1-800-236-4782.

Mission Statement

The mission of the VBTAR VEBA Trust for Retirees, is to establish and maintain quality benefits including medical, prescription drug, dental and vision benefits, at a reasonable cost to its members. The objective of the VEBA is to deliver benefits efficiently and effectively with a focus on providing quality benefits in a cost-conscious manner.

Goals

· The Trust will provide quality benefit programs to all retirees in the Airline industry in 2022.
· Qualifying participants include people eligible for the Health Coverage Tax Credit (HCTC) between the ages of 55-64 (if and when reinstated) as well as their qualifying dependents under age 65. The dependent eligibility ends 24 months after the Retiree's 65th birth month.
· Pre-65 Retirees and their dependents to enroll or to remain in these BCBSM plans regardless of their eligibility for the HCTC subsidy program.
· We also provide Medicare-eligible retirees and their eligible dependents, the ability to enroll in Medicare healthcare plans that coordinate with and/or enhance the coverage provided by original Medicare. The website for Medicare eligible retirees is **www.MyMedPlans.com**
· The Trust Board will oversee the selection of healthcare plans that will be offered each year to members of the Trust, including medical, prescription drug, dental and vision plans.
· The Board manages the selection of the plan administrator for the Trust plans each year as they support the membership in enrolling in the IRS/HCTC Program, and completing the necessary documents, required to qualify for the 72.5% subsidy when enrolling in the HCTC program (if/when reauthorized).
· The Trust Insurance Representatives will provide timely updates about the VBTAR Trust annual enrollment process as well as any changes to the plans offered including the cost of the programs during open enrollment.

Trust Board

The VBTAR VEBA Trust Board is drawn from volunteers with experience on boards with health and disability benefits and in particular, with the Airline industry. They have volunteered their time and energy to serve as Board members for the VBTAR Trust. If you are interested in serving on the board when vacancies occur, please contact the Board to express your interest. The email address for the Board Mail is **info@mymedplans.com**

Questions	Company	Phone	Web Site
Eligibility and Administration	Benistar Retiree Service Center	800-236-4782	N/A
Health Plan Benefits/Providers	Blue Cross Blue Shield of Michigan	877-354-2583	www.bcbsm.com
Dental Plan Benefits/Providers	Blue Cross Blue Shield of Michigan	877-354-2583	www.bcbsm.com
Vision Plan Benefits/Providers	Blue Cross Blue Vision (VSP)	877-354-2583	www.bcbsm.com
Contact the Board of the Trust	VBTAR VEBA Trust Board		www.info@mymedplans.com
Important Information for retirees eligible for the VBTAR VEBA Trust	Cone Retiree Healthcare Group, LLC. Insurance Representatives		Cathy@mymedplans.com John@mymedplans.com Lisa@mymedplans.com

Enrollment Period

The annual enrollment period for the VBTAR VEBA Trust will be from November 01 - December 31 each year.

Retiree Eligibility

Retirees, survivors and their families, as outlined in the eligibility section of this booklet, have the ability to enroll in the plans offered through the Trust.

Pre-Medicare retirees, survivors and their families, who are:

· Retirees of the airline Industry including those, but not limited to, the companies listed below.
· Meet the eligibility rules of the HCTC program when in effect for HCTC plan participants.
· Retirees under the age of 65 and dependents listed on the federal tax return of the eligible Retiree
· Retiree has worked at least 5 years for a company eligible to participate in the VBTAR VEBA Trust.

Based on information currently available to the Trust, the list of eligible companies includes, but is not necessarily limited to, the following companies:

Air Tran	Eastern Air Lines	SkyWest Airlines
Alaskan Airlines	ExpressJet Airlines	Southwest Airlines
Allegiant Air	Frontier Airlines	Spirit Airlines
Aloha Airlines	Hawaiian Airlines	Sun Country Airlines
American Airlines	Horizon Air	Trans World Airlines
American Connection	Jet Blue Airlines	United Airlines
American Eagle	Mesa Airlines	U.S. Airways Inc
Atlas Air	Northwest Airlines	Virgin America
Braniff Airways	Pan American World Airways	World Airways
Continental Airlines	Piedmont Airlines	Any Subsidiary of an Airline
Cape Air	Republic Airlines	
Delta Air Lines	Ryan Air	

Retiree - As an VBTAR Retiree VEBA member, you and your dependents are eligible for the medical, prescription drug, dental and vision benefits outlined in this benefit guide whether or not your pension has been trusteed by the PBGC.

Spouse/Domestic Partner/Dependents - Your spouse or same-gender domestic partner may also be eligible for medical, prescription drug, dental and vision benefits if they meet the guidelines established by the Trust.

Under Age 65 - Your spouse/domestic partner are not required to enroll in the same coverage as the retiree. **Medicare-Eligible (both under and over age 65)** - If you are enrolling in the plans offered through the Trust, each plan participant has the ability to enroll in benefits coverage tailored to their specific needs. It is not necessary for the retiree and the spouse to be enrolled in the same benefits plans.

Dependents - If you have dependents under age 65 and the retiree is under 65 or on Medicare for less than 24 months, your dependents may be eligible to participate.

Dependent Eligibility

Spouse	A legally married spouse, including a declared common-law spouse.* Only one spouse or same-gender domestic partner may be covered at any one time. *Where recognized by state.
Domestic Partner	The individual who lives in the same household and shares the common resources of life in a close, personal, intimate relationship with a retiree if, under state law, the individual would not be prevented from marrying the retiree on account of age, consanguinity, or prior undissolved marriage to another. An eligible domestic partner must be of the same gender as the retiree. Only one spouse or same-gender domestic partner may be covered at any one time.
Children	Your biological children, stepchildren, legally adopted children, children for whom you have obtained court-ordered guardianship or conservatorship; qualified children placed pending adoption; grandchildren; and children of your domestic partner if you also cover your domestic partner for the same benefit. Your children must be on the federal income tax of the Retiree to be eligible to enroll in the Dental and Vision plans through the Trust.
Dependent Grandchildren	Your unmarried grandchild must meet the requirements listed above and must also qualify as a dependent as defined by the Internal Revenue Service on your or your spouse's federal income tax return.
Disabled Children	To continue coverage past the age limit, your disabled child must otherwise meet the requirements for eligible dependents and must also meet the following definitions: A disabled child is a child who, due to a mental or physical disability, is incapable of earning a living at the time he or she would otherwise cease to be a dependent if the child is covered as a dependent at that time and if at that time he or she depends on you for principal support and maintenance. A disabled child continues to be considered and eligible dependent as long as the child remains incapacitated, unmarried, dependent on you for principal support and maintenance, and you continuously maintain the child's coverage as a dependent under the plan from the date he or she otherwise would lose dependent status. A dependent child who loses eligibility and later becomes disabled is not eligible to be covered. A disabled child who was not covered as a dependent immediately prior to the time he or she would otherwise cease to be a dependent is not eligible to be covered.

Documentation

To provide coverage for a dependent under any of the Trust benefits programs, you must submit documentation that supports your relationship to the dependent when dependents are added after initial enrollment into the Trust plans.
Please contact the **Benistar Retiree Service Center at 800-236-4782** for a list of acceptable documentation.

Persons Not Eligible to Participate

Dependents do not include:

- Individuals on active duty in any branch of military service (except to the extent and for the period required by law)
- Permanent residents of a country other than the United States
- Parents, grandparents, or other ancestors
- Grandchildren who do not meet the definition of dependent grandchildren and who are not claimed on your or your spouse's federal income tax return.

Changes in Family Status

If you have a change in your family status, such as adding or dropping a dependent, you must notify the Benistar Retiree Service Center within 31 days of any changes in family status at 1-800-236-4782. If you add or drop a dependent during open enrollment, the change becomes effective on the first day of January, the following year.

Special Qualifying Life Events

A special qualifying life event will allow you to change or enroll in coverage outside the normal open enrollment window provided you have notified the Benistar Retiree Service Center within 31 days of the qualifying life event.

Special qualifying events include:

- Certain changes in employment status for your spouse or an eligible dependent;
- Marriage or divorce
- Addition of a dependent
- Loss of a spouse or dependent
- Eligibility for Medicare due to turning 65 or classified as Social Security disabled
- Eligibility for the Health Coverage Tax Credit (HCTC) due to turning 55 or when you initially begin to draw your pension at an age past 55 or reauthorization of the HCTC program (HCTC Participants only).
- Gaining or losing a dependent resulting from marriage, divorce, birth or adoption
- Involuntary loss of other insurance coverage (proof is required)

Pre65-Eligible Survivor /Dependents upon Death of Retiree	A Pre-65 survivor or dependent is eligible for medical, prescription drug, dental and vision coverage for up to 24 months following the death of the retiree, when eligible for the Health Coverage Tax Credit Program, if in effect. The Spouse/Domestic Partner/Survivor will remain eligible for the Pre-65 program until they reach the age of 65 or become Medicare Eligible when not participating in the HCTC program.
Survivor Becoming Eligible for HCTC * * HCTC participants only	A survivor is eligible to receive the PBGC pension, following the death of the retiree, if the retiree elected "joint and survivor" option when making his or her pension election options. If the retiree chose the "joint survivor" option, the survivor will become the primary PBGC recipient, and his or her birth date will determine eligibility for participation in the HCTC Subsidy program. It will be necessary to provide a statement from the PBGC confirming the eligibility as the pension recipient if the survivor becomes the primary PBGC recipient.
Medicare Eligible Survivor	Medicare-eligible survivors, while not qualified to enroll in the HCTC program, will be qualified to participate in the Medicare and dental and vision programs offered through this Trust following proof of retiree's eligibility prior to death, such as a pension check stub or a notarized document providing the retiree's employment with an eligible company authorized to participate in this Trust.
Former Eligible Spouse	The plan administrator, Benistar, will send enrollment materials to the former spouse following a request from the individual. If enrolling as eligible for the HCTC program, they will need to show proof from the PBGC by providing a statement confirming that the spouse has become a pension recipient due to a divorce agreement reached with the retiree eligible to participate in the VBTAR VEBA Trust.
Qualified Family Member(s) of HCTC Recipient	A qualified family member (QFM) also is eligible to elect medical, prescription drug, dental and vision benefits. QFMs include the spouse or dependent of an eligible retiree who has reached the age of 65. The spouse or dependent must be claimed on the retiree's Federal Income Tax return.

Pre Medicare Health Insurance Options for HCTC and Non HCTC Participants

Members who do not qualify for the HCTC subsidy (when in effect) can elect from the same health insurance options offered to HCTC plan participants however, they must pay 100% of the monthly plan premium.**

The Medical plans offered for Pre-Medicare retirees and their dependents provide:

- Nationwide coverage in the United States
- PPO plans provide you with access to covered benefits through a network of healthcare providers and facilities. You are not required to have a referral from your primary care doctor before going to a specialist.
- Members and their dependents under the age of 65 will qualify for Medical programs offered through the Trust can select from the following health insurance options offered through BlueCross BlueShield Michigan:

  Gold, Silver, Bronze and Copper Bundled plans (all include medical, prescription drugs, dental and vision)

HCTC Program Subsidy Enrollment Requirements

General Requirements for the HCTC Program Subsidy: rules below do not apply to Pre-65 Retirees & dependents who do not qualify for HCTC program.

The HCTC is a federal tax credit/subsidy paying 72.5% of the premiums of qualifying coverage allowing eligible participants to pay just 27.5% of health insurance premiums. If you are eligible, the HCTC program is available for you to pay monthly premiums through the IRS/HCTC Advanced Monthly Payment program (AMP) or yearly when filing your federal income tax return or a combination of both. In order to qualify for the HCTC, you must be enrolled in a qualified health plan and meet all the following eligibility requirements.

THE HCTC PROGRAM HAS NOT BEEN EXTENDED AND IS SET TO EXPIRE DECEMBER 31,2021. ALL PLAN PARTICIPANTS INCLUDING QFMS WILL HAVE TO PAY 100% OF THE 2022 PLAN PREMIUM UNLESS THE HCTC PROGRAM IS EXTENDED

There are 2 groups of HCTC eligible plan participants:

You must be age 55 to 65 and receiving a pension check from the Pension Benefit Guaranty Corporation (PBGC)

Trade Adjustment Assistance (TAA), Alternative Trade Adjustment Assistance (ATAA), Reemployment Trade Adjustment Assistance (RTAA).

You must also meet some general requirements and be enrolled in a qualified health plan. At the time of your registration, you will need to certify that:

You are not enrolled in Medicare Part A, B, C or D.

You are not enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP).

You are not enrolled in the Federal Employees Health Benefits Program (FEHBP) or enrolled in the U.S. military health system (TRICARE).

You are not imprisoned under federal, state, or local authority.

You are not being claimed as a dependent on someone else's tax return.

Enrollment process for the HCTC Subsidy and Qualified Insurance Program:

Conditional on the HCTC program's reauthorization, enrollment is a two step process including the HCTC program registration and the BCBSM qualified insurance plan.

Complete the Monthly Health Coverage Tax Credit (HCTC) Group Registration/Update Form (Form 13441-A) to register for the HCTC program. (Sample forms available on our web page www.hctcplans.com or www.mymedplans.com)

Complete the Blue Cross Blue Shield Insurance Enrollment Form

Provide a copy of proof of eligibility (e.g.– IRS 1099-R, PBGC check stub or bank statement with PBGC deposit)

Payment – Once the above steps have been completed and mailed to Benistar, our plan administrator, you will receive a "Welcome to the HCTC Program" letter from the IRS and a welcome letter from BCBS within 30-60 days. The Retiree(s) will then pay 27.5% premium to the IRS by sending a check with payment voucher to the address provided in the HCTC welcome letter. The voucher including your Participant Identification Number (PIN) will be included with your payment each month. Payments must be received by the IRS before the 10th of each month. Please DO NOT pay more or less than the premium amount or the payment will be rejected and you will be required to pay 100% of the premium for that month.

It is important to note that if the HCTC program is reauthorized for 2022 and beyond the rules regarding the HCTC program and process of payment is subject to change. You will be notified of any changes.

Enrolling in the HCTC Program as a Qualified Family Member (QFM):

Dependent(s) of the retiree who is experiencing a life event such as retiree becoming eligible for Medicare, Divorce or Death of Retiree will be classified as Qualified Family Member(s) (QFM). QFM's must re-enroll in the HCTC program as a QFM and must check the "QFM" box on the enrollment form if currently enrolled as a dependent when the retiree experiences the life event. QFMs are only eligible for the HCTC program for an additional 24 months following the retirees life event. QFMs re-enroll by completing a new HCTC Monthly Registration/Update Form 13441-A, the BCBSM enrollment form and also including proof of eligibility (e.g.– Retiree's 1099-R, PBGC check stub or bank statement with PBGC deposit). For additional information on the QFM process, please contact Benistar Retiree Service Center at 1-800-236-4782.

HCTC-Eligible and Non-HCTC Plan Options

Nationwide insurance plans are provided by Blue Cross Blue Shield of Michigan.
Gold, Silver, Bronze and Copper plans are bundled to include medical, prescription drugs, dental and vision.

	Gold Plan		Silver Plan		Bronze Plan		Copper Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)	$250 Individual $500 Family	$500 Individual $1,000 Family	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family
Coinsurance	20%	40%	20%	40%	20%	40%	50%	50%
Out-Of-Pocket Maximum (includes deductible excludes all copays and penalty amounts)	$1,250 Individual $2,500 Family	$2,250 Individual $4,500 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$6,350 Individual $12,700 Family	$12,700 Individual $25.400 Family
Preventive Care Services								
Adult Routine Physical Exam (every 24 months), Annual Routine Mammogram, GYN Exam and PSA.	Covered 100%; no deductible, no copay	Not covered	Covered 100%; no deductible, no copay	Not covered	Covered 100%; no deductible, no copay	Not covered	No Charge	Not Covered
Routine Eye and Hearing Screening (one exam every 24 months)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not Covered	Not Covered
Physician Services								
Primary Doctor Office Visit	$10 office visit copay; deductible waived	40% copay, after deductible	$20 office visit copay; deductible waived	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Specialist Office Visits	$10 office visit copay; deductible waived	40% copay, after deductible	$20 office visit copay; deductible waived	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
X-ray and Lab Services (during office visit)	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Emergency Services								
Emergency Room (copay waived if admitted)	$50 copay;	$50 copay;	$150 copay;	$150 copay;	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance	50% co-insurance
Urgent Care								
Immediate Medical Attention	$10 copay	40% copay, after deductible	$20 copay	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance	50% co-insurance
Hospital Services								
Hospital Admission	20% co-insurance after deductible	40% copay, after deductible	20% copay, after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Outpatient Hospital	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible

	Gold Plan		Silver Plan		Bronze Plan		Copper Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Alternatives to Hospital Care								
Skilled Nursing (max. 120 days), this is facility benefit and covered	20% after copay, after deductible	20% after copay, after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Home Health (max. 120 days) and Urgent Care	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Other Services								
Outpatient Short-Term Rehabilitation (includes speech, physical, occupational and spinal manipulation therapy), in office setting.	20% co-insurance after deductible.	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	20% after deductible	40% copay, after deductible	50% co-insurance after deductible	Applied behavioral analysis treatment for Autism— by behavioral analyst, up to 18 pre-authorization
Prescription Drug Plan—Retail Pharmacy								
Generic	$10 copay	25% after Rx plan $10 copay	$10 copay	25% after Rx plan $10 copay	After deductible, $15 co-pay for retail	After deductible, $30 co-pay for retail	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Preferred Brand-Name Drugs	$20 copay	25% after Rx plan $20 copay	$40 copay	25% after Rx plan $40 copay	After deductible/$50 copay for retail or mail order	After deductible, $100 co-pay for retail or mail order	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Non-Preferred Brand-Name Drugs	$40 copay	25% after Rx plan $40 copay	$80 copay	25% after Rx plan $80 copay	After deductible/$70 copay or 50% co-insurance of approved amount (whichever is greater) no more than $100 copay	After deductible/$70 copay additional 20% approved amount	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Prescription Drug Plan—Mail Order (90 Day Supply)								
Generic	$20 copay	N/A	$20 copay	N/A	After deductible/$30 co-pay for 30 day supply	After deductible, co-pay plus 20% of approved amount	50% co-pay of amount	Not covered
Preferred Brand	$40 copay	N/A	$80 copay	N/A	$100 co-pay for mail order 90-day supply	After deductible, co-pay plus 20% of approved amount	50% co-pay of amount	Not covered
Non-Preferred Brand	$80 copay	N/A	$160 copay	N/A	$140 or 50 %whichever is greater, max of $200 after deductible	After deductible, co-pay plus 20% of approved amount	50% co-pay of amount	Not covered

CALL TODAY! 1-800-236-4782

2 Dental Plan Options

BCBSM Dental Plan - $50 Deductible for Class 2 and 3 Services

Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere . However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.
Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152.
1) Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
2) A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.
Blue Par Select Arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles . To find a dentist who may participate with BCBSM, please visit mibluedentist.com.
Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Benefits	Low Coverage	High Coverage
Deductible (Applies to Class 2 and Class 3 services only)	$50 per member limited to a maximum of $150 per family per calendar year	$50 per member limited to a maximum of $150 per family per calendar year
Class 1 services	100% Covered	100% Covered
Class 2 services	80%	80%
Class 3 services	50%	50%
Class 4 services	Not covered	Not covered
Annual maximum for Class 1, 2 and 3 services	$3,000 per member	$3,000 per member
Lifetime maximum for Class 4	N/A	N/A
Class 3: Major Restorative	35%	35%
Class 4: Orthodontia	N/A	50%
Dental Rates (Standalone or with another option)	**Low Dental**	**High Dental**
The rates below are priced for eligible plan participants enrolling in the Dental Plan Only.		
Single	$64.75	$72.34
Two-Person	$125.25	$140.44
Family	$216.00	$242.58
An Administration Fee of $4.25 has been added to the rate.		

BCBSM Dental Plan – High Dental Plan vs. Low Dental Plan

The Trust offers dental coverage through Blue Cross Blue Shield of Michigan (BCBSM).The dental plans provide a wide variety of covered services – either covered in full or partially by the plans. Members will continue to have the choice to enroll in High or Low dental and/or vision which requires an application to be completed.

The table below provides an overview of the dental plans benefits. For specific details about the plans, please refer to the Benefits-at-a-Glance summary of benefits on the website at www.MyMedPlans.com

LOW PLAN

Annual Dental Maximum per Person	$3,000
Class I Service	
Includes but not limited to: Oral Exams Bitewing X-rays Full Mouth X-Rays Dental prophylaxis (Teeth Cleaning) Fluoride Treatment - Under19y/o	$0 = Your Deductible 0% = Your Coinsurance * 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class II Service	
Includes but not limited to: Fillings (for permanent & primary teeth) Root Canal Oral Surgery General anesthesia or IV sedation	$50 = Your Deductible per member to a maximumof $150 per family per calendar year 20% = Your Coinsurance * 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class III Service	
Includes but not limited to: Dentures (complete & partial) Occlusal biteguards Endosteal Implants Onlays, crowns and veneer fillings- permanent teeth age 12 and older Bridge Installations	$50 = Your Deductible 50% = Your Coinsurance * 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class IV Service	
Orthodontic services for dependents under age 19	Not Covered

HIGH PLAN

Annual Dental Maximum per Person	$3,000
Class I Service	
Includes but not limited to: Oral Exams Bitewing X-rays Full Mouth X-Rays Dental prophylaxis (Teeth Cleaning) Fluoride Treatment -Any age**	$0 = Your Deductible 0% = Your Coinsurance * 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class II Service	
Includes but not limited to: Fillings (for permanent & primary teeth) Onlays, Crowns,Veneers,Inlays - permanent teeth** Occlusal biteguards** Oral Surgery Root Canal	$50 = Your Deductible per memberto a maximumof $150 per family per calendar year 20% = Your Coinsurance * 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class III Service	
Includes but not limited to: Dentures (complete & partial) Endosteal Implants Bridge Installations	$50 = Your Deductible 50% = Your Coinsurance * 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class IV Service	
Orthodontic services for dependents under age 19**	50% = YourCoinsurance
Class IV Lifetime Maximum per Individual	$2,500

*Before getting any major procedure, make sure to check with your provider for complete rates and coverage information.
**Consider these upgraded benefits when selecting the High Plan vs. Low Plan.

2022 Vision Benefits

Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined $15 copay	Member responsible for difference between approved amount and provider's charge, after $15 copay
Medically necessary contact lenses	$15 copay	Member responsible for difference between approved amount and provider's charge, after $15 copay
Note: No copay is required for prescribed contact lenses that are not medically necessary.		
Eye exam		
Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$10 copay	Reimbursement up to $45 less $10 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		
Lenses and frames		
Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or grounded, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$15 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less $15 copay (member responsible for any difference)
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor •Progressive Lenses – Covered when rendered by a VSP network doctor	One pair of lenses, with or without frames in any period of 12 consecutive months	
Standard frames	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	Reimbursement up to $70 less %15 copay (member responsible for any difference)
One frame in any period of 24 consecutive months Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.		
Contact Lenses		
Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$15 copay	Reimbursement up to $210 less $15 copay (member responsible for any difference)
One pair of contact lenses in any period of 12 consecutive months		
Elective contact lenses that improve vision (prescribed, but not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

Blue Vision Plan Information (VSP)

Insurance offered through VSP

Blue Vision insurance can be elected with any of the medical or prescription drug options, but if elected without a medical plan, you must purchase dental and vision together.

To enroll in a vision plan, please complete, sign and date the enrollment form and return it to **Benistar** at the address on the form. Please send your enrollment form, a copy of your 1099R form, or one of your PBGC checks, or another form of proof that shows you are a retiree from one of the eligible Airline companies.

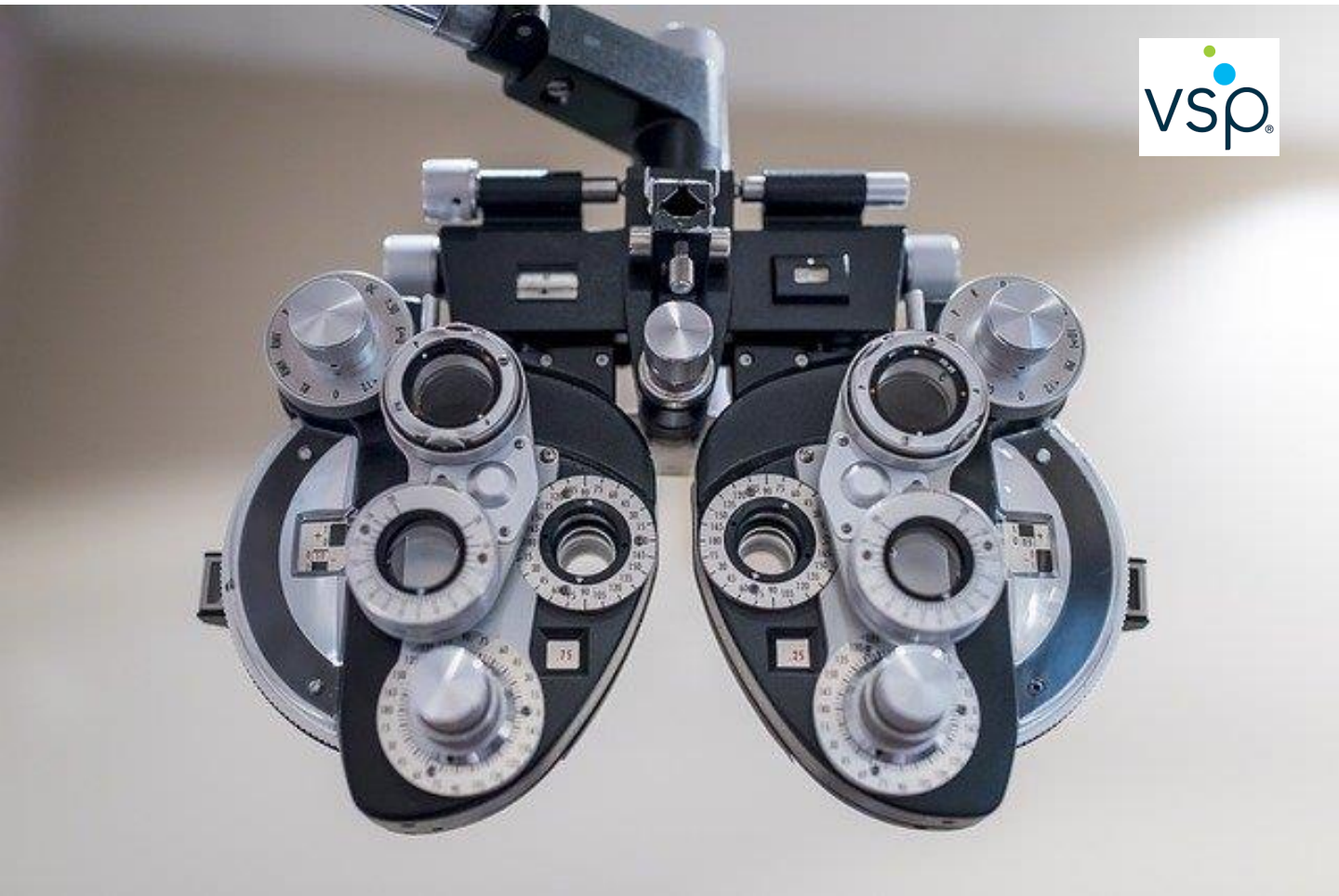
Eyewear: Choose the eyewear that's right for you and your budget. From classic styles to the latest designer fashions, you'll find hundreds of options for you or your family.

Choice of Providers: With open access to see any provider, you can see the one who's right for you.

2022 Blue Cross Blue Shield Vision Rates (VSP)

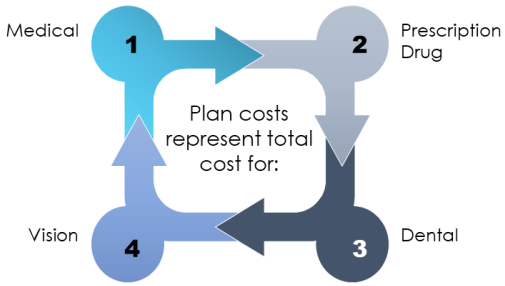
Single	$ 7.48	These Rates INCLUDE the admin fee
Two-Person	$ 14.97	
Family	$ 24.85	

Vision Plan must be purchased with Dental.



2022 PLANS AND RATES

-NON-HCTC PARTICIPANTS PAY 100% PLAN COST
-HCTC PARTICIPANTS PAY 27.5% PLAN COST
EFFECTIVE JAUNURY 2022 - DECEMBER 2022



Blue Cross Blue Shield of Michigan is the Insurance provider of choice for these Nationwide group plans available to VBTAR Trust members.

☆ Total cost includes medical, prescription drug, high dental, and vision which maximizes benefits for retirees and qualified dependents eligible for the Health Coverage Tax Credit (HCTC)

	BUNDLED PLANS (MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION) **Pre 65 HCTC Rates**		TOTAL **MONTHLY** PREMIUM	MEMBER PAYS **MONTHLY**
1	GOLD PLAN	Gold Single	$1,522.23	Congress should be announcing information on the reauthorization of the HCTC program very soon! Please check the website! www.HCTCPlans.com
		Gold Family	$4,523.15	
2	SILVER PLAN	Silver Single	$1,353.55	
		Silver Family	$4,017.14	
3	BRONZE PLAN	Bronze Single	$1,076.11	
		Bronze Family	$3,184.80	
4	COPPER PLAN	Copper Single	$884.17	
		Copper Family	$2,609.00	

If you are not eligible for the Health Coverage Tax Credit (HCTC), your monthly premium would be the total monthly premium in the chart above.

Sunset of the Health Coverage Tax Credit

To date, the Health Coverage Tax Credit (HCTC) has not been extended and funding continues to not be available. If Congress fails to extend the HCTC program before December 1, 2021, the program will shutdown for a minimum of 1-2 months into 2022 or until reauthorization is passed. If you wish to remain in the VBTAR Trust insurance plans be prepared to pay 100% of the plan premium for each month the HCTC program is not in operation. If Congress extends the HCTC Program after the VBTAR Trust open enrollment period, there will be a special open enrollment period available at a later date.

Eligibility and Administration

Q1	Can I enroll in any of the plans in the VBTAR Trust; Gold, Silver, Bronze or Copper if I am Pre-65 and do not qualify for the HCTC subsidy in 2022?	A	Yes. Any person that has worked for at least 5 years in the airline Industry has the ability to enroll in these plans and to pay 100% of the cost of the plan if they are not eligible for the HCTC Subsidy or the HCTC program is in an unauthorized status with the IRS.
Q2	I see that the medical program being offered says it is from BCBS Michigan. Does this plan provide coverage in all 50 states, or do you have to live in a certain state to qualify for this coverage being offered in the VBTAR Trust?	A	Yes, you are covered in all 50 states. In fact, all of the programs (medical, prescription drug, dental and vision) provide nationwide coverage in the U.S. and also provides international coverage for foreign travel. You could live in New York for six months out of the year and in Florida for the other six months out of the year if you wanted. For the medical plan, you will need to check the BCBSM provider directory to locate in-network doctors and find hospitals to receive the highest in-network benefits at www.bcbsm.com
Q3	What type of medical plans are being offered (HMO, POS, or PPO plans, etc)?	A	All four plans (Gold, Silver, Bronze, & Copper) are Preferred Provider Options plans. These plans provide you with access to covered benefits through a network of healthcare providers and facilities. There is no requirement to have a referral from your primary care doctor before going to a specialist.
Q4	I am permanently disabled and am on Medicare; can I qualify for the BCBSM program using the HCTC?	A	No. The BCBSM Pre-65 Plans do not offer coverage for Medicare eligible participants in the Trust. Medicare Supplement options as well as Medicare Advantage options are available to retirees who would otherwise be eligible for VBTAR VEBA Trust. These plans do not qualify for a subsidy however, they are great options for eligible participants. Contact Benistar Retiree Service Center for more information. Benistar at 1- 800-236 4782 , to request an enrollment packet.
Q5	What will happen to these plans if the HCTC programs is not reauthorized? Will we still be able to enroll in the plans and pay 100% of the cost?	A	The Blue Cross Blue Shield will continue to provide these plans to Pre-65 VBTAR Trust participants regardless of whether the Health Coverage Tax Credit program is in effect or not. There is no requirement to have the HCTC program authorized for these plans to be available to Trust participants. If enrolled in the plans and the HCTC program has not been reauthorized, those eligible for the HCTC must pay 100% of the cost
Q6	Can I choose to participate in the VBTAR Trust medical plan without participating in prescription drug plan?	A	No. The VBTAR VEBA Trust for Retirees Under 65 medical plans do not allow medical coverage to be selected without also selecting prescription drug coverage.
Q7	Will the VEBA run out of money? If it does, will this program go away?	A	No, traditionally VEBA programs are funded with small administrative fees that are added to the monthly insurance premiums for members. The Trust Board determines the administrative fee by the cost associated with maintaining the plan (insurance and compensation for board members, meeting expense, administrative expenses.
Q8	What is the VBTAR VEBA Trust Retirees and what is its relationship to my former employer?	A	The VBTAR VEBA Trust Retirees is an independent, tax-exempt VBTAR VEBA Trust set up to be the plan sponsor and contract holder of the group medical policy for retirees who have worked in eligible Airline industry companies. Spouses, dependent, and surviving spouses of eligible retirees may also be eligible to participate.
Q9	I am currently enrolled in a dental plan and in the process of getting a dental implant. Will Blue Cross cover the remaining work required on that tooth, if I move to Blue Cross plan in 2022?	A	No, Blue Cross does not cover teeth or procedures like a dental implant once the tooth has been removed and you were not enrolled in their plans when the tooth was extracted. You would need to complete the work being done to replace the tooth prior to moving over to the VBTAR Trust plan or the remaining work would not be covered.

FAQs

Frequently Asked Questions
(Continued) – Page 2

Enrollment

Q1	Do I have to complete an enrollment form to enroll in the VBTAR Retiree VEBA Plan?	A	Yes. You must complete the enrollment forms and return them to Benistar, to enroll in the plan. If you are enrolling for the first time, you will need to include your HCTC Form 13441-A)and proof of eligibility for the Trust as well as a copy of the 1099-R from received from the IRS if you are HCTC eligible and if the HCTC program has been reauthorized.
Q2	Can my spouse and I have different medical/prescription drug coverage in the Under 65 plan?	A	Yes. The retiree and spouse have the ability to enroll individually in the plans they choose to enroll in, as long as the eligible retiree remains eligible for the HCTC program or has been on Medicare for less than 24 months.
Q3	What does it mean when it says the Gold, Silver, Bronze and Copper plans are bundled?	A	It means the total costs of your medical, prescription drug, dental and vision premiums have been combined. This bundled package was created to allow HCTC retirees to take advantage of the 72.5% tax credit when HCTC qualified and have all four programs paid for at that level.
Q4	Do I have to worry about pre-existing conditions?	A	No, there are no pre-existing conditions for plan participants enrolling in our plans. You are covered in full starting on the effective date you select when you enroll in the plan, provided you have not been without credible coverage for more than 63 days.
Q5	What if I am turning 55 in the next few months? Should I enroll now or wait until I am HCTC eligible?	A	You can enroll now and pay 100% of the cost and when/if the HCTC program is reauthorized, you will be in the program . If you only want to enroll if you receive a HCTC subsidy, the rule is you must wait until the 1st day of month following your birthday month to enroll. (Example: birthday is May 15, you become eligible June 01). An eligibility list is transferred from the PBGC to the IRS each month, and that is the process used to verify eligibility. The list is updated with new eligibility at the end of each month.
Q6	As a new enrollee, when will I receive ID cards for these plans?	A	You will receive a separate ID card directly from BCBSM for the coverage you elect. If you select the Gold, Silver, Bronze or Copper plans, it will be noted on the BCBSM card you receive, noting the plans you are enrolled in (medical, prescription drugs, dental & vision.)
Q7	Does this plan cover my dependent children?	A	Yes, this plan meets all the requirements of the newly created healthcare reform laws, which include eligibility of children as long as the child/dependent is listed on the Retirees federal income tax return.
Q8	I am not sure if I am eligible to participate; how can I find out if I am eligible for this program?	A	Contact Benistar, the plan administrator services provider, at **1-800-236-4782** . They can provide you with the eligibility requirements for the program if you are unsure if you qualify.
Q9	Is this plan sponsored by any union?	A	No, this plan is not sponsored by a union. It is a Trust established under an order of the bankruptcy court, permitting HCT qualifying benefits for the Pre-65 retirees and their dependents. It is also a plan available to Pre-65 Retirees and their families not eligible for the HCTC program.
Q10	Is this plan sponsored by my former employer?	A	No. This plan is sponsored by the Trust. Created through the bankruptcy court following the proper guidelines for qualification of the HCTC as well as Non-HCTC participants.
Q11	What happens when I reach age 65?	A	You will no longer be eligible for the HCTC program however; the VEBA Trust does offer coverage for Medicare-eligible retirees. Contact Benistar, the plan administrative services provider, at **1-800-236-4782** for more information on the Medicare-eligible programs offered through the Trust or go to the website **www.mymedplans.com** . If you have dependents who are under age 65 and you have been on Medicare less than 24 months, your dependents may be eligible to participate in this HCTC program.
Q12	Can I enroll in the VBTAR Retiree VEBA Trust program at any time?	A	At this time enrollment will be open for new participants to enroll during the open enrollment window that will end December 31, 2021. Please visit our website at www.hctcplans.com or call the Benistar Retiree Service Center for more details.

FAQs

Frequently Asked Questions
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Q13	How long must I stay in the plan if I choose to enroll in 2022?	A	The type and level of coverage that is selected is intended to be for a 12-month coverage period or until the next enrollment period, whichever comes first. Once you make your initial elections, you cannot make changes unless you have a qualifying event to make you eligible for changes. Qualifying events are: · Certain changes in employment status for your spouse or an eligible dependent; · Marriage or divorce; Addition of a dependent; Loss of a spouse or dependent; · Eligibility for Health Coverage Tax Credit due to age (turning 55 or TAA status change) · Eligibility for Medicare due to age (turning 65 or disabled)
Q14	Do I have to enroll in the medical plan in order to join the Dental and/or Vision plans?	A	No, you do not have to enroll in a medical plan in order to join the Dental and Vision plans. If you are Pre-65 and enrolling and paying 100% you can enroll in the Dental and Vision only if you choose. It is important to note, if you are enrolling in the Pre-65 program and are eligible for the HCTC program, in order to receive the HCTC subsidy on your Dental and Vision coverage, you must elect the Gold, Silver, Bronze or Copper Bundled Plan. If qualified for the the HCTC you will not receive the HCTC subsidy on the Dental and Vision premium as a standalone plan.
Q15	Is there a subsidy available through the VBTAR Trust?	A	No, there are no subsidies available through the Trust, the 72.5% subsidy is only available through the IRS/HCTC if reauthorized and to eligible participants only.

Billing and Premium Payment

Q1	What will be my monthly cost for the medical plan?	A	The costs of the plan is dependent on the level of coverage you enroll in. You can also find more information about the plans available and cost by contacting: Benistar Retiree Call Center at **1-800-236-4782** or going to one of the 2 websites, www.mymedplans.com and www.hctcplans.com
Q2	Is my first month's premium payment required when I submit my enrollment form?	A	Yes. You will need to include a check for your first month's premium payment in full (100%) with your completed BCBSM Insurance Enrollment form. The check should be made out to "Benistar Retiree Service ". The only forms of payment accepted are personal check, money order or Electronic Funds Transfer (EFT).
Q3	When is my premium due if I am enrolling effective January 01, 2022?		Your first months premium is due December 01, 2021 for an insurance effective date of 01/01/2022. The sooner you get your enrollment forms in and check mailed, the sooner you will be receiving your medical cards from Blue Cross Blue Shield.
Q4	If I am eligible for the HCTC, should I sign up for the automatic payment option?	A	No. There is no automatic pay option for the HCTC program. You do have the ability to enroll in the automatic pay option if you are only selecting the Dental and Vision plans as they do not qualify for the HCTC program and are paid at a 100% cost to Benistar.
Q5	Can my premium come directly out of my bank account?	A	Yes, if you are paying 100% of the cost of the premium you can establish an EFT process with Benistar. If the HCTC program is in effect, you will need to follow the process outlined in this booklet. If you need more help in enrolling, please contact Benistar, the Plan Administrator and Call Center at 1-800-236-4782.

FAQs

Frequently Asked Questions
(Continued) – Page 4

Billing and Premium Payment

Q6	If I enroll in the plans offered, paying 100% of the cost each month, and I am eligible for the HCTC program, will I get my 72.5% subsidy money back if/when the HCTC program is reinstated, provided it is terminated and not reauthorized on January 01 of 2022? How will I know when/if it becomes reauthorized?	A	If you are enrolled in a plan through the VBTAR Trust and pay 100% for the cost of your premiums because the HCTC program has not yet been reauthorized, if/when it is reauthorized, the Congress will have the ability to determine how the process would work, and what the level of subsidy would be, and how long the program may be in effect. All of those decisions are out of the hands of the IRS/HCTC program, Benistar, the plan administrator and Cone Retiree Healthcare Group. We will provide you with updates and information as it becomes available, if the HCTC program terminates on December 31, 2021. We will also keep you informed as to the actions taken by Congress in 2021/2022, and their plans for reinstatement of the program. Please keep in mind, if the HCTC program is not reauthorized in the future, you will be required to pay the 100% cost of the insurance as long as you are enrolled in the plan.

Claims

Q1	How are my medical claims paid?	A	When you visit the doctor, simply present your ID card. Your participating provider will submit a claim to BCBSM and BCBSM will pay your provider the allowed amount of the claim. If there is any remaining amount due, you will receive an Explanation of Benefits. If you visit a nonparticipating provider, you may have to submit the claim yourself and may be billed the balance above what is reasonable and customary.
Q2	What if I am hospitalized for treatment that will last through the effective date of the new plan?	A	Typically, the coverage you had when admitted to the hospital will remain until you are discharged. After your release from the hospital, your new VBTAR Retiree Trust Medical Plan coverage will begin.
Q3	Is there a lifetime maximum on these medical plans?	A	No, there are no lifetime maximums with this program; it meets all the healthcare reform legislation passed that includes elimination of lifetime maximum limits.
Q4	Are hearing aids covered?	A	There is no hearing aid coverage.
Q5	What are my out of pocket cost and deductibles for the Bronze Plan?	A	You must individually satisfy the full $2,000 deductible for 1 person. If the person has $2,000 in eligible charges, the deductible has been met. The 1 person enrolled in the Bronze plan will have to pay a total of $3,000 in out of pockets cost each year.

Health Coverage Tax Credit (HCTC)

Q1	What is the Health Coverage Tax Credit (HCTC)?	A	The HCTC is a federal tax credit that enables you to pay just 27.5% of qualified health insurance premiums if the program is reauthorized by Congress in 2022 and beyond. If you are eligible, the HCTC is available to you monthly as premiums become due, or yearly when you file your federal tax return, or a combination of both. In order to receive the HCTC you must be enrolled in a qualified health plan, and meet all HCTC eligibility requirements.
Q2	Who is eligible for the HCTC?	A	To be eligible for the HCTC, you must be: • age 55 or older and receive benefits from the Pension Benefit Guaranty Corporation (PBGC), or • A Trade Adjustment Assistance (TAA), Alternative Trade Adjustment Assistance (ATAA), or Reemployment Trade Adjustment Assistance (RTAA) recipient. • A Medicare eligible retiree that meets all eligibility requirements and has been on Medicare for less than 24 months and has dependents who are under the age of 65. These eligible participants are classified as Qualified Family Members (QFM). You must also meet some general requirements and be enrolled in a qualified health plan.

FAQs

Frequently Asked Questions
(Continued) – Page 5

Health Coverage Tax Credit (HCTC)

Q3	What are the general requirements for the HCTC?	A	At the time of your registration, you will need to certify that: ¨ You were not enrolled in Medicare Part A, B, or C. ¨ You were not enrolled in Medicaid or State Children's Health Insurance Program (SCHIP) ¨ You were not enrolled in the Federal Employees Health Benefits Program (FEHBP) and are not enrolled in benefits under the U.S. military health system (TRICARE). ¨ You were not imprisoned under federal, state, or local authority. ¨ You are not being claimed as a dependent on someone else's tax return.
Q4	What are the qualified health plans for the HCTC?	A	Qualified health plans include the following: · COBRA (federal legislation that lets employees extend their job-based health coverage if they lose their job or a VEBA trust health plan established in lieu of COBRA.) · State-qualified health plan: health plans that a state's Department of Insurance approves as meeting the certain requirements of the Trade Act of 2002. · Spousal Coverage – only applicable if you are paying more than 50% of the premium. The IRS/HCTC will only pay 72.5% of the spouses cost, not 72.5% of the total cost of the insurance. · Non-Group/Individual Plans – only applicable if you were enrolled in an individual policy 30 days prior to the date you became eligible for HCTC and your last day of employment.
Q5	Has the HCTC Subsidy Plan been reauthorized for 2022 and beyond?	A	At the time of the printing of this enrollment form, the HCTC plan has not been reauthorized by Congress. While we had anticipated it would be reauthorized in the fall of 2021, unfortunately, to date, it has not been.
Q6	Are there any guarantees that the HCTC program will be reauthorized in 2022?	A	No, there are no guarantees that the HCTC program will be reauthorized in 2022. All the conversations we have had with members of Congress on both sides of the aisle regarding the possibility of it getting reauthorized have indicated they are supportive of reauthorization.
Q7	I am a spouse of a retiree that recently lost his eligibility to participate in the HCTC program when my husband became Medicare eligible, can I stay in this plan?	A	Yes. If the plan is reauthorized you are eligible for this program as a "Qualified Family Member" as authorized by Congress as long as the otherwise eligible retiree has not reached the age of 67 or been on Medicare for more than 24 months.
Q8	I am eligible to receive a pension from my former employer when my pension was turned over to the PBGC, but have not started receiving the checks yet. Am I eligible for the HCTC right now?	A	No, you are not eligible until you start receiving a pension check from the PBGC. You must be a PBGC recipient, not a future recipient. However, you are able to enroll in these plans paying 100% of the premium without the HCTC subsidy.
Q9	I just started my own company. When I start drawing an income from my new business, will I still be eligible for the HCTC?	A	Yes, there are no limits/caps regarding wage amounts. Your income has nothing to do with your HCTC eligibility. The answer above assumes that you are receiving a pension check or lump sum distribution from the PBGC, you are between the ages of 55-64, and that you are enrolled in a "qualified" health plan.
Q10	My son is receiving Medicaid only and is disabled, is he a qualified dependent?	A	No, he is not eligible, but you as a retiree are eligible. If you or your dependents have health coverage through Medicaid, State Children's Health Insurance Program (SCHIP), or Federal Employees Health Benefits Program (FEHBP), you/they are not eligible.
Q11	I am the owner of a company where I pay 100% of my insurance premium cost. Am I still eligible to receive the HCTC toward my healthcare cost?	A	No, you are only eligible to use the coverage of your spouse's insurance plan. Your company insurance program is not considered as a qualified plan for the HCTC program. The answer above assumes that you are receiving a pension check or lump sum distribution from the PBGC, you are between the ages of 55-64, and that you are not enrolled in a "qualified" health plan.

FAQs

Frequently Asked Questions
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Health Coverage Tax Credit (HCTC)

Q12	How do I know if I am paying more than 50% of the monthly premium for my spouse's plan?	A	You need to go your spouse's HR department and ask for a breakdown of the premium costs and provide that letter/proof to the IRS.
Q13	I am currently on my spouse's insurance plan and we are not paying more than 50%. Am I allowed to move to the VEBA program and be eligible for HCTC even if I have the ability to get coverage from my wife's plan?	A	Yes, if it is to your advantage to move over to this program, then you are eligible to do so. Your spouse is allowed to enroll as well, under your plan as a qualified dependent. Your eligibility is not determined by whether you have no other options for coverage but what coverage you choose to enroll in. If the coverage you are enrolled in is qualified for HCTC, and you meet the eligibility requirements, you can enroll in the plan. The answer assumes that you meet all other HCTC eligibility requirements.
Q14	When our XYZ Company insurance coverage was cancelled, I moved over to a High Deductible plan. Would I be eligible for the HCTC under this plan? What do you recommend?	A	You would only be eligible for the HCTC if that plan you are enrolled in is a qualified health plan as declared by your state or is a COBRA plan. You have to evaluate your own personal situation and make decisions based upon what is best for you and your qualified dependents.
Q15	Am I eligible for the HCTC if I am an Army veteran?	A	If you are enrolled in health coverage through the military health system, TRICARE / CHAPMUS then you are not eligible for HCTC. This does not include health benefits received as a Veterans Affairs benefit. VA benefits do not count.
Q16	I am a XYZ Company Retiree that is 65 years old. My spouse is 62 years old. Can my spouse stay in the VEBA plan?	A	Yes, your spouse is eligible to participate in the HCTC program since the Congress recently reinstated the QFM program for eligible dependent effective January 01, 2012. Your spouse will be permitted to enroll in the plan for an additional 24 months of eligibility, or until you reach the age of 67.
Q17	I am a surviving spouse. Do I use my age or my spouse's age to determine eligibility for the HCTC?	A	If you became the PBGC recipient upon the death of the retiree, you are now are considered the PBGC recipient, therefore, you would use your age.

Voluntary Benefit Trust for
AIRLINE RETIREES

TRUST WEBSITE
www.MyMedPlans.com

VBTAR VEBA

TRUST BOARD

George Leatherbury, Chairman

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BENISTAR RETIREE SERVICE CENTER

CALL CENTER & PLAN ADMINISTRATOR

1-800-236-4782

Fax: 1-860-408-7025

10 Tower Lane, Suite 100
Avon, CT 06001

CONE RETIREE HEALTHCARE GROUP

TRUST REPRESENTATIVES

Cathy Cone

John Cone

Lisa Andrews

INSURANCE PROVIDERS

Blue Cross Blue Shield Nationwide Providers

BCBSM - Medical Plans
BCBSM - Prescription Drugs

BCBSM - Dental

VSP Blue Vision - Vision