



Thank you for your time and attention as you enroll for benefits with the Airline (VBтар) Trust. 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		If waiting on Medicare #, Check Here* <input type="checkbox"/>		
Email Address			Retirement Date			
Effective Date / /		Salary / Hourly <input type="checkbox"/> Salary <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		If waiting on Medicare #, Check Here* <input type="checkbox"/>		

**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 1<sup>st</sup> day of the month, your coverage is effective on the 1<sup>st</sup> 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 Airline (VBтар) Trust website-go to [www.MyMedPlans.com](http://www.MyMedPlans.com) and click on 'Medicare Rates and Plans'.

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

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

Please pay special attention to the coverage options. There are two BCBSM Prescription Drug plans, High and Low available for Airline 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

<input type="checkbox"/> <b>DIAMOND</b>	<input type="checkbox"/> <b>EMERALD</b>	<input type="checkbox"/> <b>RUBY</b>
<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree
<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse
<b>TERMINATE COVERAGE CONTRACT</b>		
<input type="checkbox"/> Retiree	<input type="checkbox"/> Spouse	<input type="checkbox"/> Retiree & Spouse

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

### The Hartford

<input type="checkbox"/> <b>Premium</b>	<input type="checkbox"/> <b>Elite</b>	<input type="checkbox"/> <b>Choice</b>	<input type="checkbox"/> <b>Premium Plus</b>
<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree
<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse
<b>TERMINATE COVERAGE CONTRACT</b>			
<input type="checkbox"/> Retiree	<input type="checkbox"/> Spouse	<input type="checkbox"/> Retiree & Spouse	

### BCBSM Standalone RX

<input type="checkbox"/> <b>HIGH RX</b>	<input type="checkbox"/> <b>LOW RX</b>
<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree
<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse
<b>TERMINATE COVERAGE CONTRACT</b>	
<input type="checkbox"/> Retiree	<input type="checkbox"/> Spouse
<input type="checkbox"/> Retiree & Spouse	

### Dental & Vision - BCBSM

<input type="checkbox"/> <b>High Dental</b>	<input type="checkbox"/> <b>Low Dental</b>	<input type="checkbox"/> <b>Vision</b>
<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree
<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse
<b>TERMINATE COVERAGE CONTRACT</b>	<b>TERMINATE COVERAGE CONTRACT</b>	<b>TERMINATE COVERAGE CONTRACT</b>
<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree
<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> 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

## 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.

## ❑ BCBSM Medicare Advantage with HIGH Prescription Drug Plan

OPTIONS	Diamond	Emerald	Ruby
Type of network	Passive	Passive	Passive
Out of pocket maximum	\$0	\$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
MA Rate	\$285.99	\$224.06	\$109.04

The BCBSM Medicare Advantage rates above include the admin fee

## ❑ BCBSM Standalone Prescription Drug Plans

BCBSM (High and Low) Prescription Drug Plan	Monthly Cost
High RX	\$91.90
Low RX	\$72.92

The BCBSM PDP Standalone rates above do NOT include the \$10 admin fee

## ❑ BCBSM Dental and Vision Standalone Rates

	LOW PLAN			HIGH PLAN		
	Dental /Vision	Dental Only	Vision Only	Dental /Vision	Dental Only	Vision Only
Single	\$70.82	\$64.75	\$ 6.07	\$74.90	\$68.83	\$ 6.07
Two-Person	\$137.39	\$125.25	\$ 12.14	\$145.55	\$133.41	\$ 12.14

The BCBSM Dental & Vision Standalone rates above include the admin fee of \$4.25

## ❑ BCBSM Dental and Vision taken with Hartford or Medicare Advantage Plan Rates

	LOW PLAN			HIGH PLAN		
	Dental /Vision	Dental Only	Vision Only	Dental /Vision	Dental Only	Vision Only
Single	\$66.57	\$60.50	\$6.07	\$70.65	\$64.58	\$6.07
Two-Person	\$133.14	\$121.00	\$12.14	\$141.30	\$129.16	\$12.14

No admin fee when adding Dental to Hartford or BCBSM Medicare Advantage.

### DENTAL & VISION

Airline (VBтар) Trust 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 1-888-588-6682 or access the BCBSM Airline (VBтар) Trust enrollment form on the Airline (VBтар) Trust website – [www.MyMedPlans.com](http://www.MyMedPlans.com)

## 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 <u>LOW</u> RX (Mirrors Plan G)	\$ 248.81	\$ 281.05	\$ 312.58	\$ 322.76
Premium Choice Plan with <u>LOW</u> RX (Mirrors Plan F)	\$ 266.58	\$ 298.82	\$ 330.35	\$ 340.53
Premium Plan with <u>HIGH</u> RX (Mirrors Plan G)	\$ 285.56	\$ 317.80	\$ 349.33	\$ 359.51
Premium Choice Plan with <u>HIGH</u> RX (Mirrors Plan F)	\$ 267.79	\$ 300.03	\$ 331.56	\$ 341.74

\*Rates do include the \$3.00 administration fee.

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.

## IMPORTANT

### CHANGES FOR 2022

- The Airline (VBSTAR) Trust Medicare Eligible medical plans offered through the Hartford have been simplified. All plan levels are now available to all members in all states.
- The Airline (VBSTAR) Trust prescription drug plans are now offered by BCBSM. There are two options (High Plan and Low Plan) available to eligible members. The high plan is comparable to the previous Express Scripts plan offered.