Town of Amherst Massachusetts
AMHERST PELHAM HEALTH TRUST
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TO: Medex and HPHC Medicare Enhanced Retirees
FROM: Joanne Misiaszek, Human Resources Manager
DATE: Wednesday, March 21, 2018
SUBJECT: Informational Sessions for New Retiree Health Insurance Plan, Effective July 1, 2018

Effective July 1, 2018, the Amherst Pelham Regional School District and the Towns of Amherst and Pelham will be changing from a self-insured model by moving to fully insured health plans. We will be replacing the current Blue Cross Blue Shield Medex 3 and Harvard Pilgrim Health Care Enhance plan with **Medex 2** (medical) paired with **Blue Medicare Rx** (a Prescription Drug Plan). You will continue to have comprehensive medical and prescription drug coverage. The plan will be offered through Blue Cross Blue Shield and the MIIA (Massachusetts Interlocal Insurance Association) Health Trust.

In order to assist with the transition and answer any questions you may have, the Town will be hosting several informational sessions for our Medex and HPHC Medicare Enhanced members. **You only need to attend one session but it's important you attend to learn about the new coverage and complete an enrollment form prior to May 1st.** If you cannot attend, please feel free to send a friend or family member on your behalf. The sessions are scheduled as follows:

Amherst Town Hall, 4 Boltwood Ave., Amherst, 2nd floor, Town Room:
*Wednesday, April 4th: 10:30am – 12:00pm
*Thursday, April 26th: 10:00am – 12:00pm
*Thursday, April 26th: 1:00pm – 2:30pm

Fort River Elementary School, Gymnasium, 70 South East Street, Amherst:
*Wednesday, April 4th: 2:30pm – 4:00pm,

Crocker Elementary School, Gymnasium, 280 West Street, Amherst:
*Thursday, April 26th: 4:00pm – 6:00pm

Each session will begin promptly at the time indicated as MIIA and Blue Cross representatives will present the new plan and answer any questions you may have. The informational session is for current BCBS Medex and HPHC Enhance retirees and their spouses.

The new plan is **Medex 2** (medical plan) with **Blue Medicare Rx** (a Medicare Part D, Prescription Drug Plan-PDP). Benefit materials will be available at the sessions, in the Town Human Resources and Accounting offices plus the Schools Human Resources office. MIIA will also be mailing a notice with benefit summaries to all retirees before the July 1, 2018 effective date. Additionally, we will post benefit summaries on the Amherst website: www.amherstma.gov/APHCT

Included in today's letter you will find two (2) blank enrollments. One for you and one for your Medicare-eligible spouse, if applicable. Please complete the form(s) and either bring them with you to one of the sessions listed above or mail to: Town of Amherst, ATTN: Theresa Fleurent, Accounting Dept., 4 Boltwood Ave, Amherst, MA 01002 ***OR*** for teacher (MTRS) retirees mail to: Jennifer Ortiz, Amherst Regional Middle School, 170 Chestnut St, Amherst, MA 01002. Please be sure to include a copy of your and your spouse's (if applicable) Medicare card. See last page of this letter for sample form – please check the boxes that are highlighted and complete Section 2 - each Medicare covered person must complete an enrollment form. Each form needs a signature and please date April 1st or later per federal guidelines.

With the new Medex plan there will be an office copayment of $10 per visit to a primary care physician or specialist and a $50 copayment for an emergency room (ER) visit. The ER copayment would be waived if you were admitted as inpatient. Your Medex coverage also includes **up to** a $5,000 benefit for hearing aids every 36 months.

The Prescription Drug Benefit (PDP) will be based on a 3-tier co-payment model to cover generic, brand and non-preferred drugs. It will use a covered drug listing or formulary. Prescription co-payments will be $5/10/25 for a 30-day supply at participating retail pharmacies and $10/20/50 for a 90-day supply through mail order. The new mail order service will be with CVS Caremark beginning July 1, 2018. However, you may continue to use the same local pharmacies.

You will also receive 2 new identification (ID) cards, one for the medical portion and one for the pharmacy. The **medical ID** will come in a separate envelope and

is **blue**. The **pharmacy card** will come in a plastic packet with other communication and is **white**. You will need to open the plastic packet and the card will be inside. You will also receive a second plastic wrapped packet with materials related to the Blue Medicare Rx, prescription drug plan. It's important that you keep and open any materials from the Town, MIIA, Blue Cross Blue Shield of MA, Blue Medicare Rx or CVS Caremark (the new mail order service as of July 1st).

Please note that the plan changes take effect on **July 1, 2018** and moving forward, the plan will renew on a calendar year cycle. **Therefore, the next open enrollment and renewal will be on January 1, 2019.**

This plan does **not** require that you go to the Social Security Office to enroll in the Part D pharmacy component. Your enrollment with our group and MIIA will be sufficient.

As of May 1st, there will be a customer service line for prescription related questions available to retirees and their spouses who will be effective on the plan July 1st. The Pre-Service line, 1-866-832-9775 will be available from May 1, 2018 - June 29, 2018. **Please identify yourself as a retiree or the spouse of a retiree from the Town of Amherst, Amherst Pelham Schools and/or the Town of Pelham.** On and after July 1st, you should call the customer service numbers on the back of your new medical or prescription ID cards.

Monthly Premium Rates July 1, 2018 – December 31, 2018
Retiree or spouse: (These are all individual rates as there are no family retiree plans.)

Medex 2 + Blue Medicare Rx –	**Per person:**	$9.20/month
OR	**Surviving Spouse:**	$133.00/month

You will continue to pay premiums in the same way (either through your pension or direct pay) as you currently do.

Thank you for your cooperation during this transition. If you should have any questions prior to sessions, please contact Joanne Misiaszek at 413-259-3003.

Please Read the Instructions Before Filling Out This Form.

Please TYPE OR PRINT CLEARLY using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

MIIA

Enrollment and Change Form

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transfering To:
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY
Current Dental Group #:	Dental Group #, Transferring To	

Type of Transaction
☐ ADD ☐ CANCEL
☐ CHANGE Three digit termination code ☐☐☐
☐ TRANSFER

Remarks (i.e., qualifying event for a new add, change to family or other instruction)
☐ Open Enrollment ☐ New Hire ☐ COBRA
Change to Family ☐ Add Spouse ☐ Add Dependent
☐ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
☐ Other: _____

Do Not complete this section

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☒ Blue Medicare Rx (Part D) ☐ Dental Blue ☐ HMO Blue ☐ HMO Blue New England ☐ Managed Blue for Seniors ☒ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical) ☒ Individual ☐ 2 person ☐ Family

Membership Type (Dental) ☐ Individual ☐ 2 person ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Phone ( )

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ☐ / N ☐	Other Insurance Company Name	Member Identification Number
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ☐ / N ☐

Are you covered by Medicare?[2] Y ☒ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ☐ / N ☒	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date

Complete all of Section 2

3. Member 2

Please Check One: ☐ Spouse ☐ Divorced Spouse (court ordered)

Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ☐ / N ☐	Other Insurance Company Name	Member Identification Number
PCP ID # (see instructions)	Name of PCP	City / State		Is this your current PCP? Y ☐ / N ☐

Are you covered by Medicare?[2] Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ☐ / N ☐	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date

Do Not complete this section

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP
Is this your current PCP? Y ☐ / N ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP
Is this your current PCP? Y ☐ / N ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP
Is this your current PCP? Y ☐ / N ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: _____

Do Not complete this section

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ HSA: Health Savings Account			
☐ FSA: Health Flexible Spending Account	Start Date	End Date	Health: $
☐ FSA: Dependent Care Reimbursement Account	Start Date	End Date	Dependent Care: $

Do Not complete this section

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care. I understand that Blue Cross and Blue Shield may obtain medical and credit information about me or my business and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

Person 1 and Person 2 must sign and date (April 1st or later)

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.