THE HARTFORD

Senior Medical Insurance Plan Enrollment Form

Hartford Life and Accident Insurance Company **Policy Number: AGP- 3275 – Premier Plan**

Policyholder: **BENISTAR EMPLOYER SERVICES TRUST (BEST)**

Participating Firm: SMITH COLLEGE

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Social Security # : _____

Phone Number: _____

Gender: ☐ Male ☐ Female Date of Birth _____

Date of Retirement : _____ Medicare/HIC # : _____

Spouse's Name (Only if enrolling): _____
First Middle Last

Gender: ☐ Male ☐ Female Date of Birth _____: Social Security #: _____

Date of Retirement _____ Medicare/HIC# _____

To the best of your knowledge:

1. Do you (or your spouse, if enrolling) have another policy which supplements Medicare or certificate in force including a health care service contract or health maintenance organization (HMO) contract?

Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No If yes, please indicate below:

Covered Person	Company Name	Policy Number	Effective Date	Expiration Date

2. Do you (or your spouse, if enrolling)have any other health insurance including an employer health plan? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No If yes, please indicate below:

3.

Covered Person	Company Name	Policy Number	Type of Policy	Effective Date	Expiration Date

3. If the answer to question 1 or 2 is yes, do you (or your spouse, if enrolling) intend to replace these medical or health policies with this policy? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
If yes, for what reason are you (or your spouse, if enrolling) replacing the coverage?

☐ Additional Benefits
☐ Fewer benefits and lower premiums
☐ No change in benefits, but lower premiums
☐ Other (please specify)

4. Are you covered by Medicaid? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

Check Desired Coverage:
Plan(s)

	AGP-3275
Retiree	☐
Spouse	☐

Your Premium Payment* must accompany this enrollment form. See the attached Plan Chart to find the appropriate premium for the Plan you have selected. Please be sure to date and sign this form answering all questions. Make your check payable to BENISTAR, and mail it in the enclosed envelope to:

MountainOne Insurance
Attn: Linda Grande
795 Main St. 2nd fl
Williamstown, MA 01267

You will be billed for all future premium payments directly to your home address. You will have the option to elect to have your premium payments deducted electronically from your checking account. This method of payment is called an Authorization Agreement for Direct Payment. This payment method is explained further in the enclosed Authorization Agreement for Direct Payment literature. If you select this option of payment, please complete the Authorization Agreement Form contained in this package and send it in along with your enrollment form and initial premium.

*Your employer may have the option available to deduct premium from your pension or retirement fund, contact them for more details.

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it was satisfied under the previous policy. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____
(if enrolling)

THE HARTFORD
Group Benefits

The Group Retiree Health Insurance Plan Enrollment Form

Hartford Life & Accident Insurance Company **Policy Number:** AGP-3956 Value $1,000
Policyholder: **TRUSTEES of BENISTAR EMPLOYER SERVICES TRUST**

Participating Firm: SMITH COLLEGE

Please print clearly in ink or type
Retiree's Name: _____
First Middle Last
Street: _____

City, State, Zip: _____ Medicare/HIC # _____

Phone Number: _____ Email Address: _____

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Date of Retirement _____ Have you enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when do you intend to enroll? _____

[Dependent Spouse's Name (Only if enrolling): _____
First Middle Last
Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Medicare/HIC # _____ Date of Retirement _____

Has your dependent spouse enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when does he/she intend to enroll? _____

To the best of your knowledge:

1. Do you or your dependent spouse, if enrolling, have any other health insurance including an employer health plan? **Retiree** ☐ Yes ☐ No **Dependent Spouse** ☐ Yes ☐ No

   If so, with which company? What kind of policy? _____

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

2. If the answer to question 1 is yes, do you or your spouse, if enrolling intend to replace these medical or health policies with this policy or certificate? **Retiree** ☐ Yes ☐ No **[Dependent Spouse** ☐ Yes ☐ No **Dependent Parent** ☐ Yes ☐ **No Dependent Child** ☐ Yes ☐ **No]**

   If yes, for what reason are you (or your dependent spouse, child or parent, if enrolling) replacing the coverage?

   ☐ Additional Benefits
   ☐ Fewer benefits and lower premiums
   ☐ Integration with Medicare
   ☐ No change in benefits, but lower premiums
   ☐ Other (please specify)

3. Are you covered by Medicaid?
Retiree ☐ Yes ☐ No **Dependent Spouse** ☐ Yes ☐

Check Desired Coverage:

	AGP-3956
Retiree	
Dependent Spouse	

Complete this form and return to:

MountainOne Insurance
Attn: Linda Grande
795 Main St. 2nd fl
Williamstown, MA 01267

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it was satisfied under the previous policy. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

Date: _____ Retiree Signature: _____

Date: _____ Dependent Spouse Signature: _____
(if enrolling)

Benefit Overview

EXPRESS SCRIPTS® Medicare (PDP)

Express Scripts Medicare® (PDP)

YOUR 2020 PRESCRIPTION DRUG PLAN BENEFIT:

Smith College

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service. For maintenance medications, you have the choice of filling prescriptions for more than a one-month supply at pharmacies with preferred cost-sharing, including CVS and select retail pharmacies. These pharmacies may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within our network.

Deductible stage	You do not pay a yearly deductible				
Initial Coverage stage	You will pay the following until your total yearly drug costs (what you and the plan pay) reach $4,020:				
	Tier	**Retail One Month (31-day) Supply**	**Retail Two Month (32-60-day)**	**Retail Three Month (90-day) Supply**	**Home Delivery Three Month (90-day) Supply**
	Tier 1: **Generic Drug**	$5 Copayment	$10 Copayment	**Preferred cost-sharing** $10 Copayment **Standard cost-sharing** $15 Copayment	$10 Copayment
	Tier 2: **Preferred Brand Drugs**	$40 Copayment	$80 Copayment	**Preferred cost-sharing** $80 Copayment **Standard cost-sharing** $120 Copayment	$80 Copayment
	Tier 3: **Non-Preferred Drugs**	$75 Copayment	$150 Copayment	**Preferred cost-sharing** $180 Copayment **Standard cost-sharing** $225 Copayment	$180 Copayment
	Tier 4: **Specialty Tier Drugs**	33% Coinsurance	33% Coinsurance	33% Coinsurance	33% Coinsurance

Initial Coverage stage Continued	If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive. You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy[SM]. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. If you have any questions about this coverage, please contact the Retiree Customer Service Center at 800.236.4782 , Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.
Coverage Gap stage	After your total yearly drug costs reach $4,020, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage stage.
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs reach $6,350, you will pay **the greater of 5% coinsurance or:** • a $3.60 copayment for covered generic drugs (including drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage. • an $8.95 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.

IMPORTANT PLAN INFORMATION

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one-month supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example,retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **express-scripts.com/pharmacies**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- Beginning October 15, 2019, you can access your plan's 2020 list of covered drugs by visiting our website at **express-scripts.com/documents**.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will paythe actual cost, not the higher cost-sharing amount.
- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is $0.
- When you use your Part D prescription drug benefits, Express Scripts Medicare sends you an *Explanation of Benefits* (Part D EOB), or summary, to help you understand and keep track of your benefits. You may also be able to receive a copy electronically by visiting our website, **express-scripts.com**, or by contacting the Retiree Customer Service Center at 800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

This information is not a complete description of benefits. Call Customer Service at the numbers listed above for more information.

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

Other pharmacies are available in our network.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

(10/19)

MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
SMITH COLLEGE SPONSORED GROUP PLAN

To enroll in Express Scripts Medicare® (PDP)
Please provide the following information:

Desired Effective Date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	Mr. Mrs. Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	Social Security Number:	Home Phone Number: ( )

Permanent Residence Street Address:

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address: City: State: ZIP Code:

Emergency Contact: [Optional]

Phone Number: [Optional]_____ **Relationship to You** [Optional] _____

E-mail Address: [Optional]

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: _____

Medicare Number
_____-_____-_____

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare® (PDP) is offered by Medco Containment Life Insurance Company, which contracts with the Federal government. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

Enrollment Requirements
You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Release of Information
By joining this Medicare prescription drug plan, I acknowledge that Express Scripts Medicare can release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
I also acknowledge that Express Scripts Medicare can release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Signature:	Today's Date:

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

Benefit Overview

Express Scripts Medicare® (PDP)

EXPRESS SCRIPTS® Medicare (PDP)

YOUR 2020 PRESCRIPTION DRUG PLAN BENEFIT Smith College

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	Tier 1: **Preferred Generic Drugs**	$0 copayment	$0 copayment	$0 copayment	$0 copayment
	Tier 2: **Generic Drugs**	$15 copayment	$30 copayment	Preferred cost-sharing $30 copayment Standard cost-sharing $45 copayment	$30 copayment
	Tier 3: **Preferred Brand Drugs**	$60 copayment	$120 copayment	Preferred cost-sharing $150 copayment Standard cost-sharing $180 copayment	$150 copayment
	Tier 4: **Non-Preferred Drugs**	$100 copayment	$200 copayment	Preferred cost-sharing $250 copayment Standard cost-sharing $300 copayment	$250 copayment
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Initial Coverage Stage Continued	If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive. You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy℠. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. If you have any questions about this coverage, please contact the Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.
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- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
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- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is $0.
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MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
SMITH COLLEGE SPONSORED GROUP PLAN

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Please provide the following information:

Desired Effective Date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	Mr. Mrs. Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	Social Security Number:	Home Phone Number: ( )

Permanent Residence Street Address:		
City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address: City: State: ZIP Code:

Emergency Contact: [Optional]

Phone Number: [Optional]_____ **Relationship to You** [Optional] _____

E-mail Address: [Optional]

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: _____

Medicare Number
_____-_____- _____-__

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

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You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

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Release of Information
By joining this Medicare prescription drug plan, I acknowledge that Express Scripts Medicare can release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Express Scripts Medicare can release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Signature:	**Today's Date:**

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

Direct Debit Enrollment Electronic Funds Transfer Form

STEP 1: Complete, Sign and Date Form

STEP 2 Make sure your information is printed on the voided check

STEP 3: Attach Voided Check

STEP 4: Send Form and Voided Check to:

NOTE: **If you are a new retiree with Benistar, your first month's premium must be submitted by check.**

BENISTAR ADMIN SERVICES, INC.
Billing Dept.
10 Tower Lane - Suite 100
Avon, CT 06001

INFORMATION ABOUT YOU:

Your Name	
Your Street Address	
City, State, Zip Code	
Your Member Number or Group Name	
Phone Number	

INFORMATION ABOUT YOUR BANK:

Full Name on Bank Account		
Bank Routing Number		
Account Number		
Bank Name		
Bank Phone Number		**Checking ___ Savings ___**

I authorize Benistar/BESTCO Benefit Plans LLC to debit the account specified above, in an amount previously communicated to me, by invoice or announcement letter, for payment of my group healthcare insurance premiums. I understand that all transfers will take place between the 7th and 10th of each coverage month and that Holidays may delay the transfer. I understand that the premium to be withdrawn may change, in which case I will be notified in writing at least 10 days before the new premium is withdrawn. I agree to notify Benistar/BESTCO Benefit Plans LLC in writing or by phone, if my account information changes or to stop the direct debit authorization at least 10 days in advance of the scheduled transfer.

I further agree that if such payment is not honored, whether with or without cause and whether intentionally or inadvertently, Benistar shall be under no liability at all although such action could result in forfeiture of insurance.

Signature: (Authorized Signature for Account)	Date
Print Name:	

Withdrawals Will Be Adjusted For Any Applicable Rate Increases.