TEACHERS' RETIREMENT SYSTEM
of the State of Kentucky

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To: Teachers' Retirement System (TRS) Retiree

From: TRS Insurance Department

Re: Medicare Eligible Health Plan (MEHP) Open Enrollment

TRS Medicare Eligible Health Plan (MEHP) Open Enrollment is generally November 1 to December 7 for the effective date of January 1. The MEHP is a Medicare Advantage Plan through Humana and a Medicare Part D Prescription Drug Plan through Express Scripts. You can access benefit materials and the rate chart online at https://trs.ky.gov.

Currently, TRS pays all or a portion of the full premium for retirees based on their TRS entry date and years of service credit at retirement. In addition to paying your portion of the MEHP premium (if any), you must pay the Medicare Part B premium directly to Social Security. Reciprocity retirees with service in TRS and Kentucky Public Pensions Authority (KPPA) should contact TRS and KPPA to determine their premiums. Medicare-eligible spouses of retired members **cannot** enroll during the annual MEHP open enrollment **unless** the retiree is not currently enrolled, and the spouse enrolls with the retiree. If enrolling an eligible spouse, retiree must provide proof of marriage in the form of a marriage certificate or a copy of the top half of your most recent Federal tax return Form 1040 and proof of spouse's enrollment in Medicare Parts A and B. Please note that if Medicare indicates you have gone 63 or more days in a row without other creditable prescription drug coverage you may receive a form asking about any drug coverage you had. Complete the form and return it to Express Scripts by the deadline in the letter. If you do not return the form, you may have to pay a Part D penalty to TRS.

To request this coverage, complete an MEHP enrollment form, attach a copy of the applicant's Medicare card, and return it to TRS no later than December 7 for coverage effective January 1.

If at any time the enrollee's Medicare terminates, is enrolled in another Medicare Advantage Plan or Medicare Part D prescription drug plan, the enrollee's MEHP coverage will be terminated. Please be aware that TRS medical coverage is through the retiree. If at any time the retiree's coverage is terminated, the spouse's coverage will also be terminated.

TRS Health Care Eligibility Due to Employment: Retirees and or spouses working and eligible for health insurance through an employer that participates in one of the Kentucky state retirement systems are not eligible for health insurance through TRS. Retirees and or spouses can enroll in TRS coverage within 30 calendar days of losing employer coverage. The state retirement systems are TRS; Kentucky Public Pensions Authority (KPPA) for state, county and state police employees; and Judicial Form Retirement System (JFRS) for judges and legislators.

MEDICARE ELIGIBLE HEALTH PLAN (MEHP)

Medical & Prescription Drug Enrollment Form

TEACHERS' RETIREMENT SYSTEM (TRS)

479 Versailles Road, Frankfort, KY 40601

Phone: 502-848-8500 or 800-618-1687; Fax: 502-848-8550

Complete enrollment through Pathway Member Self Service Website at https://mss.trs.ky.gov/
OR by completing this form and returning to TRS.

TRS USE ONLY
_____
Effective Date

Reason for Application ☒ Open Enrollment

ENROLLMENT TYPE: (for TRS MEHP only) Select one

☐ Retiree Only ☐ Retiree & Spouse* ***Spouse eligible ONLY if Retiree enrolling now**

RETIREE INFORMATION

Complete this section if application is for the RETIREE

Retiree Name		**Retiree** Social Security or TRS Member ID #
Retiree Date of Birth	Gender: ☐ Male ☐ Female	Married: ☐ YES ☐ NO

SPOUSE INFORMATION

Complete this section if application is for the SPOUSE

Spouse Name	**Spouse** Social Security Number	**Spouse** Date of Birth
Retiree Social Security or TRS Member ID #	Gender: ☐ Male ☐ Female	Married: ☐ YES ☐ NO

WAIVER OF COVERAGE

Complete this section only if you DO NOT want to enroll in TRS MEHP coverage

☐ I, the **retiree**, wish to **waive** coverage. **Signature:** _____ **Date:**_____

☐ I, the **spouse**, wish to **waive** coverage. **Signature:** _____ **Date:**_____

* I N - M E - 0 8 B *

MEHP enrollment is contingent on Medicare enrollment. If you enroll in another Medicare Advantage or Medicare Part D plan, or your Medicare Part B coverage terminates, your TRS MEHP will terminate. Upon waiver or termination of the MEHP, if you are the spouse of a TRS retiree, you will not be eligible for future re-enrollment unless you have a qualifying event. For TRS retirees, changes after the effective date of your insurance may only be made during Open Enrollment or within 30 days of a qualifying event.

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IMPORTANT

Use your Medicare card to complete this page. Include a copy of the card with this form or upload a copy of the card to the online MSS application. If you have applied but not received your Medicare card, contact Social Security or sign up for your *my* Social Security account at www.ssa.gov to obtain your Medicare information.

Complete if RETIREE is enrolling in the TRS MEHP	
Retiree Name (As shown on your Medicare Card)	Social Security Number
Medicare Number – (REQUIRED) *located on your Medicare card* ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Hospital Part A Effective Date Medical Part B Effective Date **(REQUIRED)**
(REQUIRED) When coverage is needed, will you be working AND eligible for health insurance through an employer that participates in a Kentucky state retirement system? ☐**YES** ☐**NO**	

Complete if SPOUSE is enrolling in the TRS MEHP	
Spouse Name (As shown on your Medicare Card)	Social Security Number
Medicare Number – (REQUIRED) *located on your Medicare card* ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Hospital Part A Effective Date **(REQUIRED)** Medical Part B Effective Date **(REQUIRED)**
(REQUIRED) When coverage is needed, will you be working AND eligible for health insurance through an employer that participates in a Kentucky state retirement system? ☐**YES** ☐**NO**	

DEMOGRAPHIC INFORMATION (REQUIRED)		
Mailing Address		
City	State	ZIP
PERMANENT Street Address **(REQUIRED** if Mailing Address is a P.O. Box, P.O. Box Not Allowed)		
City	State	ZIP
Email Address	Primary Phone	Alternative Phone

By signing below, I confirm I have read and understand all the available materials pertaining to the TRS MEHP coverage. I also certify that I am not currently eligible for health insurance through an employer that participates in one of the Kentucky state retirement systems. I understand that if Medicare indicates I have gone 63 or more days in a row without creditable prescription drug coverage and I receive a form asking about prior drug coverage, if I do not complete the form, I may be required to pay a monthly premium penalty to TRS.

RETIREE'S SIGNATURE
(REQUIRED) _____ **DATE** _____

SPOUSE'S SIGNATURE
(Required if enrolling in coverage) _____ **DATE** _____