2022 GUIDETO BENEFITS

for Pre-65 Members

DSRA-BT

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This benefit guide provides basic information regarding the above mentioned benefit plans. It provides general instructions and descriptions that are necessary to acquaint you with some of the provisions of the Plans that come to mind during this particular time. An official detailed description of benefits, eligibility, exclusions, limitations, and other terms and conditions is contained in individual benefit Summary Plan Descriptions. Please refer to them for additional information.

What is the Health Coverage Tax Credit? (HCTC)

The Health Coverage Tax Credit is a tax credit that pays 80% of qualified health insurance premiums for eligible individuals and their families. Potential eligibility for the HCTC is limited to two groups of taxpayers. One group of eligible individuals is for Trade Adjustment Assistance (TAA) allowances because they experienced qualifying job losses. TAA is a program that provides assistance to workers who lose their jobs due to international trade. A group of workers must petition the US Department of Labor must confirm their job loss was attributable to a qualified cause for the workers to be certified. The other group consists of individual whose defined-benefit pension plans were taken over by the Pension Benefit Guaranty Corporation (PBGC) because of financial difficulties. The tax credit's purpose is to make the purchase of health insurance more affordable for eligible individuals.

2022 HCTC REAUTHORIZATION

THE HEALTH COVERAGE TAX CREDIT (HCTC) HAS BEEN MADE PERMANENT (HCTC)

The Health Coverage Tax Credit (HCTC) has been made PERMANENT by Congress in the budget reconciliation bill.
The Section 137508 states:
Permanent Credit for Health Insurance Costs. This Section makes the health coverage tax credit permanent, removing the uncertainty of annual extensions, and increases the amount of the qualified health insurance premium covered by the credit from 72.5% to 80%.

Who is Eligible for Benefits?

Retiree

As a Delphi salaried or hourly retiree member, you are eligible for the medical/prescription, dental, and vision benefits. Salaried retiree members are also eligible for voluntary term life insurance. Each benefit is outlined within this benefit guide.

Dependents

Spouse

As a Retiree, your legal spouse is also eligible for medical/prescription, dental, and vision benefits and life coverage.

Spouse is not required to have the same medical/prescription coverage as the Retiree if both are individually enrolled in Pre-65 medical/prescription drug policies.

Surviving Spouse

A surviving spouse is eligible for medical/prescription, dental, and vision and life coverage.

Former Spouse

Benistar Admin Services (Benistar), our plan administrator, will send an enrollment kit to the former spouse who is required to provide a statement from the Pension Benefit & Guaranty Corporation (PBGC) confirming that he/she has become a pension recipient in their own right due to the divorce. A former spouse is not eligible for voluntary term life insurance coverage.

Child(ren)

Dependent children are eligible for medical/prescription, dental, and vision benefits. The dependent child can remain on the coverage until they are no longer eligible to be claimed as a dependent on the retirees federal income tax return.

Child(ren) are not required to have the same medical/prescription coverage as Retiree and/or spouse if both are enrolled in Pre-65 medical/prescription drug plans.

NEW for 2022 – A disabled child on Medicare may enroll in the BCBSM Medicare Advantage Diamond PPO Plan. See the Medicare Disabled Subsidy section on the www.DSRABenefitTrust.net website or call Benistar Retiree Service Center at (888)588-6682. A disabled child loses eligibility for DSRA-BT subsidies once retiree becomes 67.

Qualified Family Members

A Qualified Family Member (QFM) is also eligible to elect medical/prescription, dental, and vision benefits. A QFM is defined as a spouse and/or dependent child(ren) of an HCTC-eligible Retiree, who is claimed as a dependent on the individual's federal income tax return. **NOTE:The HCTC is only available to a QFM for 24 months after the retiree reaches age 65.**

Termination

Retirees Under Age 65

Once a Retiree reaches age 65, his/her coverage in the Under Age 65 medical/prescription plan will terminate the first day of the month that they turn age 65. However, if the retiree carries dental &/or vision, this will automatically continue as long as they enroll with the Benistar Service Center as Medicare eligible. A Retiree will not be auto-enrolled in a Post-65 plan because an application is required. Approximately 90 - 120 days prior to the event date (65th birthday), an enrollment kit including the application will be mailed to the Retiree by Benistar, our post-65 plan administrator. Eligible dependents under the age of 65 may elect to continue the coverage.

If someone (Retiree, spouse, and/or dependent) had coverage in any of the Under Age 65 medical/prescription, dental, or vision plans and terminated it – regardless of the reason – he/she **can** re-enroll in any of the Under Age 65 medical/prescription, dental, or vision plans during a subsequent open enrollment.

If someone (Under age 65 Retiree, spouse, and/or dependent child) had voluntary life coverage through Reliance Standard or MetLife but terminated it, he/she can reapply for coverage, **but** will be subject to underwriting and approval by MetLife.

Retirees Post-65

An individual enrolled in the Post-65 medical/prescription plan who terminates coverage ***can*** re-enroll in a DSRA-BTplan during a subsequent annual open enrollment.

If someone (Retiree, spouse, and/or dependent child) had Under Age 65 medical/prescription coverage but terminated it, he/she ***can*** enroll in the Post-65 plan.

If someone (Retiree, spouse, and/or dependent child) was enrolled in dental or vision while under 65 and it was terminated, he/she ***can*** re-enroll in the dental plan when he/she turns 65.

If someone (Post-65 Retiree or spouse) had voluntary life coverage through Reliance Standard or MetLife but terminated it, he/she ***can*** reapply for coverage, but will be subject to underwriting and approval by MetLife.

Qualifying Life Events

A qualifying life event will allow someone to change or enroll in coverage mid-year within the scope of the event provided Benistar, our pre-65 plan administrator, is notified within 30 days of the event date. Qualifying events include:

- Gaining or losing a dependent (marriage, divorce, having a child, adopting a child, etc.)
- Involuntary loss of other insurance coverage (proof is required)
- HCTC eligibility coverage
- Qualified Family Member loses the DSRA subsidy due to the spouse turning 69

If the qualifying event is **gaining or losing a dependent,** you may change your coverage tier (e.g. Single,Two-Person, Family).You cannot, however, change the plan(s) in which you are enrolled.

If the qualifying event is **involuntary loss of other coverage**, you may enroll in coverage or change coverage tier (e.g. Single,Two-Person, Family). You cannot, however, change the plan(s) in which you or a family member is enrolled.

If the qualifying event is **becoming HCTC eligible** (e.g. beginning to collect a PBGC pension or receive TAA,ATAA or RTAA benefits), you may enroll in or change the plan(s) in which you are enrolled (e.g. "upgrade" your coverage).

If the qualifying event is **losing HCTC eligibility,** you may change the plan(s) in which you are enrolled (e.g. "downgrade" your coverage).

If the qualifying event is **losing the DSRA subsidy** due to their spouse turning 69, the Qualified Family Member is eligible to change plans.

If the qualifying event is **delayed initiation of your PBGC pension**, you may enroll in coverage provided you left Delphi previous to the current year, initiated receipt of pension in the current year, have filed paperwork with the PBGC to start payment and provide a copy of the PBGC pension issuance application along with your BCBSM enrollment form.

Medical & Prescription Drug Benefits

We know how important good health is to you and your family. That is why the DSRA-BT provides you medical plan options that protect against the unexpected and help meet your routine health care needs.

Retirees Under Age 65

DSRA-BT offers *four* medical plan choices to retirees under the age of 65. All nationwide medical plans are provided by Blue Cross Blue Shield of Michigan (BCBSM). The table below provides a snapshot comparison. For complete details about the plans, please refer to the Benefits-at-a-Glance summary of benefits on the website at www.dsrabenefittrust.net. Please note, these plan options are not subject to a lifetime maximum. [i]

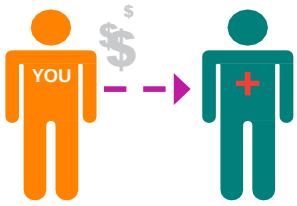
	Option #1 GOLD		Option #2 SILVER		Option #3 BRONZE		Option #4 COPPER	
Medical Plan Description	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Ded) [1, 2]								
Individual	$250	$500 [3]	$500	$1,000 [3]	$2,000 [4]	$4,000 [4]	$4,000 [4]	$8,000 [4]
Two Person	$500	$1,000 [3]	$1,000	$2,000 [3]	$4,000 [4, 5]	$8,000 [4, 5]	$8,000 [4, 5]	$16,000 [4, 5]
Family	$500	$1,000 [3]	$1,000	$2,000 [3]	$4,000 [4, 5]	$8,000 [4, 5]	$8,000 [4, 5]	$16,000 [4, 5]
Your Coinsurance % (Coins%) [6]	20%	40%	20%	40%	20%	40%	50%	50%
Annual Coinsurance Dollar Maximums [8]								
Individual	$1,250	$2,250	$2,000	$4,000	$3,000	$6,000	$6,350	$12,700
Two Person	$2,500	$4,500	$4,000	$8,000	$6,000	$12,000	$12,700	$25,400
Family	$2,500	$4,500	$4,000	$8,000	$6,000	$12,000	$12,700	$25,400
Physician Visit								
Primary Care Physician (PCP)	$10	Ded+Coins%	$20	Ded+Coins%	Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Specialist Care Physician (SCP)								
Preventive Care Services)PCP/SCP)	Cov'd 100% (up to $1,000)	Not Covered	Cov'd 100%	Not Covered	Cov'd 100%	Not Covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
In-Patient/Out-Patient Hospital Services	Ded+Coins%		Ded+Coins%		Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Emergency Room Services	$50		$150		Ded+Coins%		50% after in-network deductible	
Urgent Care Services	$10	Ded+Coins%	$20	Ded+Coins%	Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Durable Medical Equipment	Ded+Coins%		Ded+Coins%		Ded+Coins%		50% after in-network deductible	
Hearing Care Coverage	Cov'd 100%	Not Covered	Cov'd 100% after Ded	Not Covered	Cov'd 100% after Ded	Not Covered	Not Covered	Not Covered
Mental Health Care/Substance Abuse	Ded+Coins%		Ded+Coins%		Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Human Organ Transplants	Cov'd 100%	Ded+Coins%	Cov'd 100%	Ded+Coins%	Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Specified Human Organ							50% after in-network deductible	50% after in-network deductible
Bone Marrow	Ded+Coins%		Ded+Coins%		Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Specified Oncology Clinical Trials	Ded+Coins%		Ded+Coins%		Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Kidney, Cornea and Skin	Ded+Coins%		Ded+Coins%		Ded+Coins%		50% after in-network deductible	50% after out-of-network deductible
Retail Pharmacy Prescription Drug Plan 30 Day Supply					**After Deductible Copays**		**After Deductible Copays**	
Tier 1 – Generic	$10		$10	$10/$40/$80	$15		$15	
Tier 2 – Brand Name Formulary	$20	$10/$20/$40 +25%Coins	$40	+25% Coins	$50	$15/$50/$70 +20% Cons	$50	$15/$50$70 +20% Coins
Tier 3 – Brand Name Non Formulary	$40		$80		$70 or 50%		$70 or 50%	
RX Mail Order Pharmacy Prescription Drug Plan (90-day Supply)					**After Deductible Copays**		**After Deductible Copays**	
Tier 1 – Generic	$20		$20		$30		$30	
Tier 2 – Brand Name Formulary	$40	Not Covered	$80	Not Covered	$100	Not Covered	$100	Not Covered
Tier 3 – Brand Name Non Formulary	$80		$160		$140 or 50%, whichever is greater but no more than $200		$140 or 50%, whichever is greater but no more than $200	
Health Savings Account								
Eligible Medical Plan	No		No		Yes			

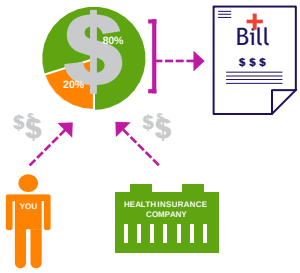
i Refer to the back of the booklet for plan footnotes.

Understanding Terminology

Deductible

A dollar value that you are responsible to pay for a covered medical expense before the coinsurance begins.



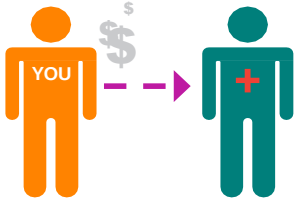


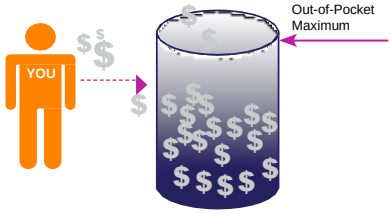
Coinsurance

Once you have satisfied your deductible, you will begin to pay coinsurance. In other words you will pay a % – such as 20% of the claim and the plan will pick up the rest – such as 80%.

Copay

A fixed fee paid for office visits and prescription drugs. For the BRONZE and COPPER medical plans, ***copays only apply to prescriptions drugs after the deductible has been met.***





Out-of-Pocket Maximum

The most you will be responsible for out-of-pocket during the calendar year. This includes your deductible and coinsurance.

Embedded v. Non-Embedded Deductibles

Now that you know what a deductible is, it is important to understand how they work – particularly if you cover dependents on the plan.

	Embedded			Non-Embedded
	GOLD	SILVER	COPPER	BRONZE
Individual Deductible	$250	$500	$4,000	$2,000
Family Deductible	$250 per person (capped at $500)	$500 per person (capped at $1,000)	$8,000	$4,000

If you cover dependents, under the GOLD, SILVER or COPPER medical plans, when any one individual family member reaches the individual deductible in expenses, their benefit plan coverage takes effect. This is called an embedded deductible.

If you cover dependents on the BRONZE medical plan option, the **entire** family deductible must be met before benefit plan coverage takes effect – by any one or combination of family members. This is called a non-embedded deductible.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed is $70, the provider may bill you the remaining $30.

Health Savings Account

A Health Savings Account, commonly known as an "HSA," is an individual account you can open, add money to, and spend on eligible health care expenses. An HSA is unique because you'll receive a tax credit for any money you add to the account, investment earnings are not taxed, money spent on eligible expenses is not taxed, and the money rolls over year to year.

Eligibility

In order to open an HSA, you must be covered by health insurance that meets the definition of a High Deductible Health Plan (HDHP). **The DSRA-BT *BRONZE* and *COPPER* medical plans are the only plans that meet these requirements through the DSRA Benefit Trust.**[i]

Setting Up Your HSA

Once you are covered by an HDHP you may set up your HSA. It is important to get your HSA set up as quickly as possible since you can't turn in expenses that you had before the account was set up. It is your responsibility to open your HSA and you choose where. Many banks and credit unions now offer HSAs.

Adding Money

Once you set up your HSA, you can begin making deposits into your account by check or cash. Keep track of your contributions so that you can deduct them from your income tax return. The government sets the annual dollar maximum that can be made to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions.

2022 IRS Annual Contribution Limits

Individual	$3,650
Family	$7,300
Catch-Up	$1,000

Eligible Expenses

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses.

For additional details refer to the *Health Savings Account FAQ* which can be found on the DSRA-BT website at www.dsrabenefittrust.net.

i The DSRA-BT **Gold** and **Silver** medical plans are not qualified High Deductible Health Plans and not eligible to use with a HSA.

Retirees Post 65

DSRA-BT offers medical plan choices through The Hartford and BCBSM PPO MA to retirees over the age of 65. If retiree carries dental and/or vision, they must re-enroll with Benistar to continue when transitioning from Pre-65 Blue Cross Blue Shield Michigan Plan options to the Post-65 Medical options. You must provide Benistar your Medicare ID number and your Part A and/or Part B effective date to receive the reduced dental and vision rates. BCBSM offers two (2) prescription plan options for members. Enrollees in The Hartford medical plan will continue to have the choice of DSRA-BT prescription plan or a prescription plan from another provider of their choice. For 2022 Enrollees can carry the BCBSM prescription coverage alone.

START

Decide how you want to get your coverage

POST-65 DSRA-BT PLAN
Hartford/BCBSM PDP

PART A | **PART B**

END

ORIGINAL MEDICARE

PART A | **PART B**

PART D
Prescription Drug Coverage

MEDIGAP
(Medicare Supplement Insurance Policy)

END

BCBSM MEDICARE ADVANTAGE PLAN
PPO

Combines **Part A, Part B,** and usually **Part D**

PART D
Prescription Drug Coverage
(included)

END

If you join a Medicare Advantage Plan, you don't need and can't be sold a Medigap policy

For complete details about the post-65 plan options including rates, please refer to the *2022 Health Matters Guide for Post-65 Members* on the website at **www.dsrabenefittrust.net**.

Dental Benefits

We understand the importance of good dental health. Good oral hygiene is important to your overall health. Regular visits to the dentist can help detect problems like gingivitis and even oral cancer. Plan on visiting your dentist once every six months.

DSRA-BT 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.dsrabenefittrust.net.

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 - Under 19y/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 maximum of $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

	$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 member to a maximum of $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% = Your Coinsurance
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.

Vision Benefits

Your eyes are your windows to wellness. Routine eye exams each year allow your eye doctor to detect symptoms of serious eye disease – such as cataracts, glaucoma, and macular degeneration – and health conditions – such as diabetes, cardiovascular disease, and high blood pressure. Caught early, many of these diseases are treatable. However, left undetected and untreated, these conditions can result in vision loss, a lower quality of life, and higher overall health care costs.

DSRA-BT will continue to offer vision benefits through Blue Cross Blue Shield of Michigan (BCBSM) Blue Vision. The vision plan offers you comprehensive coverage – including eye exams and materials – through VSP, the nation's largest vision care network, with 27,000 doctors and 41,000 locations.

Members will continue to have the choice to enroll in vision with dental which requires an application to be completed.

The table below provides an overview of the vision plan benefit. For specific details about the plan, please refer to the Benefits-at-a-Glance summary of benefits on the website at **www.dsrabenefittrust.net.** To find a VSP doctor, call 1-800-877-7195 or log on to the VSP website at **www.vsp.com**.

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)

Voluntary Life Benefits

Did you know that 61% of Americans have no life insurance coverage? The financial impact of death is not only significant, but the effects can be long-term, lasting five years or more for the surviving family members.[i]

DSRA-BT offers salaried Delphi retirees the opportunity to purchase voluntary life insurance for you and your spouse through Metlife. (NOTE: Delphi hourly retirees are not eligible for this voluntary benefit.) This plan is designed to complement the life insurance benefits you may already have and is 100% retiree-paid. Rates do change every five years on insured's birthdays ending in a 0 or 5. There is a small administrative fee to cover Benistar and DSRA-BT expenses. Notify your bank of the 2022 rate change, if you are set up on auto payments..

If you have elected voluntary coverage in the past, your elected benefit will continue into 2022. **No action is required.** If, however, you wish to make any modifications to your current election (e.g. increase or decrease your elected amount) or wish to elect voluntary term life insurance for the first time, you must complete the MetLife enrollment form and Statement of Health form. If your change is a reduction in benefits, or to cancel your benefits, then only an enrollment form is required, not a Statement of Health. This form can be found on our website - www.dsrabenefittrust.net - or you may contact Benistar, our voluntary life plan administrator, at 1-888-588-6682 to obtain a copy of the form.

The table below provides an overview of the voluntary life benefit. For specific details about the plan, please refer to the summary of benefits on the website at www.dsrabenefittrust.net.

	Retiree	Spouse[1]
Coverage	$10,000 increments	$ 10,000 increments
Minimum	$10,000	$ 10,000
Maximum	$120,000	$ 50,000

The Spousal coverage above $30,000 requires a physical.

i MetLife's Impact of Premature Death Study, 2010.

Subsidies

One subsidy is available per family with the exception of dual Delphi retiree households who carry separate policies. When a subsidy is available and application has been approved, it is automatically applied by Benistar, our pre-65 plan administrator.

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Permanent Credit for Health Insurance Costs. This Section makes the health coverage tax credit permanent, removing the uncertainty of annual extensions, and increases the amount of the qualified health insurance premium covered by the credit from 72.5% to 80%.

HCTC Eligible DSRA-BT Subsidy

Eligibility for a Trust subsidy is generally defined as being a Delphi Salaried Retiree (including spouse and eligible dependents) who retired on or before April 1, 2009. The DSRA-BT will continue to provide a health premium subsidy to eligible pre-65 salaried retirees, spouses and dependents who purchase medical insurance from the Trust in 2022
There are pre-65 salaried retirees that retired before April 02, 2009 that have not initiated their PBGC pension payout. This makes them ineligible for the Trust subsidy. We cannot approve a subsidy for these retirees.

	2022 Monthly DSRA-BT Subsidy Amount (HCTC Extended)		
Plan Option	Single		Family
Under Age 65	$650		$1,900
Under Age 65 & Medicare Disabled	$360.84		N/A
*Under 65 QFM	$650		N/A
Post-65	*No subsidy available for post-65 members*		N/A

*Available to QFMs of a retiree who is age 67 or 68 only.

***Under Age 65 QFM - The provision in the HCTC law limiting eligibility to 24 months for the pre-65 spouse/dependents of a post-65 retiree remains in effect.** The DSRA-BT is again offering an additional maximum of 24 months subsidy paid from the DSRA Benefit Trust funds to eligible QFM's of retirees that are either age 65, 66, 67 or 68 (24 months in a 4 year time period).

- Eligibility for this subsidy ends in all cases the first of the month the retiree achieves age 69.
- To receive this subsidy, you must be a QFM of a salaried retiree retired by April 1, 2009;
- You must submit a new enrollment form to our pre-65 medical plan administrator Benistar to qualify for this subsidy. If you are currently receiving a QFM subsidy, you do not need to submit a new enrollment form unless you are changing plans.
- Please submit 30 days prior to eligibility date. No retroactive subsidies will be allowed.
- One subsidy is available per family with the exception of dual Delphi retiree households who carry separate policies.

Pre-65 Medicare Disabled Subsidy

Special Circumstance subsidies are available to those members who are family members of a Medicare disabled retiree who is <65 and has been on Medicare for more than two years. The family member(s) will be eligible for the Special Circumstance subsidy until the retiree turns 67 or they turn 65, whichever comes first. If they are still under 65 when the retiree turns 67 they will be eligible for the QFM subsidy for 24 months.

DSRA-BT Hardship Grant

The DSRA-BT will continue to provide financial assistance to those in need for the 2022 plan year. The Hardship Grant is intended to assist Delphi Salaried Retirees and/or their survivors, dependents, and spouses that face serious financial hardship with funds to assist them in paying the costs for medical and prescription drug coverage.

Criteria for the Hardship Grant

Retiree must have retired by April 1, 2009 to be eligible for a Hardship Grant. All applicants must submit a Hardship Grant application to document household Modified Adjusted Gross Income (MAGI) and assets. First, home equity assets are excluded, and then a percent of net assets is added to MAGI to determine eligibility. The percent added varies for 1-person, 2-person, and family households.

For those Under Age 65, eligible for federal or state exchange plans, and eligible for an Affordable Care Act (ACA) subsidy, changes to the Hardship Grant were required to ensure you remain eligible for an ACA subsidy, and to ensure you have choices in your selection of a plan.

Per the ACA, you become INELIGIBLE for an ACA subsidy if you are provided a DSRA-BT premium subsidy to pay for any portion of your premium. To retain ACA subsidy eligibility, the DSRA-BT will once again be giving a Hardship Grant rather than a premium subsidy. If you qualify for and accept a Hardship Grant, it will be provided to you as ONE PAYMENT early in 2022.

Once you accept a Hardship Grant, you will be ineligible for health coverage provided through DSRA-BT, and your coverage will expire December 31, 2021. You will, however, be eligible to enroll in a plan through the public Health Insurance Marketplace (a.k.a. the Public Exchange) and qualify for financial assistance in the form of advance premium tax credits and cost-sharing subsidies for coverage starting January 1, 2022.

PLEASE NOTE: If you enroll in a plan through the public Health Insurance Marketplace, **you are responsible for premium payments**. The DSRA-BT cannot make payments on your behalf. Your monthly payment for an exchange plan will be the difference between the premium and your ACA subsidy. Visit Health Insurance Marketplace to complete your ACA application.

Age 65 & Over

For those Age 65 & Over, Medicare remains your primary plan. You are not eligible for an ACA subsidy. The Hartford and BCBSM Medicare Advantage Group Plans will be available to you via the DSRA-BT whether or not you are awarded a Hardship Grant. The application process remains very similar to 2021, and will be based on a MAGI and asset formula.

Application for the Hardship Grant

If you believe you might be eligible for a Hardship Grant, you are encouraged to apply. Hardship application forms are available at www.dsrabenefittrust.net under, "Resources/Hardship Fund/Click Here for the Hardship Application." Alternatively, you may request an application form from Benistar, our Hardship Grant administrator at 1-888-588-6682.

The deadline for completing the application process for both pre-65 and post-65 members is Friday, November 20, 2021. All materials must be received by this date.

Please submit your application as soon as possible to Benistar as indicated below:

Mail: Benistar DSRA-BT Service Center
10 Tower Lane, Suite 100
Avon, CT 06001

Email: memelig@benistar.com

Fax: (860)408-7025

Benistar will process applications and notify applicants of being accepted or rejected. Finally, please be aware that the Federal Government will consider your Hardship Grant as taxable income. If you receive a Grant in 2022, you will get a 1099 from DSRA-BT to be filed with your 2022 federal income tax return.

Additional details about the Hardship Grant including the qualifying criteria and application can be found on the DSRA-BT website at www.dsrabenefittrust.net.

Medical Rates

THE HEALTH COVERAGE TAX CREDIT (HCTC) HAS BEEN MADE PERMANENT

HCTC AMP Eligible Retirees Under Age 65

GOLD	Medical / High Dental / Vision	(-) 80% HCTC Subsidy	20% Member Cost
Single	$1,522.23	$1,217.78	$304.45
Family	$4,523.15	$3,618.52	$904.63
SILVER	**Medical / High Dental / Vision**	**(-) 80% HCTC Subsidy**	**20% Member Cost**
Single	$1,353.55	$1,082.84	$270.71
Family	$4,017.14	$3,213.71	$803.43
BRONZE	**Medical / High Dental / Vision**	**(-) 80% HCTC Subsidy**	**20% Member Cost**
Single	$1,076.11	$860.89	$215.22
Family	$3,184.80	$2,547.84	$636.96
COPPER	**Medical / High Dental / Vision**	**(-) 80% HCTC Subsidy**	**20% Member Cost**
Single	$884.17	$707.34	$176.83
Family	$2,609.00	$2,087.20	$521.80

All HCTC Gold, Silver, Bronze and Copper plans include Medical, High Dental and Vision Coverage
If you are eligible for a subsidy, please refer to that section in this Guide to see amounts.

Medical Rates

Eligible Retirees Under Age 65 – Non HCTC AMP

Pre-65 Medical Plan Options with **HIGH** Dental

GOLD	Medical / High Dental / Vision			
Single	$1,522.23			
Family	$4,523.15			
SILVER	**Medical / High Dental / Vision**	**Medical /High Dental**	**Medical / Vision**	**Medical Only**
Single	$1,353.55	$1,346.07	$1,285.46	$1,277.98
Family	$4,017.14	$3,992.29	$3,778.81	$3,753.96
BRONZE	**Medical / High Dental / Vision**	**Medical /High Dental**	**Medical / Vision**	**Medical Only**
Single	$1,076.11	$1,068.63	$1,008.02	$1,000.54
Family	$3,184.80	$3,159.95	$2,946.47	$2,921.62
COPPER	**Medical / High Dental / Vision**	**Medical /High Dental**	**Medical / Vision**	**Medical Only**
Single	$884.17	$876.69	$816.08	$808.60
Family	$2,609.00	$2,584.15	$2,370.67	$2,345.82

Pre-65 Medical Plan Options with **NO** Dental

Pre-65 Medical Plan Options with **LOW** Dental

GOLD	Medical / Low Dental / Vision			
Single	$1,514.64			
Family	$4,496.57			
SILVER	**Medical / Low Dental / Vision**	**Medical /Low Dental**	**Medical / Vision**	**Medical Only**
Single	$1,345.96	$1,338.48	$1,285.46	$1,277.98
Family	$3,990.56	$3,965.71	$3,778.81	$3,753.96
BRONZE	**Medical / Low Dental / Vision**	**Medical /Low Dental**	**Medical / Vision**	**Medical Only**
Single	$1,068.52	$1,061.04	$1,008.02	$1,000.54
Family	$3,158.22	$3,133.37	$2,946.47	$2,921.62
COPPER	**Medical / Low Dental / Vision**	**Medical /Low Dental**	**Medical / Vision**	**Medical Only**
Single	$876.58	$869.10	$816.08	$808.60
Family	$2,582.42	$2,557.57	$2,370.67	$2,345.82

Pre-65 Medical Plan Options with **NO** Dental

All BUNDLED Gold, Silver, Bronze and Copper plans include Medical, High Dental and Vision Coverage
If you are not included in the HCTC, you can choose the Low Dental Plan.

Medicare Disabled Retirees or Eligible Dependents Under Age 65

The rates below only apply to **pre-65 Medicare disabled** members. NEW for 2022! BCBSM Medicare Advantage plans are now available to Pre 65 Medicare Disabled members at a much lower premium or cost free to DSRA-BT Subsidy recipients.

SILVER	Medical / High Dental / Vision	Medical /High Dental	Medical / Vision	Medical Only
Single	$1,845.60	$1,839.53	$1,781.02	$1,774.95

Retirees Post-65

For complete details about the post-65 plan options including rates, please refer to the **2022 Health Matters Guide for Post-65 Members** at www.dsrabenefittrust.net. Retirees may also contact Benistar at 1-888-588-6682 for further information.

Dental &Vision Rates (StandAlone no Medical)

Retirees Under Age 65 -

LOW PLAN			
	Dental /Vision	Dental Only	Vision Only
Single	$72.23	$64.75	$7.48
Two Person	$140.22	$125.25	$14.97
Family	$240.85	$216.00	$24.85

HIGH PLAN			
	Dental /Vision	Dental Only	Vision Only
Single	$79.82	$72.34	$7.48
Two Person	$155.41	$140.44	$14.97
Family	$267.43	$242.58	$24.85

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of $4.25

Medicare Disabled Retirees or Eligible Dependents Under Age 65 Retirees Post 65 -

LOW PLAN			
	Dental /Vision	Dental Only	Vision Only
Single	$70.82	$64.75	$6.07
Two Person	$137.39	$125.25	$12.14
Family	$203.96	$185.75	$18.21

HIGH PLAN			
	Dental /Vision	Dental Only	Vision Only
Single	$74.90	$68.83	$6.07
Two Person	$145.55	$133.41	$12.14
Family	$216.20	$197.99	$18.21

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of $4.25

Dental &Vision Rates (with Hartford or Medicare Advantage Medical)

Medicare Disabled Retirees or Eligible Dependents Under Age 65 Retirees Post 65 -

LOW PLAN			
	Dental /Vision	Dental Only	Vision Only
Single	$66.57	$60.50	$6.07
Family	$133.14	$121.00	$12.14

HIGH PLAN			
	Dental /Vision	Dental Only	Vision Only
Single	$70.65	$64.58	$6.07
Family	$141.30	$129.16	$12.14

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

No admin fee is added to the BCBSM Dental & Vision rates when enrolling in a bundled medical, dental and/or vision.
Refer to Page 10 for services covered in High and Low plans..

If you are over 65 and covered by Medicare, you must provide your Medicare ID number and Part A and/or Part B effective Date in Section 1 of the Benefit Enrollment and Change of Status Form or call Benistar directly at 1-888-588-6682 to receive the reduced rate.

Voluntary Life Rates Through MetLife

Voluntary life benefits are offered through MetLife Insurance. If you are a Delphi salaried retiree and wish to elect voluntary term life insurance for the first time or make any modifications to your current election, you must complete the MetLife enrollment form and Statement of Health form. (NOTE: Delphi hourly Retirees are not eligible for this voluntary benefit.) Retiree coverage from $10,000 to $120,000 and spouse coverage from $10,000 to $50,000 is available in $10,000 increments. Retiree coverage, however, is no longer required for spouse coverage to be available.
MetLife replaces Guardian Life effective 01/01/2022. The premiums reduce an average of 6.3%. The changes and added benefits to the Life Insurance program for DSRA participants effective 01/01/2022:

- Upon death of the Retiree, a surviving Spouse has the option to remain in the DSRA Benefit Trust MetLife Insurance program until the age of 80, at which time they will have the option to move to a Whole Life Insurance plan or to discontinue coverage
- The Spouse will continue to use the age of the Retiree to determine their premium amount if the Spouse elects to continue their MetLife Insurance coverage.
- The Spouse must notify Benistar if they elect to continue coverage with the MetLife Insurance program following the death of the Retiree.
- The Spousal coverage above $30,000 requires a physical.
- An average of 6.3% decrease in premiums. Age Banded Prices guaranteed for 3 years.

Please review the DSRA-BT website www.DSRABenefitTrust.net for additional information and documents to help you with your Life Insurance questions. Benistar is always available at 1-888-588-6682 to help you or if you need additional information.

Retiree Estimated Monthly Cost [i, ii]

	AGE							
Amount	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85-89**
$10,000	$ 2.30	$ 4.30	$ 6.60	$ 12.70	$ 20.60	$ 29.83	$ 48.47	$ 63.38
$20,000	$ 4.60	$ 8.60	$ 13.20	$ 25.40	$ 41.20	$ 59.66	$ 96.94	$ 126.76
$30,000	$ 6.90	$ 12.90	$ 19.80	$ 38.10	$ 61.80	$ 89.49	$ 145.41	$ 190.14
$40,000	$ 9.20	$ 17.20	$ 26.40	$ 50.80	$ 82.40	$ 119.32	$ 193.88	$ 253.52
$50,000	$ 11.50	$ 21.50	$ 33.00	$ 63.50	$ 103.00	$ 149.15	$ 242.35	$ 316.90
$60,000	$ 13.80	$ 25.80	$ 39.60	$ 76.20	$ 123.60	$ 178.98	$ 290.82	$ 380.28
$70,000	$ 16.10	$ 30.10	$ 46.20	$ 88.90	$ 144.20	$ 208.81	$ 339.29	$ 443.66
$80,000	$ 18.40	$ 34.40	$ 52.80	$ 101.60	$ 164.80	$ 238.64	$ 387.76	$ 507.04
$90,000	$ 20.70	$ 38.70	$ 59.40	$ 114.30	$ 185.40	$ 268.47	$ 436.23	$ 570.42
$100,000	$ 23.00	$ 43.00	$ 66.00	$ 127.00	$ 206.00	$ 298.30	$ 484.70	$ 633.80
$110,000	$ 25.30	$ 47.30	$ 72.60	$ 139.70	$ 226.60	$ 328.13	$ 533.17	$ 697.18
$120,000	$ 27.60	$ 51.60	$ 79.20	$ 152.40	$ 247.20	$ 357.96	$ 581.64	$ 760.56

Spouse Monthly Cost [iii]

	AGE							
Amount	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85-89**
$10,000	$ 2.30	$ 4.30	$ 6.60	$ 12.70	$ 20.60	$ 29.83	$ 48.47	$ 63.38
$20,000	$ 4.60	$ 8.60	$ 13.20	$ 25.40	$ 41.20	$ 59.66	$ 96.94	$ 126.76
$30,000	$ 6.90	$ 12.90	$ 19.80	$ 38.10	$ 61.80	$ 89.49	$ 145.41	$ 190.14
$40,000	$ 9.20	$ 17.20	$ 26.40	$ 50.80	$ 82.40	$ 119.32	$ 193.88	$ 253.52
$50,000	$ 11.50	$ 21.50	$ 33.00	$ 63.50	$ 103.00	$ 149.15	$ 242.35	$ 316.90

[v]The rates above do NOT include the $3.50 administration fee. A Fee is only added for the Retiree or Surviving Spouse if they elect to continue coverage.
[vi]Voluntary life plan rates change in five year increments, i.e. 40, 45, 50, etc. The new rate becomes effective 1/1 after the insured enters a new age category.

[vii]Spouse costs are based on the retiree's age.

IMPORTANT change – Spouse of retiree has the option of remaining in the plan at the same rate they paid based on retiree's age until age 80 then move to a whole life plan.

Billing & Payments

Billing

Medical and Medicare Disabled – Under Age 65

Dental – Under Age 65 and Post-65

Vision – Under Age 65 and Post-65

If you elect any of the benefit plans offered through BCBSM – pre-65 medical, pre-65 Medicare Disabled medical, dental or vision (both under age 65 and post-65) – you will be billed monthly by Benistar, our plan administrator.

It is essential that your premium payments be made on time. As such, members are **highly encouraged** to set up a new automatic electronic-funds transfer with Benistar to make health premium payments.

Benistar Payments

1. **Credit Cards** are not accepted as a form of payment. EFTs and checks are the only allowable forms of payment in 2022.
2. Take advantage of automated payment plans utilizing your checking or savings account online through Benistar by enrolling in the EFT (Electronic Funds Transfer) service. Enroll with Benistar Admin Services at **1-888-588-6682.**
3. Once enrolled in the EFT program, you will no longer receive invoices. Premium deductions occur between the 7th and 10th of the current month.
4. Payments by check should be mailed to the Benistar Retiree Service Center - 10 Tower Lane, Suite 100, Avon CT 06001. Premiums are due on the first day of the covered month.

Medical – Post-65

If you elect any of the post-65 plans offered through The Hartford and BCBSM Medicare Advantage, you will be billed monthly by Benistar, our post-65 plan administrator.

Voluntary Life – Under Age 65 and Post-65

If you elect voluntary life coverage through MetLife, you will be billed monthly by Benistar, our voluntary life plan administrator.

Questions

If you have questions about the enrollment process for the pre-65 medical, dental and vision or post-65 dental and vision, please contact Benistar, our plan administrator, at 1-888-588-6682.

Payments Received After the Due Date

If you do not pay your monthly premium by the 1st of the month for which coverage is provided, you run the risk of your coverage being **terminated**.

If premiums are not paid by the due date, **coverage will be terminated as of the last day of the preceding month.** All benefits including medical, prescription, dental, and vision coverage will cease and no claims will be paid.

Medical Plan Footnotes

1 All covered services are subject to deductible, except preventive care services.
2 Calendar year deductible runs from 1.1 to 12.31.
3 Out-of-network deductible amounts also apply toward the in-network deductible.
4 Your deductible combines the deductible amounts paid under your medical coverage and your prescription drug coverage.
5 The full family deductible must be met under a two-person or family contract before benefits are paid for any person.
6 Coinsurance kicks in once the calendar-year deductible has been met.
7 For private duty nursing, your coinsurance % is 50%, in-network and out-of-network.
8 Annual coinsurance dollar maximum applies to coinsurance amounts for all covered services – including mental health and substance abuse services. For the GOLD and SILVER medical plans, it does not apply to fixed dollar copays and private duty nursing coinsurance amounts. For the BRONZE and COPPER medical plans, your coinsurance dollar maximum combines coinsurance and copay amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage.
9 Hearing care coverage includes: audiometric exam (once every 36 months), hearing aid evaluation (once every 36 months), ordering and fitting the hearing aid (once every 36 months), and hearing aid conformity test (once every 36 months). Refer to the BCBSM Summary of Benefits for additional details.
10 For mental health and substance abuse treatment, refer to the BCBSM Summary of Benefits for additional details including limits on the number of visits.
11 Specified human organ transplants and bone marrow transplants are allowed in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program – (800) 242-3504.
12 Specified human organ transplants are limited to $1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy service.
13 The 20% prescription drug out-of-network copay will not be applied toward your calendar year deductible, out-of-pocket maximum or lifetime maximum.
14 BCBSM custom formulary. A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. **Tier 2 (formulary brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. **Tier 3 (nonformulary brand)** – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.
15 Mandatory preauthorization. A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy,** an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Only claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com. Log in under "I am a Member" and click on "Prescription Drugs."
16 Mandatory maximum allowable Cost (MAC) drugs. If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you **MUST** pay the **difference** in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. **Exception**: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay
17 Physician-administered injectable drugs. Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.
18 Drug interchange and generic copay waiver. Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com.** If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver
19 Quantity limits. Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com.**
20 No more than $100.

21 Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, and any other tests or preventive measures determined to be appropriate by the attending physician.

22 If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred.

23 Semi-private room and board, general nursing, and miscellaneous services and supplies

24 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

25 In or out of the hospital and out-patient hospital treatment, such as physician's services, in-patient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

26 Blood deductible applies to **hospital confinement and out-patient medical expenses**, when furnished by a hospital or skilled nursing facility during a covered stay.

27 Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies.

28 You must meet Medicare requirements, including having been in a hospital for at least three consecutive days and having entered a Medicare-approved facility within 30 days of discharge from the hospital.

29 Supportive services needed for care and pain relief for terminally ill patients provided by a Medicare-participating hospice program when the patient elects this type of care.

30 BCBSM custom formulary. A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. **Tier 2 (formulary brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. **Tier 3 (nonformulary brand)** –Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.

31 Mandatory preauthorization. A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy,** an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Only claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com. Log in under "I am a Member" and click on "Prescription Drugs."

32 Mandatory maximum allowable Cost (MAC) drugs. If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you **MUST** pay the **difference** in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. **Exception**: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay

33 Physician-administered injectable drugs. Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.

34 Drug interchange and generic copay waiver. Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver

35 Quantity limits. Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com.**

DSRA★BENEFIT TRUST

BENEFIT PLANS FOR DELPHI RETIREES