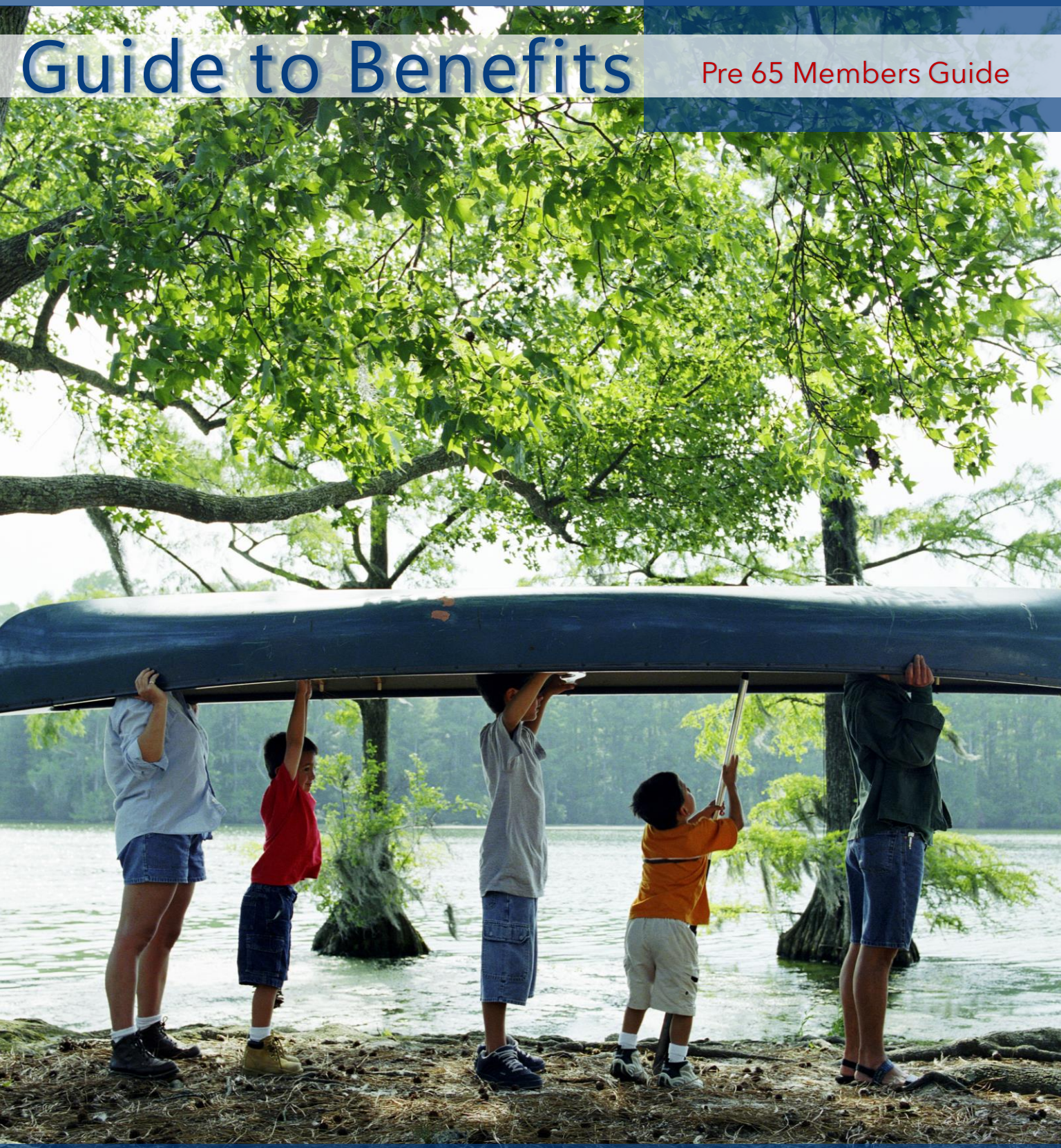
2024

Guide to Benefits

Pre 65 Members Guide



DSRA★BENEFIT TRUST

BENEFIT PLANS FOR DELPHI RETIREES

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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.

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.

Domestic Partner

The individual who lives in the same household and shares the common resources of life in a close, personal, intimate relationship with a retiree if, under state law, the individual would not be prevented from marrying the retiree on account of age, or prior undissolved marriage to another. An eligible domestic partner must be of the same gender as the retiree. Only one domestic partner may be covered at any one time.

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.

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 1(888)588-6682.

Qualifying Life Events

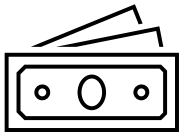
A qualifying life event will allow someone to change or enroll in coverage mid-year within the scope of the event provided Benistar, our pre-65 plan administrator, is notified within 30 days of the event date. Qualifying events include:
Gaining or losing a dependent (marriage, divorce, having a child, adopting a child, etc.)
Involuntary loss of other insurance coverage (proof is required)
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. A QFM who loses the DSRA subsidy due to retiree turning 69 is eligible to change plans

Understanding Your Medical Insurance

DEDUCTIBLE

COPAYS

COINSURANCE



OUT-OF-POCKET MAX

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

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

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%.

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.

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

If you cover dependents, under the COPPER, SILVER or GOLD 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

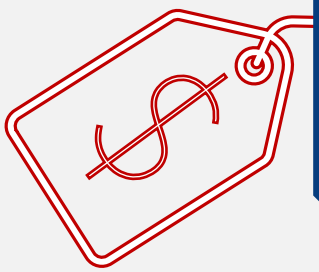
In order to open an HSA, you must be covered by health insurance that meets the definition of a High Deductible Health Plan (HDHP). The DSRA-BT BRONZE and COPPER medical plans are the only plans that meet these requirements through the DSRA Benefit Trust.[i]

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. 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.



2024 IRS Annual Contribution Limits

Individual	$4,150
Family	$8,300
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.

Medical and Prescription Drug Benefits

We know how important good health is to you and your family, which is why the DSRA-BT provides you medical plan options that protect against the unexpected and helps meet your routine health care needs. 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 COPPER		**Option #2 BRONZE**	
Medical Plan Description	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Ded) [1, 2]				
Individual	$4,000 [4]	$8,000 [4]	$2,000 [4]	$4,000 [4]
Two Person	$8,000 [4, 5]	$16,000 [4, 5]	$4,000 [4, 5]	$8,000 [4, 5]
Family	$8,000 [4, 5]	$16,000 [4, 5]	$4,000 [4, 5]	$8,000 [4, 5]
Your Coinsurance % (Coins%) [6]	50%	50%	20%	40%
Annual Coinsurance Dollar Maximums [8]				
Individual	$6,350	$12,700	$3,000	$6,000
Two Person	$12,700	$25,400	$6,000	$12,000
Family	$12,700	$25,400	$6,000	$12,000
Physician Visit Primary Care Physician (PCP) Specialist Care Physician (SCP)	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Preventive Care Services (PCP/SCP)	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered	Cov'd 100%	Not Covered
In-Patient/Out-Patient Hospital Services	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Emergency Room Services	50% after in-network deductible		Ded+Coins%	
Urgent Care Services	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Durable Medical Equipment	50% after in-network deductible		Ded+Coins%	
Hearing Care Coverage	Not Covered	Not Covered	Cov'd 100% after Ded	Not Covered
Mental Health Care/Substance Abuse	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Human Organ Transplants	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Specified Human Organ	50% after in-network deductible	50% after in-network deductible		
Bone Marrow	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Specified Oncology Clinical Trials	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Kidney, Cornea and Skin	50% after in-network deductible	50% after out-of-network deductible	Ded+Coins%	
Retail Pharmacy Prescription Drug Plan 30 Day Supply	**After Deductible Copays**		**After Deductible Copays**	
Tier 1 – Generic	$15	$15/$50$70 +20% Coins	$15	$15/$50/$70 +20% Coins
Tier 2 – Brand Name Formulary	$50		$50	
Tier 3 – Brand Name Non Formulary	$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	$30	Not Covered	$30	Not Covered
Tier 2 – Brand Name Formulary	$100		$100	
Tier 3 – Brand Name Non Formulary	$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	Yes		Yes	

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

Rates for all plans are listed on the enrollment form.

	Option #3 SILVER		Option #4 GOLD	
Medical Plan Description	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Ded) [1, 2]				
Individual	$500	$1,000 [3]	$250	$500 [3]
Two Person	$1,000	$2,000 [3]	$500	$1,000 [3]
Family	$1,000	$2,000 [3]	$500	$1,000 [3]
Your Coinsurance % (Coins%) [6]	20%	40%	20%	40%
Annual Coinsurance Dollar Maximums [8]				
Individual	$2,000	$4,000	$1,250	$2,250
Two Person	$4,000	$8,000	$2,500	$4,500
Family	$4,000	$8,000	$2,500	$4,500
Physician Visit Primary Care Physician (PCP) Specialist Care Physician (SCP)	$20	Ded+Coins%	$10	Ded+Coins%
Preventive Care Services (PCP/SCP)	Cov'd 100%	Not Covered	Cov'd 100% (up to $1,000)	Not Covered
In-Patient/Out-Patient Hospital Services	Ded+Coins%		Ded+Coins%	
Emergency Room Services	$150		$50	
Urgent Care Services	$20	Ded+Coins%	$10	Ded+Coins%
Durable Medical Equipment	Ded+Coins%		Ded+Coins%	
Hearing Care Coverage	Cov'd 100% after Ded	Not Covered	Cov'd 100%	Not Covered
Mental Health Care/Substance Abuse	Ded+Coins%		Ded+Coins%	
Human Organ Transplants	Cov'd 100%	Ded+Coins%	Cov'd 100%	Ded+Coins%
Specified Human Organ				
Bone Marrow	Ded+Coins%		Ded+Coins%	
Specified Oncology Clinical Trials	Ded+Coins%		Ded+Coins%	
Kidney, Cornea and Skin	Ded+Coins%		Ded+Coins%	
Retail Pharmacy Prescription Drug Plan 30 Day Supply	**After Deductible Copays**		**After Deductible Copays**	
Tier 1 – Generic	$10	$10/$40/$80	$10	$10/$20/$40 +25% Coins
Tier 2 – Brand Name Formulary	$40	+25% Coins	$20	
Tier 3 – Brand Name Non Formulary	$80		$40	
RX Mail Order Pharmacy Prescription Drug Plan (90-day Supply)	**After Deductible Copays**		**After Deductible Copays**	
Tier 1 – Generic	$20	Not Covered	$20	Not Covered
Tier 2 – Brand Name Formulary	$80		$40	
Tier 3 – Brand Name Non Formulary	$160		$80	
Health Savings Account				
Eligible Medical Plan	No		No	

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

Retirees Eligible for Medicare

During a subsequent open enrollment, DSRA-BT offers medical plan choices through The Hartford and BCBSM PPO Medicare Advantage (MA) to Medicare eligible retirees. 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 Medicare Medical options. You must provide Benistar your Medicare ID number and your Part A and/or Part B effective date to receive the Medicare 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. Enrollees can carry the BCBSM prescription coverage as a standalone.

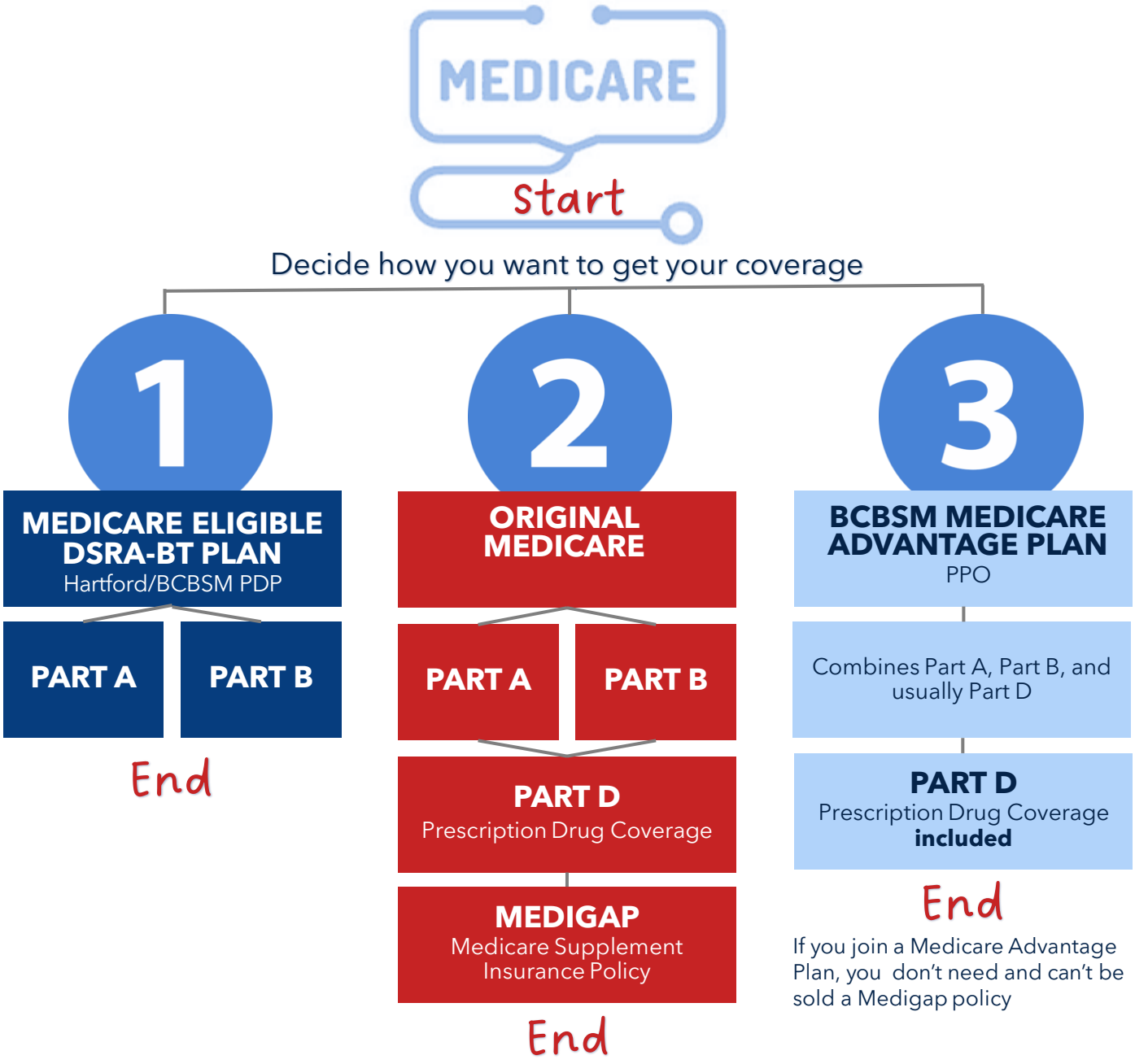
Retirees Under Age 65

Once a Retiree reaches age 65 or becomes Medicare eligible, his/her coverage in the Under Age 65 medical/prescription plan will terminate the first day of the month they become Medicare eligible. However, if the retiree carries dental &/or vision coverage, 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 Medicare plan because an application is required approximately 90 - 120 days prior to the event date (65th birthday). If becoming Medicare eligible prior to turning 65, you must contact the plan administrator/Benistar. An application will be mailed to you. Eligible dependents under the age of 65 may elect to continue the coverage in the Pre-65 plans..
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.

Medicare Eligible Retirees

A retiree or spouse enrolled in one of the Medicare plans who terminate coverage ***can*** *re*-enroll in the DSRA-BT Medicare plan.

Medicare Eligible Coverage



For complete details about the Medicare plan options, please refer to the 2024 Health Matters Guide for Post-65 Members on the website at **www.dsrabenefittrust.net**.

DENTAL AND VISION BENEFITS

DSRA-BT offers dental and vision coverage through Blue Cross Blue Shield of Michigan (BCBSM). If you would like to enroll in dental and vision coverage or change your current elections please contact the Benistar Retiree Call Center at (888)588-6682 or access the DSRA-BT enrollment form on the DSRA-BT website – www.dsrabenefittrust.net.

Understanding Your Dental Plan Options

The dental plan provides a wide variety of covered services – either covered in full or partially by the plan. Members will continue to have the choice to enroll in dental and/or vision which requires an application to be completed. Considering the relatively small cost difference between the High and Low Pans, members may want to consider the High plan which includes substantially more coverage - 80% vs 50%, for Onlays, Crowns, Veneers, Inlays-permanent teeth, even though the need for them may not be anticipated at this time.
The table below provides an overview of the dental 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.

$0 Deductible for Class 1 Services
$50 Deductible for Class 2 and 3 Services

Benefits	Low Plan Coverage	High Plan Coverage
Deductible **Class 1** Class 2 and Class 3	**$ 0** $50 per member limited to a maximum of $150 per family per calendar year	**$0** $50 per member limited to a maximum of $150 per family per calendar year
Class 1 services	100% Covered	100% Covered
Class 2 services	80%	80%
Class 3 services	50%	50%
Class 4 services	Not covered	Not covered
Annual maximum for Class 1, 2 and 3 services	$3,000 per member	$3,000 per member
Lifetime maximum for Class 4	N/A	N/A
Class 3: Major Restorative	35%	35%
Class 4: Orthodontia	N/A	50%

See enrollment form for all plan rates.

Low Plan

Annual Dental Maximum per person	$3,000
Class 1 services	
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 2 services	
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 3 services	
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 4 services	
Orthodontic services for dependents under age 19	Not Covered

See enrollment form for all plan rates.

DENTAL PLAN – LOW PLAN VS HIGH PLAN
(Continued)

High Plan

Annual Dental Maximum per person	$3,000
Class 1 services	
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 2 services	
Includes but not limited to: Onlays, Crowns,Veneers, Inlays - permanent teeth** Occlusal biteguards** 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 3 services	
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 4 services	
Orthodontic services for dependents under age 19** Class IV Lifetime Maximum per Individual	50% = Your Coinsurance $2,500

See enrollment form for all plan rates.

*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. Notice the relatively small cost difference between the High and Low Pans, Members may want to consider the High plan which includes substantially more services, even though the need for them may not be anticipated at this time.

VISION PLAN BENEFITS

DSRA-BT offers vision benefits through Blue Cross Blue Shield of Michigan (BCBSM) Blue Vision.

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 Rates Through MetLife

Voluntary life benefits are offered through MetLife Insurance. If you have elected voluntary coverage in the past, your elected benefit will continue into 2024. **No action is required.** 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 is no longer required for spouse coverage to be available.

- If you are retiring from your last place of employment and have not yet enrolled in Life Insurance through DSRA-BT, you have 90 days following your retirement date of your last employer.
- 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.
- Age Banded Prices guaranteed through 2024.

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.

See enrollment form for all plan rates.

Subsidies Provided by DSRA-BT

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

DSRA-BT Subsidy Eligibility (HCTC not in effect)

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 2024.
There are pre-65 salaried retirees that retired on or before April 01, 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.

***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 on or before 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.

DSRA-BT Hardship Grant

The DSRA-BT will continue to provide financial assistance to those in need for the 2024 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 on or before 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 2024.

Once you accept a Hardship Grant, you will be ineligible for health coverage provided through DSRA-BT, and your coverage will expire December 31, 2024.

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, 2024.

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 2023 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 Medicare eligible members is Friday, November 24, 2023. 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 2024, you will get a 1099 from DSRA-BT to be filed with your 2024 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**.

THE HEALTH COVERAGE TAX CREDIT HAS EXPIRED.
The Health Coverage Tax Credit has NOT been reauthorized.

Billing & Payments

Billing - Medical and Medicare Disabled, Under Age 65 Dental, Under Age 65 and Medicare Eligible Vision, Under Age 65 and Medicare

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 Medicare disabled) – 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 an automatic electronic-funds transfer (EFT) 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 2024.
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 address listed on your monthly billing statement.

Medical – Medicare Eligible

If you elect any of the Medicare Eligible plans offered through The Hartford and BCBSM Medicare Advantage, you will be billed monthly by Benistar, our Medicare 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. If you are retiring from your last place of employment and have not yet enrolled in Life Insurance through DSRA-BT, you have 90 days following your retirement date of your last employer.

Questions

If you have questions about the enrollment process for the pre-65 medical, dental and vision or Medicare 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.

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.

Additional Qualifications and Plan Limits

1 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.
2 For mental health and substance abuse treatment, refer to the BCBSM Summary of Benefits for additional details including limits on the number of visits.
3 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.
4 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.
5 The 20% prescription drug out-of-network copay will not be applied toward your calendar year deductible, out-of-pocket maximum or lifetime maximum.
6 The **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.
7 **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."
8 **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
9 **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.
10 **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
11 **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.**

Footnotes

12 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.
13 If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred.
14 Semi-private room and board, general nursing, and miscellaneous services and supplies
15 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.
16 **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.
17 Blood deductible applies to **hospital confinement and out-patient medical expenses**, when furnished by a hospital or skilled nursing facility during a covered stay.
21 Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies.
22 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.
23 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.

Coverage Contact Information

Benistar Phone: 1(888)588-6682

Your Call Center and Plan Administrator

Mailing Address:
Benistar Retiree Service Center
10 Tower Lane, Suite100
Avon, CT 06001

Fax Enrollment Forms:
1(860)408-7025

Medical Plan Information:	**Blue Cross Blue Shield Medical Plans**	
	Blue Cross Blue Shield of Michigan Post-Enrollment Benefits and Claims Benistar Call Center BCBSM Claims Department	 (888)588-6682 (877)354-2583
Prescription Drug Plan Information:	**Blue Cross Blue Shield Prescription Drug Plans**	
	BCBSM Pre-Enrollment Benefit Inquiries: Post-Enrollment Benefits & Claims Prescription Drug Formulary	(888)588-6682 (877)354-2583
Dental Plan Information:	**Blue Cross Blue Shield Nationwide Plans (Dental)**	
	Blue Cross Blue Shield of Michigan www.Mibluedentist.com Dental Customer Service Find a Doctor	 (888)826-8152
Vision Plan Information:	**Blue Cross Blue Shield Michigan** (Blue Vision VSP with BCBSM)	
	BCBSM Customer Service www.VSP.com or www.BCBSM.com	(800)877-7195

enroll NOW

CALL 1(888)588-6682

All billing / payment information will be listed on your Benistar invoice.

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BENEFIT PLANS FOR DELPHI RETIREES

Have Questions or need Assistance,
Please call your Call Center!
Benistar - they are there to help with personalized service!

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www.DSRABenefitTrust.net

2024 GUIDE TO BENEFITS

for Pre-65 Members