MEDICARE ELIGIBLE ENROLLMENT FORM

DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

Section A: Member Information

Retiree Name: (First) (Middle) (Last)	Gender: Male ☐ Female ☐	Social Security Number:	Date of Birth: (mm/dd/yyyy)
Spouse Name: (First) (Middle) (Last)	Gender: Male ☐ Female ☐	Social Security Number:	Date of Birth: (mm/dd/yyyy)
Address: (Street) (City) (State) (Zip)		Phone Number:	
Email Address:	Are you Eligible for Medicare: ☐ Yes ☐ No		
Medicare Currently Enrolled: ☐ Part A ☐ Part B	Medicare ID Number: (If applicable)		
Medicare Effective Date:	If Wating on Medicare # check here:		

CMS Required Race	Member	Spouse		Member	Spouse
American Indian or Alaska Native	☐	☐	Native Hawaiian	☐	☐
Asian Indian	☐	☐	Other Asian	☐	☐
Black or African American	☐	☐	Other Pacific Islander	☐	☐
Chinese	☐	☐	Samoan	☐	☐
Filipino	☐	☐	Vietnamese	☐	☐
Guamanian or Chamorro	☐	☐	White	☐	☐
Japanese	☐	☐	I choose not to answer	☐	☐
Korean	☐	☐			

CMS Required Ethnicity	Member	Spouse		Member	Spouse
Another hispanic, Latino/a or Spanish Origin	☐	☐	Not of Hispanic, Latino/a or Spanish Origin	☐	☐
Cuban	☐	☐	Puerto Rican	☐	☐
Mexican, Mexican American, Chicano/a	☐	☐	I choose not to answer	☐	☐

Please complete your information, sign and return.
The effective date of your coverage will be the first of the month following your signature date, but not prior to the month in which you become Medicare Eligible. If you become Medicare Eligible on the 1st day of the month, your coverage is effective on the 1st of the month prior. The exception to this is if you are enrolling through our annual open enrollment period. In this case, the effective date of coverage would be 1/1/2025.

To elect Medical coverage, you must complete this form. If you elect a Hartford Plan, you must also complete The Hartford Enrollment Form in addition to this form. The Hartford form is included in the enrollment packet and can also be found on the Turst website-go to www.DSRABenefitTrust.net and click on 'Post 65 Insurance Plans". You may select medical ONLY coverage, prescription drug ONLY coverage or medical coverage with prescription drug plans.

Your spouse/domestic partner can elect different medical/prescription coverage as the Retiree.

Section B: Enrollment Action

- ☐ Enroll BCBSM - Medicare Advantage
- ☐ Enroll Hartford Supplemental Plan
- ☐ Enroll Dental / Vision
- ☐ Enroll Life Insurance

Section C: Change of Status

- ☐ Address Change
- ☐ Add Member
- ☐ Terminate Coverage
- ☐ Other

Section D: Enrollee Information

- ☐ Eligible Retiree
- ☐ Eligible Retiree & Spouse / Domestic Partner
- ☐ Spouse / Domestic Partner / Surviving Spouse

Section E: Medicare Eligible Plan Options

BCBSM - Medicare Advantage

(Enroll)

- ☐ Diamond Plan
- ☐ Emerald Plan
- ☐ Ruby Plan

(Terminate)

- ☐ *Diamond Plan*
- ☐ *Emerald Plan*
- ☐ *Ruby Plan*

- ☐ Retiree
- ☐ Spouse, Domestic Partner Surviving Spouse

The Hartford Medicare Supplemental Plan

Complete this form and additional Hartford Enrollment Form

BCBSM - Standalone PDP

(Enroll)

- ☐ High PDP
- ☐ Low PDP

(Terminate)

- ☐ *High PDP*
- ☐ *Low PDP*

- ☐ Retiree
- ☐ Spouse, Domestic Partner Surviving Spouse

BCBSM - Medicare Eligible Dental and/or Vision ONLY

(Enroll)

- ☐ High Dental
- ☐ Low Dental
- ☐ High Dental with Vision
- ☐ Low Dental with Vision

(Terminate)

- ☐ *High Dental*
- ☐ *Low Dental*
- ☐ *High Dental with Vision*
- ☐ *Low Dental with Vision*

- ☐ Retiree
- ☐ Spouse, Domestic Partner Surviving Spouse

By signing below you are also agreeing to the Terms and Conditions

Signature: Date:

Print Name:

Please Read the following information. The information on this form and the following conditions are part of my contract with Blue Cross® Blue Shield® of Michigan and/or The Hartford. By joining anoy of the plans, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be dis-enrolled from any plan. I understand that my signature (or signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by applicable plan vendors or by Medicare. I am applying for coverage for myself and/or my family member identified on this application under my group's or association's contract with Blue Cross and/or The Hartford. Coverage begins on the date determined by Blue Cross and/or The Hartford. When the carrier(s) accept(s) my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage. Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by Blue Cross Blue Shield of Michigan and/or The Hartford. Authorization: I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Benistar and Blue Cross® Blue Shield® of Michigan and/or The Hartford of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize Blue Cross,The Hartford and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of mine/our medical care, administration of my coverage with Blue Cross and/or The Hartford, and for other purposes necessary for Blue Cross and/or The Hartford to fulfill its contractual and statutory obligations. Release of Information: I acknowledge that Blue Cross and/or The Hartford requires me to provide my Social Security Number. In applying for coverage, I and/or my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to Blue Cross and/or The Hartford for purpose of administering our coverage. Instructions for Completion and Submittal of ALL Forms Complete form by printing a blank form and filling in all necessary information. Contact Benistar with any question 1-800-236-4782

Completed forms can be faxed or emailed to Benistar at:
Email: memelig@benistar.com
Fax: 1-860-408-7025

If mailing send to:
Benistar Service Center
10 Tower Lane, Suite 100
Avon, Ct. 06001

PREMIUM Guide
for Medicare Eligible Members

2026

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

Call TODAY! 1-888-588-6682

www.DSRABenefitTrust.net

DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

MEDICARE ADVANTAGE PPO PROVIDERS

Your plan allows you to go to any doctor or hospital that accepts Medicare

What does this mean?

- You have freedom to choose any provider, specialist or hospital that accepts Medicare and accepts your BCBSM Medicare Advantage Plan
- Referrals aren't required
- Member out-of-pocket costs are the same as long as the doctor or hospital accepts Medicare and bills BCBSM

In-network

- A Medicare provider who has a contractual agreement to be a part of the Blue Cross Blue Shield Medicare Advantage PPO Network

YOUR MAPD PLAN CHOICES

Out Of Pocket Maximum	**$0**	**$750**	**$4,500**
OPTIONS	**Diamond**	**Emerald**	**Ruby**
Type Of Network	No Deductible	No Deductible	No Deductible
Deductible	$0	$0	$0
Coinsurance	0%	20%	20%
Inpatient	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Outpatient	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Office Visit	$0	$5	$20
Chiropractic	$0	$5	$20
Specialist	$0	$15	$40
Urgent Care	$0	$10	$50
Facility Evaluation	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Psych	$0	$5	$25
Surgical Services	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Other Physician Services	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Preventative	No Cost	No Cost	No Cost
Emergency	$0	$75	$90
Ambulance Services	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance
Durable Medical Equipment	No Cost	Subject to 20% Coinsurance	Subject to 20% Coinsurance

See enrollment form for all plan rates.

YOUR MAPD PRESCRIPTION DRUG PLANS

NO PDP Deductibles on any of these 3 plans
Your Prescription Drug Benefits **cover you through the Donut Hole**
There is no extra out-of-pocket expense

PRESCRIPTION DRUG PLANS FOR DIAMOND AND EMERALD PLANS

High Plan PDP	Preferred Rx	Standard Rx
Prior Authorization/Step Therapy	Yes	Yes
Rx Deductible	**$0**	**$0**
Tier 1	$2	$10
Tier 2	$2	$10
Tier 3	$40	$50
Tier 4	$75	$100
Tier 5	30% Member Cost	30% Member Cost
BCBS will notify you when Catastrophic Coverage Phase begins (Information can be found on your EOB, amount can change year to year)		
90 Day Supply*	x2	x2

PRESCRIPTION DRUG PLANS FOR RUBY PLAN

Ruby Plan PDP	Preferred Rx	Standard Rx
Prior Authorization/Step Therapy	Yes	Yes
Rx Deductible	**$0**	**$0**
Tier 1	$10	$15
Tier 2	$10	$15
Tier 3	$45	$50
Tier 4	$90	$100
Tier 5	30% Member Cost	30% Member Cost
BCBS will notify you when Catastrophic Coverage Phase begins (Information can be found on your EOB, amount can change year to year)		
90 Day Supply*	x2	x2

Copays are the only differences in the Diamond, Emerald High PDP and Ruby PDP Plan

Additional Prescription Drug Services on all PDP plans	
Oral and injectable contraceptives	Covered
Smoking cessation drugs	Covered
Weight loss drugs	Covered
Impotency drugs	Covered

Most Common Preferred Pharmacies: *(less expensive option)*
Walmart, Kroger & Walgreens

Most Common Standard Pharmacies:
CVS & Winn-Dixie

★ Member may get a 90-day supply at their local pharmacy or mail order for the same x2 co-pay

Out-of-pocket cost is applied based on drug tiers and pharmacy type:
Tier 1= Preferred generic drugs
Tier 2= Generic
Tier 3= Preferred brand drugs
Tier 4= Non-preferred drugs
Tier 5= Specialty drugs
Catastrophic= Over $8,000

MEDICARE ADVANTAGE PLAN BENEFITS

BRIEF DESCRIPTION OF BENEFITS

Medicare Advantage Medical / Surgical Group Benefits and Services	DIAMOND MEDICARE PLUS PPO PLAN WITH HIGH RX		EMERALD MEDICARE PLUS PPO PLAN WITH HIGH RX		RUBY MEDICARE PLUS PPO PLAN WITH RUBY RX	
Deductible	**$0**		**$0**		**$0**	
PPO Benefit Structure	**(In-Network if doctor or hospital accepts Medicare)**		**(In-Network if doctor or hospital accepts Medicare)**		**(In-Network if doctor or hospital accepts Medicare)**	
Member Out-of-Pocket Cost-Sharing Options	Deductibles, Coinsurances and Copays		Deductibles, Coinsurances and Copays		Deductibles, Coinsurances and Copays	
Combined Out-of-Pocket Maximum	**$0**		**$750**		**$4,500**	
Coinsurance	**0%**		**20%**		**20%**	
> Core Benefits						
Inpatient Facility Services (No Member Cost-Share - Home Health Care)	No Member Cost-Share		Deductibles, Coinsurances, OOPM Will Apply		Deductibles, Coinsurances, OOPM Will Apply	
Outpatient Facility Services	No Member Cost-Share		Deductibles, Coinsurances, OOPM Will Apply		Deductibles, Coinsurances, OOPM Will Apply	
> Physician / Practitioner Benefits						
Office Visits, Online Visits, and Consultations	$0		$5		$20	
Chiropractic Services	$0		$5		$20	
Specialist Services	$0		$15		$40	
Psychiatric and Psychotherapy Services	$0		$5		$25	
Facility Evaluation and Management Services	No Member Cost-Share		Deductibles, Coinsurances, OOPM Will Apply		Deductibles, Coinsurances, OOPM Will Apply	
Other Physician Services (No Member Cost-Share for Clinical Labs)	No Member Cost-Share		Deductibles, Coinsurances, OOPM Will Apply		Deductibles, Coinsurances, OOPM Will Apply	
Surgical Services (Includes Anesthesia Services, Cardiac Catheterization Services, and Therapeutic Cardiovascular Services)	No Member Cost-Share		Deductibles, Coinsurances, OOPM Will Apply		Deductibles, Coinsurances, OOPM Will Apply	
> Emergency / Other Benefits						
Urgent Care	$0		$10		$50	
Emergency Department / Emergency Room Care	No Member Cost-Share		$75		$90	
Ambulance Services	No Member Cost-Share		Ded,Coins,OOPM Will Apply		Ded,Coins,OOPM Will Apply	
DME, P & O, and Supplies	No Member Cost-Share		No Member Cost-Share		No Member Cost-Share	
Preventive Services	No Member Cost-Share		No Member Cost-Share		No Member Cost-Share	
Additional Medicare Advantage Group Benefits						
Adult Diapers / Incontinence Liners	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services
Annual Physical (removes Office Visit cost-share)	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services
Chiropractic Enhanced Services						
> Approved Radiological > Approved E & M > Approved Physical Therapy	Included	Cost-Share Same as Chiropractic Services above	Included	Cost-Share Same as Chiropractic Services above	Included	Cost-Share Same as Chiropractic Services above
Determination of Refractive State	Included	Deductible, Coinsurance, OOPM Will Apply	Included	Deductible, Coinsurance, OOPM Will Apply	Included	Deductible, Coinsurance, OOPM Will Apply
Foreign Travel (removes Emergency Room and Urgent Care restrictions)	Included	Cost-Share Same as if Services were provided in the U.S.	Included	Cost-Share Same as if Services were provided in the U.S.	Included	Cost-Share Same as if Services were provided in the U.S.
Gradient Compression Stockings	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services

MEDICARE ADVANTAGE PLAN BENEFITS
BRIEF DESCRIPTION OF BENEFITS

(Continued)

Hearing Services						
> Exam (measurement of hearing ability)	Included	Cost-Share Same as Office Visit above	Included	Cost-Share Same as Office Visit above	Included	Cost-Share Same as Office Visit above
> Hearing Aids	Included	Covered up to $500	Included	Covered up to $500	Included	Covered up to $500
Home Infusion Therapy	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services
Hospice Care (Cost-Share associated with Respite and Drugs)	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services
Human Organ Transplant (removes lifetime maximum for non-Medicare-covered organs per organ type)	Included	Cost-Share Same as Surgical Services above	Included	Cost-Share Same as Surgical Services above	Included	Cost-Share Same as Surgical Services above
Private Duty Nursing	Included	50% Coinsurance Applies (does not accumulate towards OOPMs)	Included	50% Coinsurance Applies (does not accumulate towards OOPMs)	Included	50% Coinsurance Applies (does not accumulate towards OOPMs)
Silver Sneakers Fitness Program	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services
Travel and Lodging (associated with Human Organ Transplant benefits)	Included	Covered up to $10,000 (must be 100+ miles from home)	Included	Covered up to $10,000 (must be 100+ miles from home)	Included	Covered up to $10,000 (must be 100+ miles from home)
Wigs (includes wig stands and adhesive)	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services	Included	No Member Cost-Share for these Services

Blue Cross Blue Shield - MAPD
Medicare Eligible / 2026 Rates

Plan	Rate
Diamond	$495.74
Emerald	$432.38
Ruby	$281.04

An administration fee of $10 is included above

MEDICARE SUPPLEMENT PLANS

DSRA-BT offers four medical plan choices to retirees over the age of 65.

All four plans are underwritten by The Hartford.

BENEFIT DESCRIPTION	AGP-3845 AGP-7050 Premium	AGP-3846 AGP-7051 Choice	AGP-7052 Premium Plus	AGP-3862 AGP-7053 Elite
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Out of Pocket Maximum (OOP)	$500	$1,000	N/A	N/A
(Applies to Medicare Part B Services)	√	√		
Part A				
Part A Deductible (days 1-60; Part A Deductible)	100%	100%	100%	100%
Hospital Confinement (days 61-90; 25% of Part A Deductible) (days 91-150; 50% of Part A Deductible)	100%	100%	100%	100%
Extended Hospital Confinement (Additional 365 days) payable at 100%	100%	100%	100%	100%
Skilled Nursing Facility Confinement (days 21-100; 12 1/2% Part A Deductible)	100%	100%	100%	100%
Part B				
Part B Deductible	**Not Covered**	**Not Covered**	**Not Covered**	**100%**
Physician Services Benefit	100%	100%	100%	100%
Specialist Services Benefit	100%	100%	100%	100%
Outpatient Hospital Services and Ambulatory Surgical Care	100%	100%	100%	100%
Outpatient Diagnostic and Radiology Services	100%	100%	100%	100%
Outpatient Mental Health and Substance Abuse Services	100%	100%	100%	100%
Outpatient Rehabilitative and Cardiac Rehabilitative Services	100%	100%	100%	100%
Emergency Care Benefit	100%	100%	100%	100%
Urgent Care Benefit	100%	100%	100%	100%
Ambulance Services Benefit	100%	100%	100%	100%
Durable Medical Equipment and Prosthetics Benefit	100%	100%	100%	100%
Part B Excess	100%	100%	100%	100%
Additional Services				
Preventive Care Cancer Screening	100%	100%	100%	100%
Hospice (Inpatient respite care, drugs)	100%	100%	100%	100%
Blood Deductible	100%	100%	100%	100%
Foreign Travel Emergency ($250 Deductible; 80% coinsurance up to $50,000 Lifetime Maximum)	√	√	√	√
Annual Physical Exam ($25 copay; $500 calendar year maximum)	√	√	√	√

See enrollment form for all plan rates.

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

ii. 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 arow.

★Silver&Fit was elected by the members of DSRA-BT to add the benefit to the Hartford Plan.

Hartford Supplement Plan
Medicare Eligible / 2026 Rates

STANDALONE PLAN MONTHLY RATES Admin fee already included (plan administration, billing and claims)	INSURED'S AGE BANDED RATES				
	65-69	70-74	75-79	80-84	85+
Choice Plan	$137.03	$166.86	$205.43	$248.41	$277.00
Premium Plan	$165.37	$202.81	$251.23	$305.16	$341.06
Premium Plus Plan *(Mirrors G Plan)*	$194.94	$240.31	$299.02	$364.37	$407.88
Elite Plan *(Mirrors F Plan)*	$217.04	$268.37	$334.73	$407.66	$457.87
Florida Residents ONLY	$272.97				

Standalone - An administration fee of $7 is included above

MEDICAL + LOW RX PLAN MONTHLY RATES					
Choice Plan	$363.24	$393.07	$431.64	$474.62	$503.21
Premium Plan	$391.58	$429.02	$477.44	$531.37	$567.27
Premium Plus Plan *(Mirrors G Plan)*	$421.15	$466.52	$525.23	$590.58	$634.09
Elite Plan *(Mirrors F Plan)*	$443.25	$494.58	$560.94	$633.87	$684.08
Florida Residents ONLY	$499.18				
MEDICAL + HIGH RX PLAN MONTHLY RATES					
Choice Plan	$394.52	$424.35	$462.92	$505.90	$534.49
Premium Plan	$422.86	$460.30	$508.72	$562.65	$598.55
Premium Plus Plan *(Mirrors G Plan)*	$452.43	$497.80	$556.51	$621.86	$665.37
Elite Plan *(Mirrors F Plan)*	$474.53	$525.86	$592.22	$665.15	$715.36
Florida Residents ONLY	$530.46				

Medical + RX Plan - An administration fee of $10 is included above

BCBSM Standalone Prescription Drug Plans

The Trust offers two prescription drug plans for participants enrolling in a Supplemental Medical plan or enrolling in a Standalone Prescription Drug Plan.

	High RX Plan		Low RX Plan	
	Preferred Cost-Shares	**Standard Cost-Shares**	**Preferred Cost-Shares**	**Standard Cost-Shares**
Tier 1 (Preferred Generic)	$2	$10	$5	$10
32-90 Day Supply Mail Order Copay Multiplier	X2	X2	X2	X2
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Not Applicable		Not Applicable	
Tier 2 (Generic)	$2	$10	$5	$10
32-90 Day Supply Mail Order Copay Multiplier	X2	X2	X2	X2
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Not Applicable		Not Applicable	
Tier 3 (Preferred Brand)	$40	$50	$50	$60
32-90 Day Supply Mail Order Copay Multiplier	X2	X2	X2	X2
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Not Applicable		Not Applicable	
Tier 4 (Non-Preferred Drug)	$75	$100	$80	$100
32-90 Day Supply Mail Order Copay Multiplier	X2	X2	X2	X2
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Not Applicable		Not Applicable	
Tier 5 (Specialty)	30%	30%	35%	35%
32-90 Day Supply Mail Order Copay Multiplier	Not Applicable - Tier 5 Unavailable for 32-90 Day Mail Order		Not Applicable - Tier 5 Unavailable for 32-90 Day Mail Order	
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Not Applicable		Not Applicable	

Admin Fee of $10 will be added for RX Standalone Plans

Blue Cross Blue Shield – PDP Standalone

Medicare Eligible / 2026 Rates

STANDALONE PDP MEDICARE Rates

Plan	Rate
High PDP	$254.49
Low PDP	$223.21

Does not include the $3 VEBA Fee.
Medical + RX Plan - An administration fee of $10 is included above

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 and complete new enrollment form. www.dsrabenefittrust.net.

Understanding the TWO BCBSM Dental Plans

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.

DENTAL PLAN – HIGH PLAN VS LOW PLAN

The Trust offers dental coverage through Blue Cross Blue Shield of Michigan (BCBSM). 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 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 – HIGH PLAN VS LOW 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

*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.

Blue Cross Blue Shield
(Medical Plan + Dental/ Vision) Medicare Eligible / 2026 Rates

LOW PLAN

	Dental +Vision	Dental Only
Single	$73.09	$65.65
Two Person	$146.18	$131.30
Family	$219.27	$196.95

HIGH PLAN

	Dental +Vision	Dental Only
Single	$77.52	$70.08
Two Person	$155.04	$140.16
Family	$232.56	$210.24

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

Blue Cross Blue Shield - Dental / Vision
(Standalone no Medical) Medicare Eligible / 2026 Rates

LOW PLAN

	Dental +Vision	Dental Only
Single	$77.34	$69.90
Two Person	$150.43	$135.55
Family	$223.52	$201.20

An administration fee of $4.25 is included above

HIGH PLAN

	Dental +Vision	Dental Only
Single	$81.77	$74.33
Two Person	$159.29	$144.41
Family	$236.81	$214.49

An administration fee of $4.25 is included above

VOLUNTARY LIFE BENEFITS

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 required for spouse coverage to be available.

Current retiree members that have not elected life coverage within 90 days of retiring are no longer eligible to elect life insurance coverage.

MetLife replaced Guardian Life effective 01/01/2022. The premiums were reduced 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.
- 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 (888)588-6682 to help you or if you need additional information.

Amount	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95+
$10k	$ 2.46	$ 4.35	$ 6.84	$ 13.03	$ 21.49	$ 35.64	$ 57.91	$ 95.55	$ 154.80	$ 250.77
$20k	$ 4.92	$ 8.70	$ 13.68	$ 26.06	$ 42.98	$ 71.28	$ 115.82	$ 191.10	$ 309.60	$ 501.54
$30k	$ 7.38	$ 13.05	$ 20.52	$ 39.09	$ 64.47	$ 106.92	$ 173.73	$ 286.65	$ 464.40	$ 752.31
$40k	$ 9.84	$ 17.40	$ 27.36	$ 52.12	$ 85.96	$ 142.56	$ 231.64	$ 382.20	$ 619.20	$ 1,003.08
$50k	$ 12.30	$ 21.75	$ 34.20	$ 65.15	$ 107.45	$ 178.20	$ 289.55	$ 477.75	$ 774.00	$ 1,253.85
$60k	$ 14.76	$ 26.10	$ 41.04	$ 78.18	$ 128.94	$ 213.84	$ 347.46	$ 573.30	$ 928.80	$ 1,504.62
$70k	$ 17.22	$ 30.45	$ 47.88	$ 91.21	$ 150.43	$ 249.48	$ 405.37	$ 668.85	$ 1,083.60	$ 1,755.39
$80k	$ 19.68	$ 34.80	$ 54.72	$ 104.24	$ 171.92	$ 285.12	$ 463.28	$ 764.40	$ 1,238.40	$ 2,006.16
$90k	$ 22.14	$ 39.15	$ 61.56	$ 117.27	$ 193.41	$ 320.76	$ 521.19	$ 859.95	$ 1,393.20	$ 2,256.93
$100k	$ 24.60	$ 43.50	$ 68.40	$ 130.30	$ 214.90	$ 356.40	$ 579.10	$ 955.50	$ 1,548.00	$ 2,507.70
$110k	$ 27.06	$ 47.85	$ 75.24	$ 143.33	$ 236.39	$ 392.04	$ 637.01	$ 1,051.05	$ 1,702.80	$ 2,758.47
$120k	$ 29.52	$ 52.20	$ 82.08	$ 156.36	$ 257.88	$ 427.68	$ 694.92	$ 1,146.60	$ 1,857.60	$ 3.009.24

Spousal coverage only available up to $50,000.

-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.

-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.

-Spouse costs are based on the retiree's age.

IMPORTANT – 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.

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	(888)588-6682
	BCBSM Claims Department	(877)354-2583
Prescription Drug Plan Information:	**Blue Cross Blue Shield Prescription Drug Plans**	
	BCBSM Pre-Enrollment Benefit Inquiries:	(888)588-6682
	Post-Enrollment Benefits & Claims	
	Prescription Drug Formulary	(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	(800)877-7195
	www.VSP.com or www.BCBSM.com	

enroll NOW

CALL 1(888)588-6682

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