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# DELPHI SALARIED RETIREE ASSOCIATION BENEFIT TRUST

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## Supplemental Care Coverage

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at [medicare.gov](http://medicare.gov) or at any Social Security office).

## Member's responsibility (deductibles, coinsurance, copays and dollar maximums)

**Note:** Medicare deductible and coinsurance amounts are effective January 1, 2016 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	<ul style="list-style-type: none"> <li><b>Medicare Part A</b> \$1,288 (for days 1-60) each benefit period</li> <li><b>Medicare Part B</b> \$166 per calendar year</li> </ul>	None
Coinsurance/fixed dollar copays	<ul style="list-style-type: none"> <li><b>Hospital stay</b> \$322 per day (for days 61-90) and \$644 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime)</li> <li><b>Skilled nursing facility stay</b> (a limit of 100 days each benefit period) \$161 per day (for days 21-100)</li> </ul>	None
Coinsurance/percent copay amounts	<ul style="list-style-type: none"> <li>20% of Medicare approved amount for most general services</li> <li>20% of Medicare approved amount for outpatient mental health care</li> </ul>	None

## Preventive care services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months  <b>Note:</b> Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered  <b>Note:</b> Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50  <b>Note:</b> A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

\* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be

required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - <b>does not</b> include private duty nursing	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance use disorder)	Covers Medicare deductible
<ul style="list-style-type: none"> <li>Days 1-60 of each benefit period</li> </ul>		
<ul style="list-style-type: none"> <li>Days 61-90 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Additional days</li> </ul>	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

Alternatives to hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria	Covered at 100% of Medicare approved amount	Covered in full by Medicare
<ul style="list-style-type: none"> <li>Days 1-20 of each benefit period</li> </ul>		
<ul style="list-style-type: none"> <li>Days 21-100 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
<ul style="list-style-type: none"> <li>Days 101 and after</li> </ul>	Not covered	Not covered

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a <b>Medicare-certified</b> home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

Surgical services provided by a physician		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

## Human organ transplants

**Note:** Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered	Not covered
	<b>Note:</b> Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	<b>Note:</b> Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

Mental health care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
<b>Inpatient</b> mental health care in psychiatric facility	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance)	Covers Medicare deductible and daily coinsurance
<ul style="list-style-type: none"> <li>Days 1-190 <b>lifetime</b></li> </ul>	<b>Note:</b> In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	
<ul style="list-style-type: none"> <li>Additional days after 190 lifetime days are used</li> </ul>	Not covered	Not covered
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
	<b>Note:</b> If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	

## Other covered services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

## Foreign travel

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

## BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy). If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy).

## Member's responsibility (copays and coinsurance amounts)

**Note:** Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage

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**Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs \* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services				
Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved <b>generic</b> and <b>select brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved <b>brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved <b>generic</b> and <b>select brand name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved <b>brand name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/ coinsurance	100% of approved amount less plan copay/ coinsurance	100% of approved amount less plan copay/ coinsurance	75% of approved amount less plan copay/ coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
<b>Note:</b> Needles and syringes have no copay/ coinsurance.				

\* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

## Features of your prescription drug plan

Custom Drug List	<p>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 drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - 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/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, 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. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>
Drug interchange and generic copay/ coinsurance waiver	<p>BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> 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. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>