DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

Post 65 Benefit Enrollment and Change of Status Form

DSRA Benefit Trust

Thank you for your time and attention as you enroll for benefits with the DSRA-BT. Please complete in ink and check the applicable boxes (☐) below.

❒ SECTION 1: Member Information

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /
Address	City	State	Zip
Telephone Number	Social Security Number	Gender ☐ Male ☐ Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: ☐ Part A ☐ Part B	If waiting on Medicare #, Check Here* ☐
Email Address	Retirement Date		
Effective Date / /	Salary / Hourly ☐ Salary ☐ Hourly	If Hourly, Name of Union	

❒ SECTION 2: Spouse/Surviving Spouse Information (If Enrolling)

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /
Retirement Date	Social Security Number	Gender ☐ Male ☐ Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: ☐ Part A ☐ Part B	If waiting on Medicare #, Check Here* ☐

❒ SECTION 3: Important Notes to Help You Correctly Select & Compare Your Coverage Election

1. 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 turn 65. If you turn 65 on the 1st of the month, your coverage is effective on the 1st of the month prior to your 65th birthday. 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 1/1/2022.
2. Please review all information and sign and date where necessary.

❒ SECTION 4: Select Your Coverage

To elect Medical coverage, you must 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 DSRA-BT 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 now offered.

Please refer to the 2022 Health Matters Brochure for the monthly medical and prescription drug plan premiums.

*If you are enrolling and not the Retiree, include Retiree's Name and Date of Birth and Retirement Date from Delphi in the provided fields above.

Please pay special attention to the coverage options. There are two BCBSM Prescription Drug plans, High and Low available for DSRABT participants with the Hartford Medigap plans, BCBSM Medicare Advantage plans or as "standalone" plans.

Medical Plan Selection -

NEW BCBSM Medicare Advantage is Paired with the BCBSM RX HIGH Plan - BCBSM

☐ DIAMOND	☐ EMERALD	☐ RUBY
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse		

A Prescription Drug Plan is included with all of the Medicare Advantage Plans

The Hartford

☐ Premium	☐ Elite	☐ Choice	☐ Premium Plus
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse			

BCBSM Standalone RX

☐ HIGH RX	☐ LOW RX
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse	

Dental & Vision - BCBSM

☐ High Dental	☐ Low Dental	☐ Vision
☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse	☐ Retiree ☐ Spouse ☐ Retiree & Spouse
TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse	TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse	TERMINATE COVERAGE CONTRACT ☐ Retiree ☐ Spouse ☐ Retiree & Spouse

❒ SECTION 5: Signature

Retiree Signature: (If Enrolling) _____ **Date:** _____

Spouse/Domestic Partner Signature: (If Enrolling) _____ **Date:** _____

❒ SECTION 5: Release of Information

By joining this plan, 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 this 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.

❒ SECTION 6: Signature

Retiree Signature: (If Enrolling) _____ **Date:** _____

Spouse/Domestic Partner Signature: (If Enrolling) _____ **Date:** _____

If you are the authorized representative, please provide the following information:

Name _____

Address _____

Phone Number _____

Relationship to Retiree _____

Please return your completed enrollment form AND your Hartford form if enrolling in or changing medical plans to Benistar, our plan administrator:

Mail: Benistar Admin Services
10 Tower Lane, Suite 100
Avon, CT 06001

Email: memelig@benistar.com

Fax: 1-860-408-7025

❒ Terms & Conditions

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.

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. Coverage begins on the date determined by Blue Cross. When Blue Cross accepts 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.

Authorization: I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Blue Cross® Blue Shield® of Michigan 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 and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with Blue Cross, and for other purposes necessary for Blue Cross to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross requires me to provide my Social Security Number. In applying for coverage, I and 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 for purpose of administering our coverage. Upon my request, Blue Cross will tell me where the information was sent.

❒ BCBSM Medicare Advantage with HIGH Prescription Drug Plan

OPTIONS	Diamond	Emerald	Ruby
Type of network	Passive	Passive	Passive
Out of pocket maximum	$0	$750	$4,500
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
MA Rate	$285.94	$224.02	$109.04

The BCBSM Medicare Advantage rates above include the admin fee

❒ BCBSM Standalone Prescription Drug Plans

BCBSM (High and Low) Prescription Drug Plan	Monthly Cost
High RX	$91.90
Low RX	$72.92

The BCBSM PDP Standalone rates above do NOT include the $10 admin fee

❒ BCBSM Dental and Vision Standalone Rates

	LOW PLAN			HIGH PLAN		
	Dental /Vision	Dental Only	Vision Only	Dental /Vision	Dental Only	Vision Only
Single	$70.82	$64.75	$ 6.07	$74.90	$68.83	$ 6.07
Two-Person	$137.39	$125.25	$ 12.14	$145.55	$133.41	$ 12.14

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

DENTAL & VISION

DSRA-BT offers dental and vision coverage through Blue Cross Blue Shield of Michigan (BCBSM). Both plans offer comprehensive coverage. If you would like to enroll in dental and vision coverage or change your current elections, please contact Benistar at 1-888-588-6682 or access the BCBSM DSRA-BT enrollment form on the DSRA-BT website – www.dsrabenefittrust.net.

VOLUNTARY LIFE – Delphi hourly retirees are not eligible for this voluntary benefit

If you elected voluntary coverage in the past, your benefit will continue through 2022. No action is required. If, however, you are a Delphi salaried retiree and wish to elect voluntary term life insurance with Guardian Life for the first time or make any modifications to your current election, you must complete the Guardian Evidence of Insurability Form. This form can be found on the DSRA-BT website – www.dsrabenefittrust.net.

❒ The Hartford with BCBSM Prescription Drug Plans

Premiums for 2022 are summarized in the following charts:

STANDALONE PLAN RATES Admin fee already included (plan administration, billing and claims)	INSURED'S AGE BANDED RATES				
	65-69	70-74	75-79	80-84	85+
Elite (Mirrors Plan F)	$ 169.55	$ 208.83	$ 259.62	$ 316.19	$ 353.85
Premium Plus Plan (Mirrors Plan G)	$ 152.64	$ 187.36	$ 232.29	$ 282.30	$ 315.60
Premium Plan	$ 130.01	$ 158.60	$ 195.72	$ 236.99	$ 264.46
Choice Plan	$ 108.32	$ 131.15	$ 160.67	$ 193.56	$ 215.44
Florida Residents ONLY	$ 224.76 *(NO AGEBANDS for FL)*				
MEDICAL PLAN + HIGH RX PLAN - MONTHLY RATES					
Elite (Mirrors Plan F)	$ 261.45	$ 300.73	$ 351.52	$ 408.09	$ 445.75
Premium Plus Plan (Mirrors Plan G)	$ 244.54	$ 279.26	$ 324.19	$ 374.20	$ 407.50
Premium Plan	$ 221.91	$ 250.50	$ 287.62	$ 328.89	$ 356.36
Choice Plan	$ 200.22	$ 223.05	$ 252.57	$ 285.46	$ 307.34
MEDICAL PLAN + LOW RX PLAN - MONTHLY RATES					
Elite (Mirrors Plan F)	$ 242.47	$ 281.75	$ 332.54	$ 389.11	$ 426.77
Premium Plus Plan (Mirrors Plan G)	$ 225.56	$ 260.28	$ 305.21	$ 355.22	$ 388.52
Premium Plan	$ 202.93	$ 231.52	$ 268.64	$ 309.91	$ 337.38
Choice Plan	$ 181.24	$ 204.07	$ 233.59	$ 266.48	$ 288.36

*Rates do include the $3.00 DSRA-BT administration fee.

IMPORTANT

CHANGES FOR 2022

- The DSRA BT Post-65 medical plans offered through the Hartford have been simplified. All plan levels are now available to all members in all states.
- The DSRA-BT prescription drug plans are now offered by BCBSM. There are two options (High Plan and Low Plan) available to members. 85% of DSRA Benefit Trust members never reach the coverage gap "donut hole". Having the low plan option could save you money. The high plan is comparable to the previous Express Scripts plan offered.