



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		If waiting on Medicare #, Check Here* <input type="checkbox"/>		
Email Address			Retirement Date			
Effective Date / /		Salary / Hourly <input type="checkbox"/> Salary <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		If waiting on Medicare #, Check Here* <input type="checkbox"/>		

☐ 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 1/1/2021.
2. Your spouse/domestic partner must have the same medical/prescription coverage as the Retiree.
3. 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 2021 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 AETNA Prescription Drug plans, High and Low available for DSRA-BT participants with the Hartford Medigap plans, AETNA Medicare Advantage plans or as “standalone” plans. 85% of DSRA-BT members do not reach the coverage gap “donut hole”. Enrolling in the Low plan could save you money.

Medical Plan Selection - The Hartford

<input type="checkbox"/> Premium <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Elite <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Choice <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Premium Plus <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse
<input type="checkbox"/> Terminate Contract If coverage is terminated (Retiree, spouse/domestic partner, and/or dependent) – regardless of the reason – you CANNOT re-enroll in any of the Post-65 medical/prescription plans at a later date including during a subsequent open enrollment.			

NEW Medicare Advantage - AETNA

<input type="checkbox"/> Aetna \$20 PPO w/ High RX (11S3) <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Aetna \$25 PPO w/ Low RX (1203) <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse
<input type="checkbox"/> Terminate Contract If coverage is terminated (Retiree, spouse/domestic partner, and/or dependent) – regardless of the reason – you CANNOT re-enroll in any of the Post-65 medical/prescription plans at a later date including during a subsequent open enrollment.	

NEW Prescription Drug Plan Selection - AETNA

<input type="checkbox"/> High RX (11S3) <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Low RX (1203) <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse
<input type="checkbox"/> Terminate Contract If coverage is terminated (Retiree, spouse/domestic partner, and/or dependent) – regardless of the reason – you CANNOT re-enroll in any of the Post-65 medical/prescription plans at a later date including during a subsequent open enrollment.	

Dental & Vision - BCBSM

<input type="checkbox"/> High Dental <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Terminate Coverage	<input type="checkbox"/> Low Dental <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Terminate Coverage	<input type="checkbox"/> Vision <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Terminate Coverage
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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.

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 2021. 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 AETNA Prescription Drug Plans

Premiums for 2021 are summarized in the following charts:

PLAN OPTIONS Medical & RX	Age Band	Monthly Premium Per Person	RX Low Plan Per Person	RX High Plan Per Person	Total Premium w/ Low RX	Total Premium w/ High RX
ELITE Retiree Medical Plan	65-69	\$166.55	\$90.93	\$116.10	\$257.48	\$282.65
	70-74	\$205.83	\$90.93	\$116.10	\$296.76	\$321.93
	75-79	\$256.62	\$90.93	\$116.10	\$347.55	\$372.72
	80-84	\$313.19	\$90.93	\$116.10	\$404.12	\$429.29
	85+	\$350.85	\$90.93	\$116.10	\$441.78	\$466.95
PREMIUM Retiree Medical Plan	65-69	\$127.01	\$90.93	\$116.10	\$217.94	\$243.11
	70-74	\$155.60	\$90.93	\$116.10	\$246.59	\$271.76
	75-79	\$192.72	\$90.93	\$116.10	\$283.65	\$308.82
	80-84	\$233.99	\$90.93	\$116.10	\$324.92	\$350.09
	85+	\$261.46	\$90.93	\$116.10	\$352.39	\$377.56
CHOICE Retiree Medical Plan	65-69	\$105.32	\$90.93	\$116.10	\$196.25	\$221.42
	70-74	\$128.15	\$90.93	\$116.10	\$219.08	\$244.25
	75-79	\$157.67	\$90.93	\$116.10	\$248.60	\$273.77
	80-84	\$190.56	\$90.93	\$116.10	\$281.49	\$306.66
	85+	\$212.44	\$90.93	\$116.10	\$303.37	\$328.54
PREMIUM PLUS Retiree Medical Plan	65-69	\$149.64	\$90.93	\$116.10	\$240.57	\$265.74
	70-74	\$184.36	\$90.93	\$116.10	\$275.29	\$300.46
	75-79	\$229.29	\$90.93	\$116.10	\$320.22	\$345.39
	80-84	\$279.30	\$90.93	\$116.10	\$370.23	\$395.40
	85+	\$312.60	\$90.93	\$116.10	\$403.53	\$428.70

*Rates do Not include the \$3.00 DSRA-BT administration fee.

IMPORTANT *CHANGES FOR 2021*

- 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 AETNA. 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.

AETNA Medicare Advantage with Prescription Drug Plans

Medicare Advantage Plans	Medical \$20 PPO with High RX (11S3)		Medical \$25 PPO with LOW RX (1203)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$0	\$0	\$0	\$0
Annual Out-of-Pocket	\$6,700	\$10,000 for in and out of network services combined	\$6,700	\$10,000 for in and out of network services combined
Primary Care Physician Selection	Optional	Not Applicable	Optional	Not Applicable
Referral Requirement	There is no requirement for member pre-certification. Your provider will do for you.		There is no requirement for members pre-certification. Your provider will do for you	
PREVENTATIVE CARE				
Annual Wellness Exams	\$0	20%	\$0	25%
Routine Physical Exams	\$0	20%	\$0	25%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	\$0		\$0	
Routine GYN Care)Cervical and Vaginal Cancer Screening	\$0	20%	\$0	25%
Routine Mammograms (Breast Cancer Screening) one Annual Screening	\$0	20%	\$0	25%
Routine Prostate Cancer Screening Exam for males over age 50, every 12 months	\$0	20%	\$0	25%
Routine Colorectal Cancer Screening	\$0	20%	\$0	25%
Routine Bone Mass Measurements	\$0	20%	\$0	25%
Additional Medicare Preventative Services	\$0	20%	\$0	25%
Routine Eye Exams	\$0	20%	\$0	25%
Routine Hearing Screening	\$0	20%	\$0	25%
Physician Services				
Primary Doctor Office Visit	\$10 copay	20%	\$25 copay	25%
Specialist Office Visit (includes mental health & substance abuse)	\$20 copay	20%	\$25 copay	25%
Outpatient Diagnostic Testing, Imaging, X-ray, Complex Imaging	\$20 copay	20%	\$25 copay	25%
Emergency/Urgent Care Services				
Emergency Care Worldwide (copay waived, if admitted)	\$50 copay	\$50 copay	\$90 copay	\$90 copay
Urgent Care: Worldwide	\$35	\$35	\$25	\$25
Ambulance	\$0	\$100	\$25 copay	25%
Hospital Services				
Hospital Admissions member cost sharing applies to covered benefits incurred during member's inpatient stay	Covered 100%	20%	\$250 per stay	25%

 AETNA Standalone Prescription Drug Plans

AETNA (High and Low) Prescription Drug Plan	Monthly Cost
High RX (11S3)	\$122.10
LOW RX (1203)	\$96.93

The AETNA PDP Standalone rates above include the \$6 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	\$66.12	\$60.84	\$5.28	\$69.94	\$64.66	\$5.28
Two-Person	\$127.99	\$117.43	\$10.56	\$135.63	\$125.07	\$10.56
Family	\$189.86	\$174.02	\$15.84	\$201.32	\$185.48	\$15.84

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

 BCBSM Dental and Vision taken with Hartford or Medicare Advantage Plan Rates

	LOW PLAN			HIGH PLAN		
	Dental /Vision	Dental Only	Vision Only	Dental /Vision	Dental Only	Vision Only
Single	\$61.87	\$56.59	\$5.28	\$65.69	\$60.41	\$5.28
Two-Person	\$123.74	\$113.18	\$10.56	\$131.38	\$120.82	\$10.56
Family	\$185.61	\$169.77	\$15.84	\$197.07	\$181.23	\$15.84

No admin fee is added to the BCBSM Dental & Vision rates when enrolling in a bundled medical, dental and/or vision.