DSRA★BENEFIT TRUST

BENEFIT PLANS FOR DELPHI RETIREES

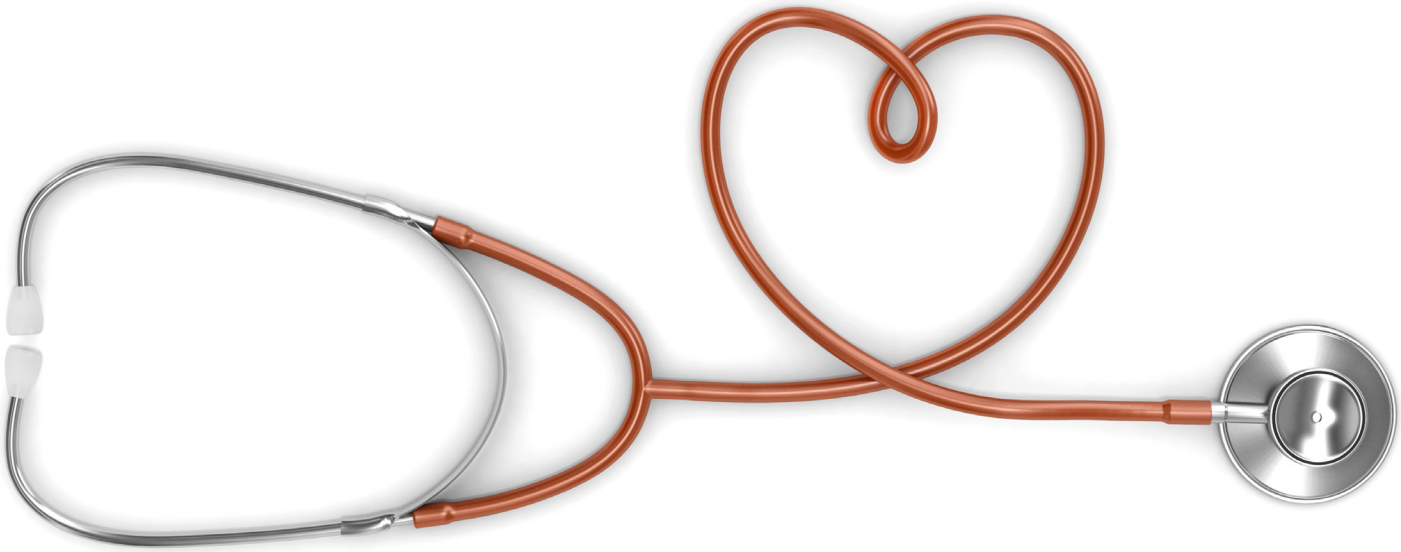
2019 GUIDE TO BENEFITS

for Pre-65 Members

Table of Contents

Who is Eligible for Benefits? 3
Medical & Prescription Drug Benefits 5
- Retirees Under Age 65 5
  - Understanding Terminology 6
  - Health Savings Account 7
- Medicare Disabled Retirees or Eligible Dependents Under Age 65 8
- Health Insurance Marketplace 9
- Retirees Post 65 9

Dental Benefits 10
Vision Benefits 11
Voluntary Life Benefits 12
Subsidies 12
Medical Rates 15
Dental & Vision Rates (Stand Alone) 16
Voluntary Life Rates Through Guardian 16
Billing & Payments 17
Medical Plan Footnotes 18



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 and 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. Spouse only life coverage is NOT available.

Spouse must have the same medical/prescription coverage as the Retiree if both are enrolled and in the same age category:

- Under Age 65
- Post-65

The exception to this is if the Retiree and spouse are both Under Age 65 but one of them is on Medicare. A spouse may have dental and/or vision with or without Retiree coverage.

Surviving Spouse

A surviving spouse is eligible for medical/prescription, dental, and vision coverage.

Former Spouse

Blue Cross Blue Shield of Michigan (BCBSM), 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. A dependent child is defined as an unmarried child up to age 26. The dependent child can remain on the coverage through the end of the calendar year during which they were no longer eligible, i.e. March 29th birthday can continue until December 31st. A disabled child is not subject to the age limitation. (Disabled child must have been on coverage prior to becoming disabled if beyond maximum age limitations).

Child(ren) must have the same medical/prescription coverage as Retiree and/or spouse if both are enrolled in Under Age 65 medical/prescription. Exceptions to this include:

- Retiree and spouse are both Under Age 65, but one of them is on Medicare
- Disabled child is on Medicare

A disabled child on Medicare must enroll in the BCBSM Pre-65 Medicare Disabled plan. Child(ren) may have dental and/or vision with or without Retiree coverage.

Qualified Family Members

A Qualified Family Member (QFM) is also eligible to elect medical/prescription, dental, and vision benefits. A QFM is defined as a spouse or dependent child(ren) of an HCTC-eligible Retiree, who can be claimed on the individual's federal income tax return. **NOTE: The HCTC is only available to a QFM for 24 months after the retiree reaches age 65.**

Termination

Retirees Under Age 65

Once a Retiree reaches age 65, his/her coverage in the Under Age 65 medical/prescription plan will terminate the first day of the month that they turn age 65. Eligible dependents under the age of 65 may elect to continue the coverage. However, if retiree carries dental &/or vision, this will automatically continue. A Retiree will not be auto-enrolled in a Post-65 plan because an application is required. Approximately 120 days prior to the event date (65th birthday), an enrollment kit will be mailed to the Retiree by Mercer, our post-65 plan administrator.

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.

If someone (Under age 65 Retiree, spouse, and/or dependent child) had voluntary life coverage through Reliance Standard but terminated it, he/she can reapply for coverage, ***but*** will be subject to underwriting and approval by Guardian.

Retirees Post-65

An individual enrolled in the Post-65 medical/prescription plan who terminates coverage ***can*** re-enroll in the plan during a subsequent annual open enrollment.

If someone (Retiree, spouse, and/or dependent child) had Under Age 65 medical/prescription coverage but terminated it, he/she ***can*** enroll in the Post-65 plan.

If someone (Retiree, spouse, and/or dependent child) was enrolled in dental or vision while under 65 and it was terminated, he/she ***can*** re-enroll in the dental plan when he/she turns 65.

If someone (Post-65 Retiree, spouse, and/or dependent child) had voluntary life coverage through Reliance Standard but terminated it, he/she ***can*** reapply for coverage, but will be subject to underwriting and approval by Guardian.

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 BCBSM, our pre-65 plan administrator, or Mercer, our post-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)
- HCTC eligibility coverage
- **NEW!** Qualified Family Member loses the DSRA subsidy due to the spouse turning 69

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.

If the qualifying event is **involuntary loss of other coverage**, you may enroll in coverage or change coverage tier (e.g. Single, Two-Person, Family). You cannot, however, change the plan(s) in which you or a family member is enrolled.

If the qualifying event is **becoming HCTC eligible** (e.g. beginning to collect a PBGC pension or receive TAA, ATAA, or RTAA benefits), you may enroll in or change the plan(s) in which you are enrolled (e.g. "upgrade" your coverage).

If the qualifying event is **losing HCTC eligibility,** you may change the plan(s) in which you are enrolled (e.g. "downgrade" your coverage).

If the qualifying event is **losing the DSRA subsidy** due to their spouse turning 69, the Qualified Family Member is eligible to change plans.

If the qualifying event is **delayed initiation of your PBGC pension**, you may enroll in coverage provided you left Delphi previous to the current year, initiated receipt of pension in the current year, have filed paperwork with the PBGC to start payment and provide a copy of the PBGC pension issuance application along with your BCBSM enrollment form.

Medical & Prescription Drug Benefits

We know how important good health is to you and your family. That is why the DSRA-BT provides you medical plan options that protect against the unexpected and help meet your routine health care needs.

Retirees Under Age 65

DSRA-BT offers *four* medical plan choices to retirees under the age of 65. All medical plans are administered 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]

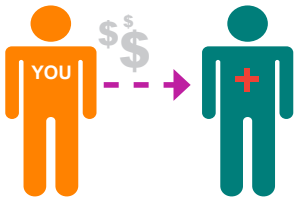
	Option #1 – GOLD		Option #2 – SILVER		Option #3 – BRONZE		Option #4 – COPPER	
Medical Plan Description	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Ded) [1,2]								
Individual	$250	$500 [3]	$500	$1,000 [3]	$2,000 [4]	$4,000 [4]	$4,000 [4]	$8,000 [4]
Two Person	$500	$1,000 [3]	$1,000	$2,000 [3]	$4,000 [4,5]	$8,000 [4,5]	$8,000 [4,5]	$16,000 [4,5]
Family	$500	$1000 [3]	$1,000	$2,000 [3]	$4,000 [4,5]	$8,000 [4,5]	$8,000 [4,5]	$16,000 [4,5]
Your Coinsurance % (Coins%) [6]	20% [7]	40%	20%	40%	20%	40%	20%	40%
Annual Coinsurance Dollar Maximums [8]								
Individual	$1,000	$3,000	$2,500	$5,000	$1,000	$2,000	$1,250	$2,250
Two Person	$2,000	$6,000	$5,000	$10,000	$2,000	$4,000	$2,450	$4,500
Family	$2,000	$6,000	$5,000	$10,000	$2,000	$4,000	$2,450	$4,500
Physician Visit								
Primary Care Physician (PCP) / Specialist Care Physician (SCP)	$10	Ded+Coins%	$20	Ded+Coins%	Ded+Coins%		Ded+Coins%	
Preventive Care Services (PCP / SCP)	Cov'd 100% (up to $1,000)	Not Covered	Cov'd 100%	Not Covered	Cov'd 100%	Not Covered	Cov'd 100%	Not Covered
In-Patient/Out-Patient Hospital Service	Ded+Coins%		Ded+Coins%		Ded+Coins%		Ded+Coins%	
Emergency Room Services	$50		$150		Ded+Coins%		Ded+Coins%	
Urgent Care Services	$10	Ded+Coins%	$20	Ded+Coins%	Ded+Coins%		Ded+Coins%	
Durable Medical Equipment	Ded+Coins%		Ded+Coins%		Ded+Coins%		Ded+Coins%	
Hearing Care Coverage [9]	Cov'd 100%	Not Covered	Cov'd 100% after Ded	Not Covered	Cov'd 100% after Ded	Not Covered	Cov'd 100% after Ded	Not Covered
Mental Health Care/Substance Abuse [10]	Ded+Coins%		Ded+Coins%		Ded+Coins%		Ded+Coins%	
Human Organ Transplants								
Specified Human Organ [11]	Cov'd 100% [12]	Ded+Coins%	Cov'd 100%	Ded+Coins%	Ded+Coins%		Ded+Coins%	
Bone Marrow [11]	Ded+Coins%		Ded+Coins%		Ded+Coins%		Ded+Coins%	
Specified Oncology Clinical Trials	Ded+Coins%		Ded+Coins%		Ded+Coins%		Ded+Coins%	
Kidney, Cornea and Skin	Ded+Coins%		Ded+Coins%		Ded+Coins%		Ded+Coins%	
Retail Pharmacy Prescription Drug Plan (30-day Supply) [13,14,15,16,17,18,19]					**After Deductible Copays**		**After Deductible Copays**	
Tier 1 – Generic	$10	$10/$20/$40 + 25% Coins	$10	$10/$40/$80 + 25% Coins	$15	$15/$50/$70 + 20% Coins	$15	$15/$50/$70 + 20% Coins
Tier 2 – Brand Name Formulary	$20		$40		$50		$50	
Tier 3 – Brand Name Non Formulary	$40		$80		$70 or 50% [20]		$70 or 50% [20]	
Rx Mail Order Pharmacy Prescription Drug Plan (90-day Supply) [13,14,15,16,17,18,19]					**After Deductible Copays**		**After Deductible Copays**	
Tier 1 – Generic	$20	Not Covered	$20	Not Covered	$30	Not Covered	$30	Not Covered
Tier 2 – Brand Name Formulary	$40		$80		$100		$100	
Tier 3 – Brand Name Non Formulary	$80		$160		$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	No		No		*Yes!*		*Yes!*	

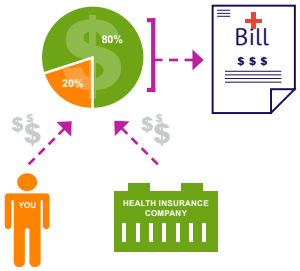
i Refer to the back of the booklet for plan footnotes.

Understanding Terminology

Deductible

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



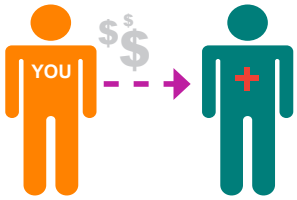


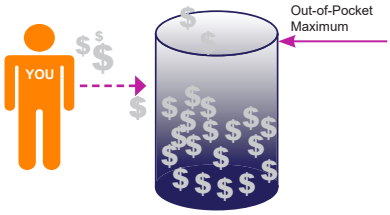
Coinsurance

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%.

Copay

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





Out-of-Pocket Maximum

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.

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

If you cover dependents, under the GOLD, SILVER or COPPER 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.** [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 where. 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.

2019 IRS Annual Contribution Limits

Individual	$3,500
Family	$7,000
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.

Medicare Disabled Retirees or Eligible Dependents Under Age 65

DSRA-BT offers a medical plan – administered by Blue Cross Blue Shield Michigan (BCBSM) – to **Medicare disabled** retirees or dependents under the age of 65. The table below provides an overview of the medical plan. For complete details about the plans, please refer to the Benefits-at-a-Glance summary of benefits on the website at **www.dsrabenefittrust.net**.[i]

- Dental and vision are not included in this plan and must be purchased separately.
- Separate enrollment forms are required if the household has more than one member.

		Pre-65 Medicare Disabled Plan	
Medical Plan Description	Medicare	BCBSM	You
Preventive Care Screening [21, 22]			
Pap Test – Laboratory Service Only (every 2 years)	80-100%	100% after Medicare	$0
Gynecological Exam (every 2 years after age 50)	80-100%	100% after Medicare	$0
Prostate Cancer Screening (1x/year)	80%	100% after Medicare	$0
Mammogram Screening (1x/year after age 50)	$80	100% after Medicare	$0
Hospital Confinement Benefit [23, 24]			
1 – 60th Day	All but $1,316	$1,316	$0
61st – 90th Day	All but $329/day	$329/day	$0
91st – 150th Day (60 Day Lifetime Reserve Period)	All but $658/day	$658/day	$0
Once Lifetime Reserve Days are Used (or Ended) Addt'l 365 Days per Person per Lifetime	$0	100% (up to an addt'l 275 days)	$0 (until you use all addt'l 275 days, then you pay 100%)
Home & Office Visits	All but $147	$0	100%
Out-Patient Mental Health Care	All but $147	100%	$0
Out-Patient Medical Expenses [25]			
Medicare Part B Deductible of Medicare-Approved Amounts	$0	$147	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services	100%	$0	$0
Part B Excess Charges	$0	$0	100%
Blood Deductible [26]			
1 – 3 Pints	$0	100%	$0
Addt'l Amounts	100%	$0	$0
Skilled Nursing Facility Care [27, 28]			
1 – 20th Day	100%	$0	$0
21st – 100th Day	All but $161/day	Up to $161/day	$0
101st – 365th Day	$0	$0	All costs
Hospice Care [29]	All costs (limited to costs for out-patient drug & in-patient respite care)	Co-insurance charges (in-patient respite care, drugs & biological approved by Medicare)	$0
Foreign Travel Emergency	$0	Covered hospital services for up to 30 days & covered physician services up to BCBSM-approved amount	All costs for non-covered services
Retail Pharmacy Prescription Drug Plan (30-day Supply) [30, 31, 32, 33, 34, 35]			
Tier 1 – Generic	N/A		$10
Tier 2 – Brand Name Formulary	N/A		$40
Tier 3 – Brand Name Non Formulary	N/A		$80
Rx Mail Order Pharmacy Prescription Drug Plan (90-day Supply) [30, 31, 32, 33, 34, 35]			
Tier 1 – Generic	N/A		$20
Tier 2 – Brand Name Formulary	N/A		$80
Tier 3 – Brand Name Non Formulary	N/A		$160

i **All Medicare benefits are based on 2018 reimbursements.**

Health Insurance Marketplace

Under the Affordable Care Act (ACA), a.k.a. "health care reform" or "Obamacare," the Health Insurance Marketplace offers a resource for purchasing health coverage that will be operated by either the federal or state government depending on the member's state of residence. If you buy insurance in the Health Insurance Marketplace you **DO NOT** qualify for the HCTC.

The Individual Mandate

The ACA includes a requirement that most individuals buy "minimum essential coverage," both for themselves and for children residing in the taxpayer's household who are also tax dependents. This requirement is also referred to as the "individual mandate." Most types of major medical insurance coverage will satisfy this requirement, including health coverage purchased through an employer and qualified individual health insurance policies purchased in the public Health Insurance Marketplace or in the private market, as well as Medicare Part A, Medicaid or state high risk pool coverage. **Health coverage purchased through the DSRA-BT will satisfy the requirements of the individual mandate.**

Beginning January 1, 2019, the federal tax penalty for someone who does not purchase health coverage to satisfy the individual mandate has been reduced to $0. However, some states have begun implementing their own individual mandate penalty. As of January 1, 2019, residents of Massachusetts and New Jersey will be subject to a tax penalty if they do not puchase health coverage. Additional states may follow suit in the future.

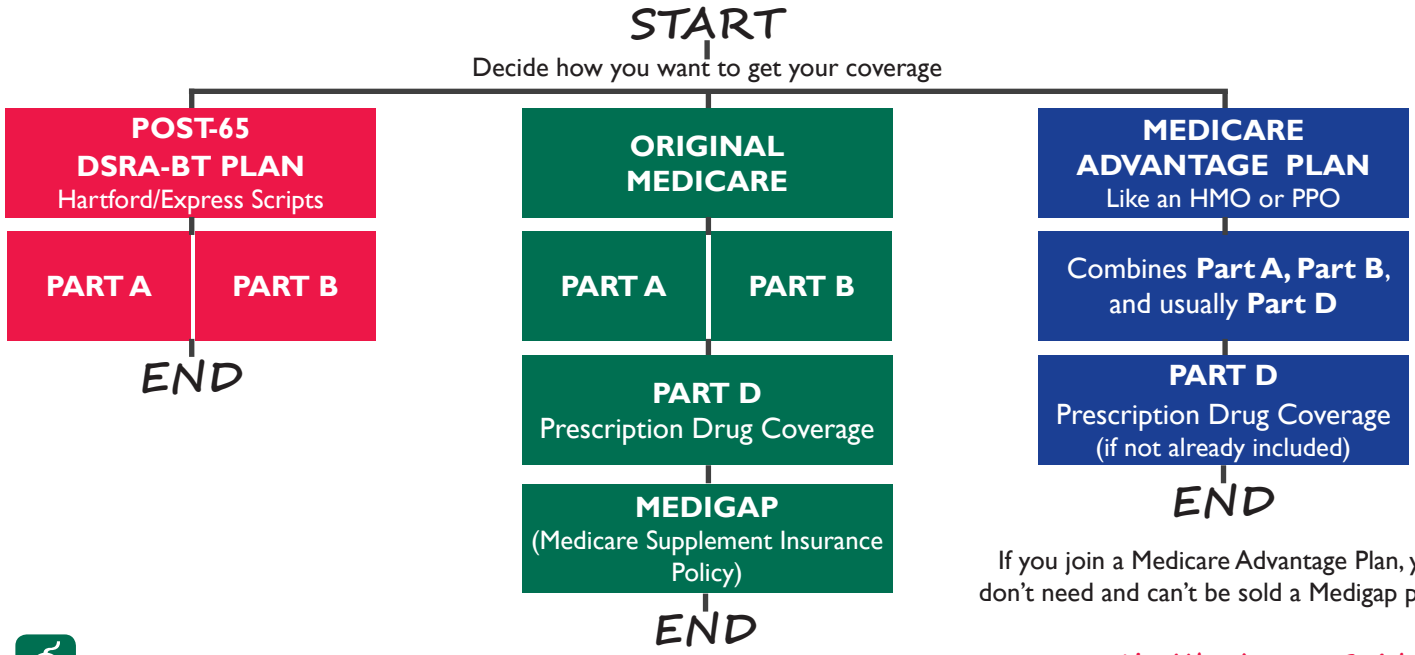
Federal Financial Assistance for Low Income Individuals

Under ACA provisions, individuals will qualify for financial assistance (in the form of advance premium tax credits and cost-sharing subsidies) if household modified adjusted gross income (MAGI) falls between 100% and 400% of the Federal Poverty Line (FPL). You are urged to consult your tax professional to determine your household MAGI for purposes of the ACA.

Retirees Post 65

DSRA-BT offers medical plan choices through The Hartford, which will remain unchanged for 2019, to retirees over the age of 65. Continued again for 2019, we will offer post-65 Medicare eligible retirees plans through The Hartford or a SelectQuote "hybrid" solution which explores other options for "an individual" Medicare supplement / Part D prescription or Medicare Advantage plan in their area. DSRA-BT has partnered with SelectQuote who can assist post-65 retirees with evaluating health care needs and understanding of which plan coverage option(s) best meet those needs. This is a free service to DSRA-BT participants. If retiree carries dental &/or vision, this will automatically continue when transitioning the from pre-65 Blue Cross Blue Shield Michigan Plan Option to the post-65 Medical options. You must provide BCBSM your Medicare ID number and your Part A and/or Part B effective date to receive the reduced dental and vision rates.

Express Scripts will offer one prescription plan option for members. Enrollees in The Hartford medical plan will continue to have the choice of the DSRA-BT prescription plan or a prescription plan from another provider of your choice. However, the enrollee cannot carry Express Scripts prescription coverage alone. They must also choose the Hartford Plan.



For complete details about the post-65 plan options including rates, please refer to the *2019 Health Matters Guide for Post-65 Members* on the website at **www.dsrabenefittrust.net**. Retirees may also contact a SelectQuote counselor at 1-877-336-DSRA (3772) for further information.

Dental Benefits

We understand the importance of good dental health. Good oral hygiene is important to your overall health. Regular visits to the dentist can help detect problems like gingivitis and even oral cancer. Plan on visiting your dentist once every six months.

DSRA-BT offers dental coverage through Blue Cross Blue Shield of Michigan (BCBSM). The dental plan provides a wide variety of covered services – either covered in full or partially by the plan. HCTC AMP-eligible members will automatically be enrolled in dental coverage regardless of medical plan selection (Gold, Silver, Bronze, or Copper). Non-HCTC AMP members will continue to have the choice to enroll in dental and/or vision which requires an application to be completed.

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**.

Annual Dental Maximum per Person	$3,000
Class I Service	
Includes but not limited to:	
Oral Exams Bitewing X-rays	0% = Your Coinsurance
Full Mouth X-Rays Fluoride Treatment	* 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 II Service	
Includes but not limited to:	
Fillings (for permanent & primary teeth) Repairs and Recementation of Onlays, Crowns, Veneers, Inlays, & Bridge	$50 = Your Deductible 20% = Your Coinsurance
Oral Surgery Root Canal	* 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 III Service	
Includes but not limited to:	
Dentures (complete & partial)	$50 = Your Deductible 50% = Your Coinsurance
Endosteal Implants Bridge Installations	* 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 IV Service	
Orthodontic services for dependents under age 19	50% = Your Coinsurance
Class IV Lifetime Maximum per Individual	$2,500

*Before getting any major procedure, make sure to check with your provider for complete rates and coverage information.

Vision Benefits

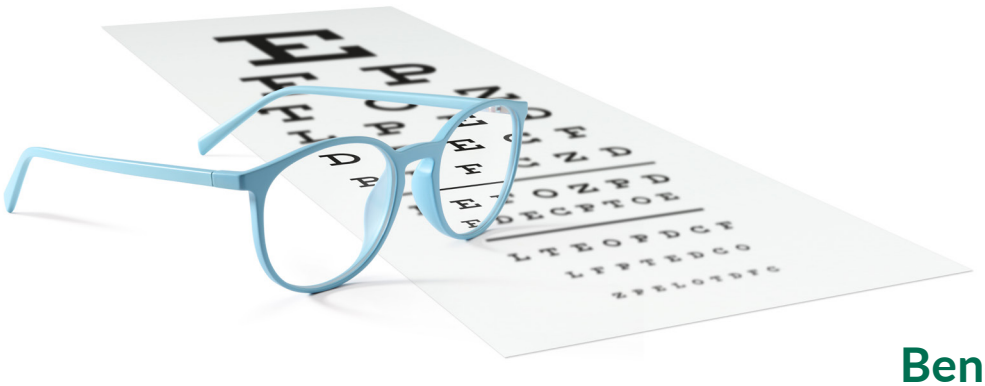
Your eyes are your windows to wellness. Routine eye exams each year allow your eye doctor to detect symptoms of serious eye disease – such as cataracts, glaucoma, and macular degeneration – and health conditions – such as diabetes, cardiovascular disease, and high blood pressure. Caught early, many of these diseases are treatable. However, left undetected and untreated, these conditions can result in vision loss, a lower quality of life, and higher overall health care costs.

DSRA-BT will continue to offer vision benefits through Blue Cross Blue Shield of Michigan (BCBSM). The vision plan offers you comprehensive coverage – including eye exams and materials – through VSP, the nation's largest vision care network, with 27,000 doctors and 41,000 locations.

HCTC AMP-eligible members will automatically be enrolled in vision coverage regardless of medical plan selection (Gold, Silver, Bronze, or Copper). Non-HCTC AMP members will continue to have the choice to enroll in vision and/or dental which requires an application to be completed.

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**.

	In-Network	Out-of-Network
Eye Exam		
Frequency	One eye exam in any period of 12 **consecutive** months	
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	Plan Reimburses Up to $45
Frames		
Frequency	One frame in any period of 24 **consecutive** months	
Standard frames	$15 Copay (Up to $130 Allowance)	Plan Reimburses Up to $70
Lenses		
Frequency	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground glass or plastic.	$15 Copay	*Single Vision:* Plan Reimburses Up to $30 *Bifocal:* Plan Reimburses Up to $50 *Trifocal:* Plan Reimburses Up to $65 *Lenticular:* Plan Reimburses Up to $100
Lens Options		
	Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor	Discounts are not available out-of-network
Contact Lenses		
Frequency	One pair of contact lenses in any period of 12 **consecutive** months	
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$15 Copay	Plan Reimburses Up to $210
Elective & disposable contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	$130 Allowance Applied toward contact lens exam (fitting and materials) and the contact lenses	$105 Allowance Applied toward contact lens exam (fitting and materials) and the contact lenses



Voluntary Life Benefits - New Carrier for 2019

Did you know that 61% of Americans have no life insurance coverage? The financial impact of death is not only significant, but the effects can be long-term, lasting five years or more for the surviving family members. [i]

DSRA-BT offers salaried Delphi retirees the opportunity to purchase voluntary life insurance for you and your spouse through Guardian. (NOTE: Delphi hourly retirees are not eligible for this voluntary benefit.) This plan is designed to complement the life insurance benefits you may already have and is 100% retiree-paid. Rates are guaranteed through 12/31/2021. Rates do change every five years on insured's birthdays ending in a 0 or 5. There is a small administrative fee to cover Mercer and DSRA-BT expenses.

If you have elected voluntary coverage in the past, your elected benefit will be transferred to Guardian into 2019. **No action is required.** If, however, you wish to make any modifications to your current election (e.g. increase or decrease your elected amount) or wish to elect voluntary term life insurance for the first time, you must complete the Guardian enrollment form and Statement of Health form. If your change is a reduction in benefits, then only an enrollment form is required, not a Statement of Health. This form can be found on our website - **www.dsrabenefittrust.net** - or you may contact Mercer, our voluntary life plan administrator, at 1-877-336-DSRA (3772) to obtain a copy of the form.

The table below provides an overview of the voluntary life benefit. For specific details about the plan, please refer to the summary of benefits on the website at **www.dsrabenefittrust.net**.

	Retiree	Spouse[1]
Coverage	$10,000 increments	$10,000 increments
Minimum	$10,000	$10,000
Maximum	$120,000	$30,000

i MetLife's Impact of Premature Death Study, 2010.

Subsidies

There are TWO distinct and separate subsidy programs you may be eligible for: 1. DSRA-BT subsidy from the Trust, 2. HCTC from the government. You cannot receive benefits from both of these programs at the same time.

DSRA-BT Subsidy

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 that are not eligible for the HCTC and who purchase medical insurance from the trust in 2019.

For 2019, the Board of Directors has determined the subsidies as follows:

	2019 Monthly DSRA-BT Subsidy Amount		
Plan Option	Single	Two Person	Family
Under Age 55 & Special Circumstance	$615	$1,470	$1,840
Under Age 65 & Medicare Disabled	$830	$1,660	N/A
*Under 65 QFM	$425		N/A
Post-65	*No subsidy available for post-65 members*		N/A

*Available to QFMs of a retiree who is age 67 or 68 only.

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 which makes them ineligible for the HCTC. The family member(s) will be eligible for the Special Circumstance subsidy until the retiree turns 67 or they turn 65, whichever comes first. If they are still under 65 when the retiree turns 67 they will be eligible for the QFM subsidy for 24 months.

There are pre-65 salaried retirees that retired before 4-2-09 that have not initiated their PBGC pension payout. This makes them ineligible for the HCTC and thus 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 67 or 68.

- Eligibility for this subsidy ends the first of the month the retiree achieves age 69.
- To receive this subsidy, you must be an eligible pre-April 2, 2009 salaried retiree; the retiree must be age 67 or 68 and thus no longer eligible for the HCTC to qualify for this subsidy.
- You must submit a new enrollment form to our pre-65 medical plan administrator (BCBSM) to qualify for this subsidy.
- 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.

Health Coverage Tax Credit

The Health Coverage Tax Credit (HCTC) was reauthorized June 29, 2015 and will remain in effect through the end of 2019. The HCTC provides premium assistance for 72.5% of healthcare premiums. You can obtain the HCTC in two different ways:

Option 1 = Pay your premiums in full and then claim the HCTC on your 2019 tax return through Form 8885, Health Coverage Tax Credit.
Option 2 = Take advantage of the Advance Monthly Payment program (see below).

Note: For 2019, if you purchase medical insurance through the Affordable Care Act Health Insurance Marketplace Insurance, you will not be eligible for the HCTC.

HCTC Eligibility

You may be eligible to elect the HCTC only if you are one of the following:

- An eligible trade adjustment assistance recipient, alternative TAA recipient or reemployment TAA recipient,
- An eligible Pension Benefit Guaranty Corporation payee, or
- The family member of an eligible TAA, ATAA, or RTAA recipient or PBGC payee who is deceased or who finalized a divorce with you.

You are **not** eligible for the HCTC if you:

- Can be claimed as a dependent on another person's federal income tax return or
- Are enrolled in Medicare, Medicaid, the Children's Health Insurance Program, or the Federal Employees Health Benefits Program or are eligible to receive benefits under the U.S. military health system (TRICARE)

The IRS administers the HCTC and anyone interested in the HCTC can visit the IRS HCTC website to review guidelines and for any additional information at https://www.irs.gov/credits-deductions/individuals/hctc.

QFM eligibility for the HCTC is established based on the age of the retiree. The HCTC law provides eligibility for QFM's for a limited 24 month time period. Once the retiree reaches the age of 65, his or her QFM's are eligible for the HCTC for a maximum of 24 months or until the retiree attains the age of 67 or the QFM attains the age of 65. The IRS does not monitor your eligibility for this subsidy. It is your responsibility upon the expiration of your HCTC eligibility to notify both the IRS and BCBSM. Upon termination of HCTC eligibility, if the QFM is still under the age of 65, you should review the subsidy eligibility requirements for the DSRA-Benefit Trust QFM subsidy.

Advance Monthly Payment Program (AMP)

The Advance Monthly Payment (AMP) program allows you to pay 27.5% of the premium to the IRS directly. The IRS then pays the entire premium to Blue Cross Blue Shield of Michigan on a monthly basis.

If you are currently in the AMP program you do not need to submit a new 13441-A form to the IRS. The IRS will work directly with BCBSM to update premiums. This is true whether you stay with your current plan or you want to change your plan (e.g. from Bronze to Gold).

If you are electing the HCTC (AMP) for the first time and are currently enrolled in a DSRA-BT healthcare plan, IRS Form 13441-A Monthly Health Coverage Tax Credit Group Registration is required along with a copy of your invoice from the last 60 days. Handwrite the 2019 premium on this invoice (i.e. 2019 Premium =____). It must be completely filled out and mailed to the IRS. (Visit our website at www.dsrabenefittrust.net or go to the IRS website at https://www.irs.gov/credits-deductions/individuals/hctc to obtain this form.) Once you receive your enrollment confirmation letter from the IRS, send it via mail, email, or fax along with your DSRA-BT/BCBSM benefit enrollment form to BCBSM.

For those people who are not currently in our plans and want to enroll in both the DSRA-BT healthcare with BCBSM and want to take advantage of the HCTC AMP program, you must first submit an enrollment form to BCBSM requesting the coverage tier you want (Gold, Silver, Bronze or Copper) with no mention of the HCTC. Wait at least FIVE business days and then call BCBSM customer service and request a letter from them indicating you will have healthcare coverage with them effective January 1, 2019. Once you receive this letter, fill out IRS form 13441-A and attach the BCBSM letter. If all your paperwork is filled out correctly, the IRS will send you an "enrolled letter" indicating you have been approved for the HCTC AMP. Your final step is to fill out another BCBSM enrollment form indicating you want to enroll for the HCTC AMP and attach the "enrolled letter" from the IRS. Refer to the HCTC FAQs > November 2018 Enrollment section > FAQ #3 for more details. This document is posted at our website.

Make sure you print out the IRS payment coupon, Form 13973, and mail it with your payment to the IRS between the 24th of December and the 10th of January for January coverage. Sample 13441-A Forms for various situations can be found at the following link: https://www.dsrabenefittrust.net/dsrabene/index.php/document-center/Health-Coverage-Tax-Credit-(HCTC)/Sample-Documents/. If you have questions regarding HCTC, please feel free to contact the IRS at 1-844-853-7210.

DSRA-BT Hardship Grant

The DSRA-BT will continue to provide financial assistance to those in need for the 2019 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 before April 2, 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.

Under Age 65

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 2019.

Once you accept a Hardship Grant, you will be ineligible for health coverage provided through DSRA-BT, and your coverage will expire December 31, 2018. 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, 2019.

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 and 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 group plan 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 2018, 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 Mercer, our Hardship Grant administrator at 1-877-336-DSRA (3772).

The deadline for completing the application process for both pre- and post-65 members is Friday, November 16, 2018. All materials must be received by this date.

Please submit your application as soon as possible to Mercer as indicated below:

Mail:	Mercer PO Box 14464 Des Moines, IA 50306	**Email:**	DSRA.services@mercer.com
Overnight Mail:	Mercer ATTN: Application Processing 12421 Meredith Dr. Urbandale, IA 50398	**Fax:**	(515) 365-1520

Mercer 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 2019, you will get a 1099 from DSRA-BT to be filed with your 2019 federal 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**.

Medical Rates

HCTC AMP Eligible Retirees Under Age 65

GOLD	Medical / Dental / Vision*	(-) 72.5% HCTC Subsidy	27.5% Member Cost
Single	$1,379.53	$1,000.16	$379.37
Two-Person	$3,282.31	$2,379.67	$902.64
Family	$4,173.38	$3,025.70	$1,147.68
SILVER	**Medical / Dental / Vision**	**(-) 72.5% HCTC Subsidy**	**27.5% Member Cost**
Single	$1,166.73	$845.88	$320.85
Two-Person	$2,771.61	$2,009.42	$762.19
Family	$3,535.00	$2,562.87	$972.13
BRONZE	**Medical / Dental / Vision**	**(-) 72.5% HCTC Subsidy**	**27.5% Member Cost**
Single	$911.24	$660.65	$250.59
Two-Person	$2,158.41	$1,564.85	$593.56
Family	$2,768.51	$2,007.17	$761.34
COPPER	**Medical / Dental / Vision**	**(-) 72.5% HCTC Subsidy**	**27.5% Member Cost**
Single	$794.64	$576.11	$218.53
Two-Person	$1,878.59	$1,361.98	$516.61
Family	$2,418.72	$1,753.57	$665.15

All HCTC Gold, Silver, Bronze, and Copper plans include Medical, Dental, and Vision Coverage.

NON-HCTC AMP Eligible Retirees Under Age 65

GOLD	Medical / Dental / Vision *			
Single	$1,379.53			
Two-Person	$3,282.31			
Family141	$4,173.38			
SILVER	**Medical / Dental / Vision**	**Medical / Dental**	**Medical / Vision**	**Medical Only**
Single	$1,166.73	$1,161.62	$1,100.41	$1,095.30
Two-Person	$2,771.61	$2,761.38	$2,638.97	$2,628.74
Family	$3,535.00	$3,518.03	$3,302.89	$3,285.92
BRONZE	**Medical / Dental / Vision**	**Medical / Dental**	**Medical / Vision**	**Medical Only**
Single	$911.24	$906.13	$844.92	$839.81
Two-Person	$2,158.41	$2,148.18	$2,025.77	$2,015.54
Family	$2,768.51	$2,751.54	$2,536.39	$2,519.43
COPPER	**Medical / Dental / Vision**	**Medical / Dental**	**Medical / Vision**	**Medical Only**
Single	$794.64	$789.53	$728.32	$723.21
Two-Person	$1,878.59	$1,868.36	$1,745.95	$1,735.72
Family	$2,418.72	$2,401.75	$2,186.61	$2,169.64

If you are eligible for a subsidy, please refer to that section in this Guide to see amounts.

Medicare Disabled Retirees or Eligible Dependents Under Age 65

The rates below only apply to **pre-65 Medicare disabled** members.

SILVER	Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only
Single	$1,708.44	$1,704.31	$1,646.45	$1,642.32
Two-Person	$3,416.88	$3,408.62	$3,292.90	$3,284.64

If you are eligible for a subsidy, please refer to that section in this Guide to see amounts.

Retirees Post-65

For complete details about the post-65 plan options including rates, please refer to the **2019 Health Matters Guide for Post-65 Members** at **www.dsrabenefittrust.net**. Retirees may also contact Mercer at 1-877-336-DSRA (3772) for further information.

Dental & Vision Rates (Stand Alone)

Retirees Under Age 65

	Dental / Vision	Dental Only	Vision Only
Single	$71.43	$66.32	$5.11
Two-Person	$142.87	$132.64	$10.23
Family	$249.08	$232.11	$16.97

Medicare Disabled Retirees or Eligible Dependents Under Age 65 Retirees Post-65

	Dental / Vision	Dental Only	Vision Only
Single	$66.12	$61.99	$4.13
Two-Person	$132.24	$123.98	$8.26
Family	$198.36	$185.97	$12.39

If you are over 65 and covered by Medicare, you must provide your Medicare ID number and Part A and/or Part B effective Date in Section 1 of the Benefit Enrollment and Change of Status Form or call BCBSM directly at (877) 354-2583 to receive the reduced rate.

Voluntary Life Rates Through Guardian

Retiree Estimated Monthly Cost [i, ii]

	Age									
Amount	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85-89**
$10,000	$1.03	$1.55	$2.38	$4.21	$6.62	$12.60	$20.79	$34.48	$56.03	$73.27
$20,000	$2.06	$3.10	$4.76	$8.42	$13.24	$25.20	$41.58	$68.96	$112.06	$146.54
$30,000	$3.09	$4.65	$7.14	$12.63	$19.86	$37.80	$62.37	$103.44	$168.09	$219.81
$40,000	$4.12	$6.20	$9.52	$16.84	$26.48	$50.40	$83.16	$137.92	$224.12	$293.08
$50,000	$5.15	$7.75	$11.90	$21.05	$33.10	$63.00	$103.95	$172.40	$280.15	$366.35
$60,000	$6.18	$9.30	$14.28	$25.26	$39.72	$75.60	$124.74	$206.88	$336.18	$439.62
$70,000	$7.21	$10.85	$16.66	$29.47	$46.34	$88.20	$145.53	$241.36	$392.21	$512.89
$80,000	$8.24	$12.40	$19.04	$33.68	$52.96	$100.80	$166.32	$275.84	$448.24	$586.16
$90,000	$9.27	$13.95	$21.42	$37.89	$59.58	$113.40	$187.11	$310.32	$504.27	$659.43
$100,000	$10.30	$15.50	$23.80	$42.10	$66.20	$126.00	$207.90	$344.80	$560.30	$732.70
$110,000	$11.33	$17.05	$26.18	$46.31	$72.82	$138.60	$228.69	$379.28	$616.33	$805.97
$120,000	$12.36	$18.60	$28.56	$50.52	$79.44	$151.20	$249.48	$413.76	$672.36	$879.24

Spouse Monthly Cost [iii]

	Age									
Amount	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85-89**
$10,000	$1.03	$1.55	$2.38	$4.21	$6.62	$12.60	$20.79	$34.48	$56.03	$73.27
$20,000	$2.06	$3.10	$4.76	$8.42	$13.24	$25.20	$41.58	$68.96	$112.06	$146.54
$30,000	$3.09	$4.65	$7.14	$12.63	$19.86	$37.80	$62.37	$103.44	$168.09	$219.81

i In addition to the above rates there is an administration charge of $4.50 per month.

ii 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.

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

Billing & Payments

Billing

Medical and Medicare Disabled – Under Age 65
Dental – Under Age 65 and Post-65
Vision – Under Age 65 and Post-65

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 post-65) – you will be billed monthly by BCBSM, our plan administrator unless you are in the HCTC AMP program (see below).

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 to make health premium payments.

BCBSM Payments

1. Enroll online through BCBSM's Member Secured Services at **www.bcbsm.com** to view your invoice and make a one-time monthly payment via eBilling.
2. Take advantage of automated payment plans utilizing your checking or savings account online through BCBSM's Member Secured Services at **www.bcbsm.com.**
3. Call BCBSM customer service using the number on your invoice or the back of your BCBSM ID card to make a payment over the phone with your checking, savings account, or credit card.

Special Notice for HCTC Members – Advance Monthly Payments (AMP)

The benefit of the Health Coverage Tax Credit will be offered on a monthly basis for 2019. You can choose to have 72.5% of your qualified health insurance premiums paid in advance directly to BCBSM each month on your behalf to lower your out-of-pocket payments for your monthly premiums, leaving you to pay the remaining 27.5% of the premium to the IRS. This is done through the **Advance Monthly Payments (AMP)** program.

If you are in the HCTC AMP program, late payments (after the 10th of the month) will be returned to you and the IRS will not pay your premium for that month to BCBSM. You will be responsible for the entire premium to maintain coverage.

If you don't participate in the AMP and, instead, pay 100% of your health insurance premiums in 2019, you can claim your HCTC when you file your federal income tax return in 2019. This will increase your refund or lower the amount of tax that you would otherwise owe.

Medical – Post-65

If you elect any of the post-65 plans offered through The Hartford, you will be billed monthly by Mercer, our post-65 plan administrator.

Voluntary Life – Under Age 65 and Post-65

If you elect voluntary life coverage through Guardian, you will be billed monthly by Mercer, our voluntary life plan administrator.

Questions

If you have questions about the enrollment process for the pre-65 medical, dental and vision or post-65 dental and vision, please contact BCBSM, our pre-65 plan administrator, at 1-877-354-2583.

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.
7 For private duty nursing, your coinsurance % is 50%, in-network and out-of-network.
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.
9 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.
10 For mental health and substance abuse treatment, refer to the BCBSM Summary of Benefits for additional details including limits on the number of visits.
11 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.
12 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.
13 The 20% prescription drug out-of-network copay will not be applied toward your calendar year deductible, out-of-pocket maximum or lifetime maximum.
14 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.
15 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."
16 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
17 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.
18 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
19 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.**
20 No more than $100.

21 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.
22 If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred.
23 Semi-private room and board, general nursing, and miscellaneous services and supplies
24 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.
25 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.
26 Blood deductible applies to **hospital confinement and out-patient medical expenses**, when furnished by a hospital or skilled nursing facility during a covered stay.
27 Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies.
28 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.
29 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.
30 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.
31 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."
32 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
33 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.
34 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
35 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.**

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