

2014 Calendar Year

City of Detroit Retiree Health Care Plan



THIS BOOKLET DESCRIBES SIGNIFICANT CHANGES TO RETIREE HEALTH BENEFITS THE CITY OF DETROIT WILL PROVIDE TO ITS RETIREES EFFECTIVE JANUARY 1, 2014. IT IS IMPORTANT THAT YOU REVIEW THIS BOOKLET AND UNDERSTAND WHAT ACTIONS YOU NEED TO TAKE TO RECEIVE BENEFITS.

To All City Retirees

As a consequence of the dire financial situation faced by the City of Detroit, the City is making significant changes to its retiree health benefits program effective January 1, 2014. This *City of Detroit Retiree Health Care Plan* booklet is intended to be an easy-to-read summary guide to explain those changes, and to provide enrollment information.

Effective January 1, 2014, the City of Detroit will no longer provide retirees with the health insurance coverage currently offered. As described in more detail in this booklet, the health benefits a retiree will receive from the City effective January 1, 2014 will depend upon whether the retiree is Medicare eligible. Generally a retiree is Medicare eligible if he or she is age 65 or older, and has worked to earn Medicare coverage or has eligibility through a spouse.

■ **MEDICARE ELIGIBLE RETIREES.** Effective January 1, 2014, Medicare eligible retirees will be able to select either:

- (i) one of three Medicare Advantage insurance plans that includes drug benefits for which the City of Detroit will pay most or all of the premium, or
- (ii) a Medicare Part D drug benefit only plan for which the City of Detroit will pay all of the premium.

■ **NON-MEDICARE ELIGIBLE RETIREES.** Effective January 1, 2014, non-Medicare eligible retirees will need to obtain their own health insurance coverage (for themselves or their dependent family members). Under the Patient Protection and Affordable Care Act (hereinafter called the “Affordable Care Act,” sometimes known as Obamacare), Health Insurance Marketplaces – also known as Exchanges – will be available in every state, including Michigan. Non-Medicare eligible retirees will be able to enroll in and obtain an individual insurance policy to cover the retiree and his or her family from the Marketplace that serves the state where the retiree lives. A Non-Medicare eligible retiree may also be eligible to enroll in coverage offered by their current employer or their spouse’s employer. For most Non-Medicare eligible retirees, effective January 1, 2014 the City will provide a stipend of \$125 per month (\$200 per month for duty disabled non-Medicare retirees). Eligible retirees may use this stipend to defray the cost of premiums for health insurance coverage, acquired through a Marketplace or through the retiree’s or the retiree’s spouse’s employer.

■ For more information on Marketplace see Q&A question #4 on page 10.

New Enrollment Requirements related to these changes are described on pages 17 thru 19.

The statements contained in this booklet regarding eligibility for coverage apply to all City retirees. It is important that you read this booklet in its entirety and that you keep it with your other important papers so that you can reference it as needed throughout the year.

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Health Coverage Options For Medicare Eligible Retirees



Attention All Medicare Eligible Retirees

All City retirees and surviving spouses who are now eligible for Medicare, or will be eligible for Medicare in the 2014 Calendar Year, will have a choice between either:

- A Medicare Advantage Plan, or
- A Medicare Part D Drug Benefit only plan.

Except for one of the Medicare Advantage Plan options (BCBSM Medicare Plus Blue PPO), the monthly premium cost to the Medicare Eligible Retiree will be zero.

These new options will be available to all City retirees who are Medicare eligible. It does not matter whether you worked as a general employee or uniformed employee prior to retirement. It does not matter whether you were part of the lawsuit known as the Weiler class action. If you are a Medicare-eligible retiree, these are the only choices that the City will offer you for health coverage for 2014.

You may enroll either (i) electronically by a web-based enrollment process, or (ii) by telephone. Information on how to enroll under these two options is provided on pages 18 thru 19.

YOU MUST MAKE AN ELECTION FOR COVERAGE IF YOU ARE NOT CURRENTLY ENROLLED IN A MEDICARE ADVANTAGE PLAN OFFERED BY THE CITY OR IF YOU WANT TO CHANGE MEDICARE ADVANTAGE PLANS.

IF YOU ARE NOT CURRENTLY ENROLLED IN A MEDICARE ADVANTAGE PLAN OFFERED BY THE CITY AND YOU DO NOTHING, YOU WILL RECEIVE NO HEALTH COVERAGE FROM THE CITY.

IF YOU ARE CURRENTLY ENROLLED IN A MEDICARE ADVANTAGE PLAN OFFERED BY THE CITY AND YOU DO NOTHING, YOU WILL AUTOMATICALLY BE ENROLLED AS SHOWN IN THE GRID AT RIGHT.

2013 Health Plan	2014 Health Plan
Medicare Plus Blue Group PPO Option E	BCBSM Medicare Plus PPO
Medicare Plus Blue Group PPO Option F	BCBSM Medicare Plus PPO
Medicare Plus Blue Group PPO Option G	BCBSM Medicare Plus PPO
BCN Advantage	BCN Advantage HMO-POS
Health Alliance Plan (HAP) Senior Plus	HAP Senior Plus

If you reach age 65 during the 2014 coverage plan year, you will receive a written notice with instructions on how to make a Medicare Advantage Plan selection if you are enrolling in Medicare at that time. If you are deferring Medicare enrollment because you have coverage from a current employer, you are responsible for notifying the City when you are ready to enroll in Medicare.

1. What is a Medicare Advantage Plan?

A Medicare Advantage Plan is Medicare health coverage offered through a health care plan that contracts with the Center for Medicare and Medicaid Services (CMS). If you choose a Medicare Advantage plan, you are still a Medicare recipient and have all of the same Medicare rights and protections as under “Original Medicare,” but your benefits are covered by the health care plan you choose, not directly by Medicare. If you enroll in a Medicare Advantage plan, you will receive all of your Medicare Part A (hospitalization benefits) and Medicare Part B (physician and other medical benefits) coverage. You will also receive coverage for certain hospital and medical services costs and charges that Medicare Parts A and B do not cover. A Medicare Advantage Plan may also provide prescription drug coverage. **Thus, a Medicare Advantage Plan provides you both your Medicare Parts A and B benefits, plus additional supplemental benefits.** In order to enroll in a Medicare Advantage Plan, you must be enrolled in Medicare Parts A and B coverage. To enroll in Medicare Parts A and B, you need to contact the Social Security Administration.

A Medicare Advantage Plan can be a PPO or an HMO plan. If you decide to enroll in a Medicare Advantage Plan you must decide whether you want an HMO plan or a PPO plan.

1a. What is a Health Maintenance Organization (HMO) Plan?

An HMO is a health care plan that manages and coordinates your medical care. You must select a primary care physician who will provide the majority of the medical services you may require. Your primary care physician will also coordinate other services you may need such as specialty care, hospital services and any required tests or diagnostic procedures. Because you are required to use the network of HMO health care providers, your out-of-pocket expenses for covered benefits are usually less in an HMO than in other types of health care plans. It is important to note that retirees who select an HMO plan must reside in the network service area of the plan. If you move outside of the service area, you are no longer eligible for the HMO plan and must switch to another plan. Annual deductibles and copayments are required for certain services.

1b. What is a Preferred Provider Option (PPO)

This type of plan consists of a network of independent physicians, hospitals and other health care providers that have agreed to accept a pre-approved amount as full payment for services provided to subscribers. Under this arrangement, your out-of-pocket expenses will be lower for covered benefits if you use network health care providers rather than out-of-network providers. However, the plan still covers some of the costs for care from health care providers who are outside of the plan network. Annual deductibles and copayments apply for certain services.

1c. Will a Medicare Advantage Plan Cover My Spouse?

A Medicare Advantage Plan will cover your spouse only if he or she is also Medicare eligible. Your spouse must enroll in the same Medicare Advantage option as you to obtain coverage. If your spouse is not Medicare eligible, the Medicare Advantage Plan will not provide any hospital, medical, or drug benefit coverage for your spouse. If your spouse is not Medicare eligible, your spouse will **not** receive the \$125 monthly stipend from the City. See Q&A 3e below.

1d. If I Want to Elect A Medicare Advantage Plan, What Are My Options?

The City of Detroit will pay part or all of the premium for three Medicare Advantage plans effective January 1, 2014. Charts that summarize the coverage and cost-sharing features for each of these three options are on pages 24 thru 27.

- BCBSM Medicare Plus Blue PPO
- BCN Advantage HMO-POSSM (HMO), or
- HAP Senior Plus HMO (HMO).

Please remember that if you enroll in a Medicare Advantage Plan your Medicare Parts A and B coverage will be included in the coverage provided by that Medicare Advantage Plan. Please also remember that if you enroll in a HMO Medicare Advantage Plan (BCN Advantage HMO or HAP Senior Plus HMO) – as opposed to

the PPO Medicare Advantage Plan – you are covered only for services from the doctors, specialist, or hospitals in the HMO provider network except in an emergency. The City of Detroit will not pay the premium for any other Medicare Advantage Plan.

1e. What if I live outside the State of Michigan? What if I live in Michigan but outside the network area of the Medicare Advantage Plan? What are the consequences?

The BCBSM Medicare Plus Blue PPO has access to a network of hospitals and providers throughout the United States. The network of hospitals and providers for the BCN Advantage HMO-POS and HAP Senior Plus HMO are exclusively located in Michigan. If you live outside of Michigan you have the option to enroll in the BCBSM Medicare Plus Blue PPO.

If you live in Michigan and want to learn information on the hospitals and providers within the BCN Advantage HMO-network, please call toll-free 1-866-966-2583.

If you want to learn information on the HAP Senior Plus hospital and provider network, please call toll free 1-800-801-1770.

And, if you want information on the nationwide network for the BCBSM Medicare Plus Blue PPO please call toll-free 1-866-684-8216.

2. What Is A Medicare Part D Drug Benefit Plan?

A Medicare Part D drug benefit plan offers prescription drug coverage to a retiree who is enrolled in Medicare. It **only** provides prescription drug benefits. Such a plan does not offer hospitalization or medical services coverage, and it does not supplement or pay for hospitalization or medical services that are not covered by Medicare Parts A and B or a Medicare Advantage Plan. A retiree may elect a Medicare Part D drug benefit plan only if the retiree is enrolled in Parts A and B of Medicare or in a Medicare Advantage Plan that does not offer prescription drug benefits.

2a. If a Medicare Part D Drug Benefit Plan only offers prescription drug coverage, why would I want to elect a Medicare Part D Drug Plan option over one of the Medicare Advantage Plan options?

Although the Medicare Advantage Plan options provide coverage for certain hospitalization and medical services and costs that Medicare Part A (hospitalization) and Medicare Part B (medical) do not cover, as well as prescription drug benefits, the Medicare Part D Drug Benefit Plan option may under certain circumstances offer more generous prescription drug coverage than the three Medicare Advantage Plan options. You should speak with a representative from HAP or Blue Cross Blue Shield of Michigan to determine whether the Part D drug benefit plan option would better fit your needs.

2b. Will a Medicare Part D Drug Benefit Plan cover my spouse?

A Medicare Part D drug benefit plan will cover your spouse only if he or she is also Medicare eligible and has enrolled either in Medicare Part A and Medicare Part B or in a Medicare Advantage plan. If your spouse is not Medicare eligible, the Medicare Part D drug benefit plan will not provide any drug benefit coverage for your spouse.

2c. If I Want To Elect A Part D Drug Benefit Plan, What Are My Options?

The City of Detroit will offer one Medicare Part D Drug Benefit Plan option, and pay all of the premiums for such option, effective January 1, 2014:

- HAP Part D Drug only plan.

The City of Detroit will not pay the premium for any other Medicare Part D Drug Benefit Plan.

2d. What if I live in Michigan but outside the service area of the HAP Senior Plus HMO? What are the consequences if I elect the HAP Part D Drug Plan?

If you live outside of the HAP Senior Plus HMO service area, which is exclusively within the state of Michigan, you may not enroll in the HAP Part D Drug only benefit plan.

Charts that summarize the coverage and cost-sharing features of this option are on pages 24 thru 27.

2e. What if I am a Medicare eligible Retiree but my spouse is not Medicare eligible and she is employed full-time by the City of Detroit as an active employee? Will I receive the opportunity to elect either the Medicare Advantage Plan or the Part D Drug Benefit Plan?

Yes. As a Medicare eligible retiree, you will receive your option to enroll in either the Medicare Advantage Plans or the Part D drug benefit plans. Your spouse will not be able to also enroll you as a covered dependent under the active employee health benefits options offered to active employees.

Monthly Stipend For Non-Medicare Eligible Retirees



Attention All Non-Medicare Eligible Retirees

You Will Need to Find Your Own Health Insurance Coverage

If you are a retiree from the City who is not Medicare eligible, the City will no longer provide you, your spouse, or your dependents with group health benefits and prescription drug coverage. Instead, you will be responsible for obtaining your own health coverage. The City will provide you a monthly stipend that you may use to pay for such coverage.

If you are under the age of 65, you are generally not Medicare eligible. But retirees who are receiving Social Security benefits due to a disability may be Medicare eligible even if under the age of 65.

If you are a Non-Medicare eligible retiree and you or your spouse is employed, your employer (or your spouse's employer) may offer health coverage that you may be eligible to receive.

If you are a Non-Medicare eligible retiree and neither you nor your spouse has access to health coverage from another employer, you may obtain health insurance coverage for yourself or your spouse by enrolling in an individual policy offered by an insurance company under one of the Public Insurance Marketplaces – also known as Exchanges.

For more information on Marketplace see Q&A question #4 on page 10.

3. Will The City Pay Non-Medicare Eligible Retirees A Monthly Stipend That Can Be Used To Help Pay For Your Own Health Coverage?

Beginning with January 2014, the City will provide to each Non-Medicare eligible retiree – except for duty disabled retirees – a monthly stipend of \$125 that the Non-Medicare retiree may use to pay for health coverage. If you are a Non-Medicare eligible retiree, you could use the \$125 per month stipend as reimbursement for a portion of the cost of coverage for a policy you buy through a Marketplace. If instead of buying a policy through a Marketplace, you enroll in health coverage offered by an employer other than the City or through your spouse's employer, you can use the \$125 per month stipend to help pay the portion of the premium the employer charges for coverage.

Disabled retirees who are Non-Medicare eligible and who became disabled in the line of duty – persons who are known as Duty Disabled Retirees – will receive a \$200 per month stipend. You do not have to enroll for the stipend. It will be provided to you automatically.

3a. Am I required to use the monthly stipend to pay for health insurance coverage? Will I have to pay taxes on the monthly stipend?

The City will not require you to use the \$125 monthly stipend to pay for the premium cost of health coverage, although the City urges that you do. Because you will not be legally required to use the stipend for health coverage, the stipend amount will be treated as taxable income for federal and state tax purposes. The same rule will apply to the \$200 monthly stipend provided to duty disabled retirees. For retired police and firefighters, it may be possible for you to have your payment treated as a tax-free distribution if you elect that it be used to purchase insurance coverage. More information on taxation of the stipend will be provided at Retiree Information Meetings or at www.mydetroitbenefits.com.

The City has made the decision not to require you to use the \$125 stipend to pay for health coverage in order to ensure that receipt of the stipend will not prevent you from receiving a federal tax subsidy under the Affordable Care Act that could pay a substantial portion of your monthly premium if you buy coverage through a Marketplace. Non-Medicare eligible retirees may be eligible for these tax subsidies. See Section 5 below for a discussion of the federal tax subsidy. The City reserves the right to change its position and require you to use the stipend to pay for health coverage if it receives guidance from the federal government that having such a requirement will allow the stipend to be exempt from income taxation and also will not cause it to jeopardize eligibility for the federal tax subsidy under the Affordable Care Act.

3b. Am I required to obtain my own coverage now that the City will not provide Non-Medicare eligible retirees with health insurance coverage?

Starting in 2014, as a result of the Affordable Care Act, each individual living in the United States, including each retiree, will be required to obtain health coverage, qualify for an exemption, or pay a tax. More information on the requirement to have coverage, the available exemptions, and the amount of the potential tax is available at www.healthcare.gov and www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3c. If I am married, and both my spouse and I are not Medicare eligible, will I receive a \$250 per month stipend?

No. The stipend will be \$125 per month (\$200 for a duty-disabled retiree) regardless of whether or not you are married, or have dependent children.

3d. For duty disabled retirees, will the monthly \$200 subsidy continue for my life?

No. The monthly \$200 subsidy will continue until you are Medicare eligible, which in the case of a disabled person may be **prior** to your actually turning age 65. Once you are Medicare eligible and enroll in Medicare, you will be given the Medicare Advantage and Medicare Part D drug benefit options described in Q&As 1-d and 2-c.

3e. What if I am Medicare eligible and my spouse is not? What benefits will we receive?

If you are Medicare eligible you will have the health coverage options for Medicare eligible retirees described in Q&As 1-d and 2-c. Your spouse will not receive the \$125 monthly stipend. During the period your spouse is not Medicare eligible, he or she will not be given any health benefits from the City of Detroit. However, when your spouse becomes Medicare eligible, he or she will be able to enroll in the same Medicare Advantage Plan that you are enrolled in.

3f. What if I am not Medicare eligible and my spouse is Medicare eligible? What benefits will we receive?

If you are not Medicare eligible you will receive the \$125 monthly stipend. During the period you are not Medicare eligible, your spouse will not be given any health benefits from the City of Detroit. However, when you become Medicare eligible, your spouse will be able to enroll in the same Medicare Advantage Plan that you are enrolled in.

3g. What retiree health benefits will surviving spouses receive?

A surviving spouse who is eligible for and receiving a survivor pension under the City's pension program will "stand in the shoes" of the deceased retiree, and will receive the same benefits that the deceased retiree would have received. The surviving spouse will receive the \$125 monthly stipend until he or she becomes Medicare eligible. At the time the surviving spouse becomes Medicare eligible and enrolls in Medicare, he or she will be given the Medicare Advantage and Medicare Part D drug benefit options described in Q&As 1-d and 2-c.

3h. What health benefits will surviving dependent children of deceased retirees receive?

A dependent child under the age of 18 who is a survivor of a deceased City of Detroit retiree will be eligible to receive a \$125 monthly stipend until such child reaches age 18. A dependent child will receive the stipend up to the age of 18 regardless of whether the child is currently a survivor receiving coverage under one of the existing retiree health benefit plan options or becomes a survivor on or after January 1, 2014.

3i. Are there City Retirees Over the Age of 65 Who are Not Eligible for Medicare?

Yes. If you are a retired policeman or fireman who receives a pension from the Detroit Police & Firefighters Retirement System, and you were employed by the City on March 31, 1986, you will not be eligible for free Medicare Part A (unless you were terminated and then rehired by the City on or after April 1, 1986, or you are Medicare eligible through your other employment or the employment of your spouse). Retired policeman and firemen who are not eligible for free Medicare Part A will be treated as a Non-Medicare eligible retiree, and will receive the \$125 monthly stipend described in this section even if they are age 65 or older.

The Following Q&As Only Apply To Non-Medicare Retirees

4. What Are The State Public Insurance Marketplaces, Also Known As "Exchanges"?

Under the Affordable Care Act, each state will have a health insurance Marketplace in which licensed health insurance companies will offer individual health insurance coverage. No insurance company (whether offering policies on or off the Marketplace) can turn you down for individual health insurance coverage, and no insurance company can impose pre-existing condition limitations on its individual health insurance coverage. Individuals and families will be able to learn about policies, compare them, and purchase coverage through the Marketplace. The Marketplace will also determine whether applicants for coverage are eligible for financial assistance with the cost of health coverage, either through new federal tax subsidies (see further discussion on page 12 below) or through Medicaid or the Children's Health Insurance Program (CHIP).

4a. What type of coverage can I acquire through a Marketplace?

Each Marketplace will offer multiple health plans. There will be four different levels of coverage: (i) Bronze, (ii) Silver, (iii) Gold, and (iv) Platinum. Platinum coverage is the most generous coverage. It generally will have the lowest annual deductibles and copayments. But it also will likely have the most expensive monthly premium. Bronze coverage generally will have the highest annual deductibles and other forms of copayment, but the monthly premium for Bronze coverage generally will be the least expensive.

Health plans offered on a Marketplace at all four levels are required to provide ten categories of benefits:

- Out-patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Pediatric services (including oral and vision care).

4b. When will the Marketplace open? When can I research insurance policies and obtain pricing for the policies in the Marketplace?

The Marketplace for each state opened on October 1, 2013. You can now access the Marketplace's web-site, obtain information on the individual insurance policies that will be offered by that Marketplace, and see the pricing for policies at the Bronze, Silver, Gold, and Platinum levels. You will be able to purchase a policy for you or your family this fall that will be effective January 1, 2014. You must complete your plan selection with the Marketplace by December 15, 2013 to be assured that your coverage will go into effect on January 1, 2014. More information can be found at www.HealthCare.gov.

4c. Does Michigan have a Marketplace?

Yes. Michigan has a Marketplace. It is jointly operated by both the federal government and the State of Michigan. The Michigan Marketplace opened on October 1, 2013. More information about the Michigan Health Insurance Marketplace can be found on www.healthcare.gov/what-is-the-marketplace-in-my-state/#state=michigan.

4d. Where can I go to get help in selecting a policy from the Michigan Health Insurance Marketplace?

For each state Marketplace, there are organizations called “navigators” to help you find a policy right for you. For the Michigan Marketplace, the “navigators” are as follows:

Community Bridges Management, Inc.: 1-586-741-8360
Arab Community Center for Economic and Social Services: 1-313-842-7010
American Indian Health and Family Services of SE Michigan: 1-313-846-6030
Michigan Consumers for Healthcare: 1-517-487-5436

Please be aware that assistance from any of these navigators is free.

4e. Will the City provide me with help in acquiring information about and selecting an individual policy on the Michigan Health Insurance Marketplace?

Yes. The City has contracted with Blue Cross and Blue Shield of Michigan (“BCBSM”), which will offer individual policies on the Michigan Marketplace, to provide information and support to Non-Medicare eligible retirees about the health insurance policies that it will offer on the Marketplace, and how to select and enroll in one of those policies. BCBSM will be sending you a separate mailing that provides information on how BCBSM can help you to select one of their policies on the Michigan Marketplace, including the number for a call center that BCBSM will operate dedicated to provide information to City retirees, as well as information on a series of person-to-person meetings that BCBSM will sponsor for City Non-Medicare eligible retirees. Assistance from BCBSM will be free.

You do not have to use the services of BCBSM. The decision is entirely up to you. If you choose to get assistance from a different source or if you are a Medicare eligible retiree, and you select a plan from an insurer other than Blue Cross Blue Shield, it will not affect the benefits available to you.

5. How Does The Federal Premium Subsidy For Policies Acquired On The Marketplaces Work?

5a. What is the federal premium subsidy?

A key objective of the Affordable Care Act is to make the cost of health insurance coverage more affordable. The Affordable Care Act accomplishes this goal in part by giving a subsidy to certain individuals who purchase insurance after January 1, 2014 through a Marketplace. The subsidy is available only for health insurance policies acquired on a Marketplace. Non-Medicare Eligible Retirees who are eligible for this subsidy can use it to reduce the cost of the premium for the insurance policies they acquire through the Marketplaces. The premium assistance subsidy is in the form of a tax credit. Most importantly, when you sign up for a policy through a Marketplace, you can get an estimate of the amount of the federal tax subsidy that you will receive. The estimated amount can be applied automatically to reduce your monthly cost for the policy. You do not have to pay the full cost of the insurance policy and then wait until you file your federal tax return to obtain the subsidy.

5b. Who is eligible for the premium subsidy?

Individuals are eligible for a premium subsidy if (a) they are not eligible for government-sponsored health coverage (like Medicare and Medicaid) or affordable employer-sponsored coverage; and (b) their income falls between 100% and 400% of the federal poverty line. Medicare eligible retirees are not eligible for a premium subsidy. Retirees who are eligible for certain veterans' health coverage or TRICARE are not eligible for a premium subsidy. Medicaid eligibility will vary from State to State. The Marketplace will be able to check whether an individual is eligible for Medicaid.

For an unmarried retiree with no dependents who is not eligible for government-sponsored coverage and does not have access to an affordable employer sponsored coverage from a current employer, a premium subsidy is available in 2014 if income is between \$11,490 and \$45,960.

For a married retiree with no dependents who is not eligible for government-sponsored coverage and does not have access to affordable employer sponsored coverage from a current employer or the spouse's employer, a premium subsidy is available in 2014 if income is between \$15,510 and \$62,040.

5c. How much is the subsidy?

The determination of the amount of the federal premium subsidy is complicated. The subsidy amount is determined on a sliding scale based on household income. Non-Medicare retirees at the lower end of the income scale get the largest subsidy. Thus, a married, Non-Medicare Eligible retiree with household income of \$45,000 will receive a larger subsidy than a married Non-Medicare Eligible retiree with household income of \$60,000. But both such retirees will receive a federal subsidy toward the cost of insurance purchased through the Marketplace.

5d. Can I be assured I will be able to receive the federal premium subsidy?

No. Eligibility and the amount of any subsidy will vary from individual to individual. In addition, and as with any new public benefit program, there are ongoing political and legal questions about the Affordable Care Act that will be settled as it goes into full operation. The Federal Government, which is operating the Michigan Marketplace in partnership with the State of Michigan, is firmly committed to the subsidy, which, among other changes, may ultimately require the State to run the Marketplace independently.

5e. If I am eligible for the federal tax subsidy, will I lose my right to the \$125 per month stipend from the City?

No. The City intends to structure the \$125 monthly stipend so that it can be used along with the federal tax subsidy to lower the cost of premiums for insurance coverage acquired through a Marketplace.

5f. How can I obtain more information about whether I will be eligible for the federal tax subsidy, and the amount of the subsidy I am likely to receive?

If you would like to read more about how the federal tax subsidy works, the following web sites provide helpful information:

[www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/
kff.org/interactive/subsidy-calculator/
www.treasury.gov/press-center/Documents/36BFactSheet.pdf](http://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/kff.org/interactive/subsidy-calculator/)

The navigators discussed in question 4d above, as well as Blue Cross Blue Shield of Michigan, can provide you with information to help you calculate your likely federal premium subsidy for 2014.

Elimination of City Subsidy for Dental & Vision Coverage



Attention All Retirees

Elimination of City Subsidy for Dental and Vision Coverage

The City will no longer subsidize dental and vision coverage effective January 1, 2014 for all retirees. All retirees, regardless of age or Medicare eligibility, who want dental and vision coverage will be required to pay the full cost of the dental and vision. The City will offer Blue Cross Blue Shield of Michigan dental and Heritage Vision plan options. All other plan options are eliminated.

Monthly Rate for Blue Cross Blue Shield of Michigan Dental
\$60.35

Monthly Rate for Heritage Vision Plan
\$6.80

NOTE: Unless you are receiving a duty disability stipend payment, dependent children are not eligible for dental and vision coverage.

Premium Contributions By Medicare Eligible Retirees



Attention All Medicare Eligible Retirees

The City will not be obligated to pay any penalty that might be added to the premium for retirees who previously failed to timely enroll in Medicare.

If you select BCN Advantage HMO-POSSM, HAP Senior Plus HMO, or HAP Part D Drug Benefit, the City of Detroit will pay the entire premium for you (and for your spouse if your spouse is also enrolled in the plan you select).

If you select the BCBSM Medicare Plus Blue Group option, you will pay approximately \$30 per month for the coverage for yourself (and an additional amount of approximately \$30 per month for coverage for your spouse, if your Medicare eligible spouse also is enrolled in the plan you select).

January 1, 2014 - December 31, 2014 Monthly Medicare Advantage Plan Contributions

Plan	Monthly Retiree Contribution for Single Coverage	Monthly Retiree Contribution Two Person Coverage
HAP Part D Drug Only Benefit	\$0.00	\$0.00
HAP Senior Plus HMO	\$0.00	\$0.00
BCN Advantage HMO-POS	\$0.00	\$0.00
BCBSM Medicare Plus Blue Group PPO	\$29.43	\$58.86

Monitoring Deductions from your Pension Check

If you are a Medicare eligible retiree and you select the BCBSM Medicare Plus Blue Group option, you will pay \$29.43 per month for the coverage. You will pay twice this amount, or \$58.86 per month – if you also enroll your Medicare eligible spouse. This amount will be deducted from your pension check each month.

You are responsible for checking your pension check stubs to verify that the proper amount of money for premium contributions is being deducted from your check. Your medical care contribution (sometimes referred to as a “premium copay” deduction) is listed on your pension check stub next to the word “Hospital.” It is an 8-position code that begins with five letters and ends with three numbers (Example: AAADA200). If you do not elect the BCBSM Medicare Plus Blue Group option, there should be no premium contribution deduction from your pension check. If an error is made, you must immediately call the Benefits Administration Customer Service Line at 1-855-224- 6200.

Proper Notification of Medicare Enrollment.

A Medicare Eligible retiree is a retiree who is eligible for Medicare Parts A and B. The City is not responsible for any contributions made because the retiree failed to provide proper notification of Medicare enrollment. Proper notice of enrollment in Medicare is the submission of a copy of your Medicare card. If you have not previously provided the City with a copy of your Medicare card showing that you are enrolled in Parts A and B, you will need to fax or mail a copy of the Medicare card or letter from the Social Security Administration to the Benefit Administration Office in order to enroll in one of the new Medicare Advantage or Part D drug benefit plan options.

If you are a retiree who is not eligible to enroll in Medicare Part A, you must provide the City of Detroit with a copy of a letter from the Social Security Administration confirming that you are not eligible.

If you fax a copy of the Medicare card or the letter from the Social Security Administration please do so to 1-313-224-4456.

If you want to mail a copy of the Medicare card or the letter from the Social Security Administration to the Benefit Administration Office, please mail to:

Benefit Administration Office
2 Woodward Avenue, Suite 1026
Detroit MI, 48226

You are urged to keep a copy of all City of Detroit health care enrollment and termination forms and other health care documents.

Providing False Information

Retirees who submit false information intended to allow them to enroll their alleged spouses for health care coverage will be held financially responsible for all premiums paid, and will be required to reimburse the City for such premiums respecting the ineligible person claimed as a spouse.

Action Retirees Need to Take to Enroll in the New Program

If you are a retiree or expect to retire in 2014, you should,

- **Review** this booklet to familiarize yourself with the various changes to the retiree health care benefits that are available to you as a retiree of the City of Detroit.
- **Determine** whether you or your spouse are currently eligible for Medicare or will be eligible in 2014 for Medicare. Eligibility for Medicare will determine what health care benefits you may receive from the City.

If you are not eligible for Medicare,

- **Investigate** the health coverage available through the new Health Insurance Marketplace, including any potential federal tax subsidies you may be eligible to receive that would lower your monthly premium costs. If you would like to purchase coverage through the Marketplace, and you want the coverage to go into effect on January 1, 2014 when your current retiree coverage will end, you must complete the application process and select a plan through the Marketplace by December 15, 2013.
- **Investigate** any health coverage available to you through a current employer or through a spouse's employer. If you are eligible for health coverage from a current employer or a spouse's employer, ask the employer immediately about the deadline for enrollment for coverage that starts January 1, 2014. The deadline could be in October, 2013. If the employer offers coverage that starts at a different time in the year, you will be eligible for a special enrollment period because your current coverage from the City of Detroit is terminating.

If you are eligible for Medicare,

- **Determine** which health care plan options for which the City of Detroit offers premium assistance best meets your needs. If you have a spouse, it is a good idea to review your plan choices together before making your decision.
- **Call the Benefits Administration Customer Service Line toll-free at 1-855-224-6200 if you have questions about this mailing.**

Live representatives will take calls from 8:30 a.m. - 7:00 p.m. EST Monday – Friday.

Extended Hours - The Benefits Administration Customer Service Line will return messages during the following hours.

Monday – Friday: 8:30 a.m. – 9:00 p.m. EST

Saturday – Sunday: 11:00 a.m. – 5:00 p.m. EST

- **Email** the Benefits Administration Customer Service Center at **help@mybenefitexpress.com**.
- **Call** a health care plan insurance carrier directly if you would like specific information about their network health care providers, facilities or services, or for directories of providers. The telephone numbers for each of the Medicare Advantage and Part D drug benefit carriers are as follows:
 - BCN Advantage HMO – 1-866-966-2583.
 - HAP Senior Plus – 1-800-801-1770.
 - BCBSM Medicare Plus Blue PPO – 1-866-684-8216.
- **Choose carefully.** The City of Detroit, as sponsor of these group plan options, will not allow changes in health care plans for 2014 after open enrollment ends.
- **IMPORTANT: THERE IS A NEW OPEN ENROLLMENT PROCESS FOR MEDICARE ELIGIBLE RETIREES.**
 - **If you are currently enrolled in a Medicare Advantage plan offered by the City through Blue Cross Blue Shield of Michigan, Blue Cross Network, or HAP, and you want to stay with the Medicare Advantage plan the City will offer through your insurer for 2014, you do not need to do anything. You will automatically be enrolled in the Medicare Advantage plan that the City offers through your insurer for 2014.**
 - **If you are not currently enrolled in a Medicare Advantage plan, or if you want to switch to a plan offered by a different insurer than is covering you currently, you must complete your health care enrollment either online or via phone. You will be able to select your health care plan option, add or delete your spouse or report other changes affecting your health care coverage.**
 - **The Benefits Administration Office must have proof of Medicare eligibility (copy of Medicare ID card) prior to your selecting and enrolling in one of the Medicare Advantage or Medicare Part D drug benefit options.**
 - If you previously sent a copy of your Medicare ID card (or your spouse's card) to the Benefit Administration Office, you do not need to re-send the card.
 - If you did not previously send a copy of your Medicare ID card to the Benefit Administration Office, you will need to fax or mail a copy of the Medicare card. You can do that by faxing a copy of the card to the Benefit Administration Office using Fax Number 313-224-4456, or by mailing the card to the Benefit Administration Office, at 2 Woodward Avenue, Suite 1026, Detroit MI 48226.
 - If your spouse is eligible for Medicare and you want to enroll your spouse, you also must provide proof of your spouse's Medicare eligibility.

Open enrollment is scheduled to begin at or near the end of October, 2013. You will receive a separate letter notifying you when open enrollment formally begins.

When open enrollment begins, visit www.mydetroitbenefits.com or call toll-free 1-855-224-6200 to speak to a live representative.

YOUR INITIAL WEBSITE LOG-IN IS:

DET + first 5 characters of your last name + the last 4 digits of your SSN

YOUR INITIAL PASSWORD IS

Full date of birth in the format MMDDYYYY.

Example:

Name: William Johnson

Date of Birth: 12/01/1964,

Last 4 digits of your SSN: 6789

Log-in: DETjohns6789

Password: 12011964

NOTE: When you first log into the system, you will be immediately prompted to create your own unique password, which will be case-sensitive

Review your health care elections carefully. Upon completing the enrollment process, you will be able to print a confirmation statement showing all of your elections. A copy of your elections will remain on the site for you to access at any time.

Mid-Year Enrollments

Any requests during the year for adding Medicare eligible spouses (e.g., marriage) must be made within thirty (30) calendar days of the event. You may make such changes online at www.mydetroitbenefits.com or by calling toll-free 1-855-224-6200 to speak with a live representative. Coverage will be made retroactive to the date of the event after the change is requested and required documentation is received by Benefit Administration Office. If your request is not received within the thirty (30) calendar day period, you must wait until the next Open Enrollment period to add the spouse to your health care coverage.

Note to All Retirees About Submitting Claims for Current 2013 Retiree Coverage

The changes in retiree health benefits described in this booklet are effective January 1, 2014. Nothing has changed about the retiree health benefits currently in effect in 2013. Retirees may submit claims during 2014 for reimbursement under their 2013 coverage subject to the terms of that coverage.

Disqualifying Events

A Medicare eligible retiree who enrolls his or her Medicare eligible spouse is required to report the death of the spouse and provide a copy of the death certificate. In order to remove a spouse from your coverage due to divorce or legal separation, you **MUST** provide a copy of the divorce decree or separation agreement. To ensure that premiums for the spouse are terminated, you must submit the request online at www.mydetroitbenefits.com or by calling toll-free 1-855-224-6200 to speak to a live representative and provide proper documentation to the Benefit Administration Office within thirty (30) calendar days of the disqualifying event. The coverage termination date for an ex-spouse is the date of the divorce decree, and for the deceased it is the date of death.

Our Commitment Regarding Your Personal Protected Health Information

We understand the importance of your Personal Protected Health Information (hereafter referred to as “PHI”) and follow strict policies (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic data, that can be reasonably used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care.

We must follow the privacy practices described in this notice while it is in effect. This notice is directed to recognize our responsibilities under the Health Insurance Portability and Accountability Act (HIPAA), which went into effect April 14, 2003, and will remain in effect until we replace or modify it consistent with provisions of the Act.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. These revised practices will apply to your PHI regardless of when it was created or received. Before we make a material change to our privacy practices, we will mail a revised notice to our subscribers.

Where multiple state or federal laws protect the privacy of your PHI, we will follow the requirements that provide greatest privacy protection. For example, when you authorize disclosure to a third party, state law requires the City of Detroit to condition the disclosure on the recipient’s promise to obtain your written permission to disclose to someone else.

If you have any questions regarding the City’s policy on PHI, please go online to www.mydetroitbenefits.com or call the Benefits Administration Customer Service Line toll-free at 1-855-224-6200.

Telephone Calls to the Benefits Administration Customer Service Line

If you have questions or concerns regarding the medical, dental or vision coverage in effect through the end of 2013 or the retiree health benefits available in 2014, please go online to www.mydetroitbenefits.com or call the Benefits Administration Customer Service Line toll-free at 1-855-224-6200 to speak to a live representative. When you call you will be asked specific questions to verify that we are speaking directly to the retiree or beneficiary who is the contract holder for the City of Detroit health care plan and who receives the pension check from the City. This security procedure is in accordance with the City of Detroit policies and is in place to protect your privacy.

Notice to Retirees Regarding Medicare

Under the City-sponsored plan options described in this booklet, a Medicare eligible retiree will be personally responsible for all premium expenses and additional medical expenses, and will be ineligible for coverage under the options discussed, if the retiree is eligible for and fails to enroll in Medicare. To avoid losing coverage from the City, if you are over 65 and eligible for Medicare, you and your spouse, if eligible, must enroll in Medicare Parts A & B.

Medicare Initial Enrollment begins 3 months before your 65th birthday, the month during your 65th birthday and the 3 months following your 65th birthday. **If you have missed Medicare Initial Enrollment, you can enroll in Medicare Parts A and B during Medicare General Enrollment at your Social Security Office.** Medicare General Enrollment begins each year on January 1 and ends on March 31. If you or any dependents are eligible for, but have missed the initial enrollment period you must apply during the next general enrollment period. Your Medicare coverage will become effective on the following July 1st.

Contact the Social Security Office if you have questions or concerns about enrollment in Medicare Parts A and B or the effective date of Medicare coverage.

When you receive your new Medicare card(s), you must notify the Benefits Administration Office by sending or faxing a copy of your card(s) to City of Detroit Benefits Administration Office. If you fax a copy of the Medicare card(s) please do so to 1-313-224-4456. If you want to mail a copy of the Medicare card to the Benefit Administration Office, please mail to: Benefit Administration Office, 2 Woodward Avenue, Suite 1026, Detroit MI 48226. Be sure to include the Social Security Number of the person who gets the pension check or other statement from the Pension Bureau on all correspondence.

Medicare Tips

1. Most people become eligible for Medicare at age 65. In addition to the City requirement for such enrollment, you or your dependents will want to enroll for Medicare when you first are eligible because Medicare charges financial penalties to those persons who do not sign up when first eligible and who seek to enroll at a later date. This penalty is a 10% increase in your monthly Medicare premium for each 12-month period that you were eligible for Medicare but did not enroll. Also when you are covered by Medicare, you may be eligible for some services which are not covered under your selected City plan.
2. However, if you or one of your dependents have a severe long-term disability, end-stage renal disease, or undergo a kidney transplant, you may be eligible for Medicare coverage prior to age 65. If you or one of your dependents fits any of these categories, you should contact your nearest Social Security Administration office to have your case evaluated.

CAUTION

If you or your spouse on your City of Detroit health care plan is Medicare-eligible due to age or disability, City rules require that you **MUST** enroll in and maintain Medicare Parts A and B to be eligible to enroll in one of the new Medicare Advantage or Medicare Part D Drug Benefit plans sponsored by the City of Detroit. This rule is strictly enforced.

If you have questions, contact the City's Benefit Administration Office.

Coordination of Benefits

If you or your spouse is Medicare eligible and becomes enrolled in one of the options described in this booklet, and also becomes enrolled in health insurance from a source other than the City of Detroit health plan – such as your spouse's health insurance coverage – coordination of benefits will take place. You are required to disclose information about such other coverage to the Benefits Administration Office.

Summaries of Medicare Advantage and Medicare Part D Drug Benefit Plan Options

On the following pages are charts that summarize the design of the Medicare Advantage plans and Medicare Part D drug benefit plan available to City of Detroit Medicare eligible retirees. These plans are only available if you are Medicare eligible and have in fact enrolled in Medicare.

If you have questions as to whether or not a particular health care service or expense is covered, contact the health care carrier and whenever possible, obtain pre-approval before having services performed. Because Non-Medicare eligible retirees will receive only the \$125 monthly stipend (\$200 per month for duty disabled retirees) and no other health benefits, the charts on the following pages relate to coverage options only for Medicare eligible retirees.

Medical and Prescription Drug Plan Offerings To Medicare Eligible Retirees

Benefits	BCN Advantage HMO-POS	BCBSM Medicare Plus Blue Group		HAP Senior Plus HMO
		In-Network	Out-of-Network	
Deductibles, Copay and Dollar Maximums				
Deductible	\$750 per member per calendar year	\$750 per member per calendar year		\$500 Single \$1,000 Family
Percent Copayments	20% for select services	20% for select services	20% for select services	10% for select services
Coinsurance Maximum (Percent Copayments)	\$1,500	N/A	N/A	\$2,700 Single \$5,400 Family
Maximum-Out-of-Pocket (For covered medical services)	\$2,500	\$2,500	\$5,000	\$3,200 Single \$6,400 Family
Routine Office Visits				
Office Visits	\$25 copay	\$25 copay	\$50 copay	\$20 copay
Specialist Care (includes GYN, Eye exams and Hearing exams)	\$25 copay after deductible	\$25 copay	\$50 copay	\$40 copay
Preventive Services				
Health Maintenance Exam	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Annual Gynecological Exam	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Mammography Screening	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Pap Smear Screening	Plan Pays 100% (lab only)	Plan Pays 100% (lab only)	Plan Pays 100% (lab only)	Plan Pays 100%
Immunizations	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Services in the Hospital				
Number of days of care	Unlimited Days	Unlimited Days	Unlimited Days	Unlimited Days
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Plan Pays 80% after deductible, ground and air service, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (one bariatric surgery procedure per lifetime; \$2,700 max applies)
Outpatient Surgery	Plan Pays 80% after deductible, ground and air service, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (\$2,700 max applies)

continued

Benefits	BCN Advantage HMO-POS	BCBSM Medicare Plus Blue Group		HAP Senior Plus HMO
		In-Network	Out-of-Network	
Emergency Care				
Hospital Emergency Room	\$65 copay after deductible (waived if admitted)	\$65 copay after deductible (waived if admitted)	\$65 copay after deductible (waived if admitted)	\$65 copay (deductible does not apply - waived if admitted)
Urgent Care	\$25 copay	\$25 copay	\$50 copay	\$40 copay
Ambulance - medically necessary	Plan Pays 80% after deductible, ground and air service, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (\$2,700 max applies)
Diagnostic Services				
Laboratory and pathology tests	Plan Pays 100%	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (\$2,700 max applies)
Diagnostic tests and X-rays	Plan Pays 80% after deductible, ground and air service, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (\$2,700 max applies)
Alternatives to Hospital Care				
Skilled Nursing Care in a nursing home	Plan Pays 100% after deductible	Plan Pays 80% after deductible	Plan Pays 80% after deductible	730 days, Plan Pays 90% after deductible
Mental Health Care				
Inpatient mental health care	Plan Pays 100% when authorized by BCN	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (\$2,700 max applies)
Outpatient mental health care	Plan Pays 100% when authorized by BCN	\$25 Copay	\$50 copay	\$20 copay
Appliances & Prosthetic Devices				
Prosthetics & Orthotics	Plan Pays 100%	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (\$2,700 max applies) for approved equipment
Durable Medical Equipment	Plan Pays 100%	Plan Pays 80% after deductible	Plan Pays 80% after deductible	Plan Pays 90% after deductible (\$2,700 max applies) for approved equipment

continued

Benefits	BCN Advantage HMO-POS	BCBSM Medicare Plus Blue Group		HAP Senior Plus HMO
		In-Network	Out-of-Network	
Chiropractic Services				
Chiropractic Care	Chiropractic spinal manipulation when referred by PCP - \$20 copay after deductible	Covered- \$20 copay	\$40 copay	\$20 copay (manipulation of spine for subluxation only)
Prescription Drugs				
Certain drugs require prior authorization and have quantity restrictions.				
Prescription Drug Deductible	None	None		\$100
Retail Preferred Generic	\$20 copay up to a 34 day supply	\$20 copay up to a 31 day supply		\$3 copay
Retail Non-Preferred Generic	\$20 copay up to a 34 day supply	\$20 copay up to a 31 day supply		\$15 copay
Retail Preferred Brand Name	\$60 copay up to a 34 day supply	\$60 copay up to a 31 day supply		Not in coverage gap* - \$45 copay In coverage gap* - Not covered
Retail Non-Preferred Brand Name	50% coinsurance with \$80 minimum copay and \$100 maximum copay up to a 34 day supply	50% coinsurance with \$60 minimum copay and \$120 maximum copay up to a 31 day supply		Not in coverage gap* - 30% Coinsurance In coverage gap* - Not covered
Retail Specialty Drugs	50% coinsurance with \$160 minimum copay and \$200 maximum copay up to a 34 day supply	50% coinsurance with \$300 minimum copay and \$600 maximum copay up to a 31 day supply		Not in coverage gap* - 30% Coinsurance In coverage gap* - Not covered
Mail Order Prescription Drugs	Two times the applicable generic and brand copay for a 90-day supply; (Specialty drugs cannot be filled for a 90 day supply)	Two times the applicable generic and brand copay for a 90-day supply; (Specialty drugs cannot be filled for a 90 day supply)		90 day supply for both eligible maintenance and non-maintenance drugs at two times retail copay
Part D- Catastrophic Coverage	Once member's out-of-pocket costs reach over \$4,550, the copay is the greater of 5% or \$2.55 generics and \$6.35 brands.	Same copayments as above apply.		Same copayments as above apply.

*In 2014, the coverage gap begins when the total cost of your prescription drugs (both what you and the City have paid) reaches \$2,850 and ends when your out-of-pocket costs reach \$4,550. The HAP Senior Plus HMO does not provide full coverage in the coverage gap and as a result, there may be increased cost-sharing for you.

continued

Benefits	HAP Prescription Drug Only Plan
Certain drugs require prior authorization and have quantity restrictions.	
Prescription Drug Deductible	None
Formulary Drug – Generic	\$10 copay
Formulary Drug – Non-Preferred Generic	\$30 copay
Formulary Drug – Brand Name	\$50 copay
Formulary Drug – Non-Preferred Brand Name	30% coinsurance
Formulary Drug – Specialty Drugs	30% coinsurance
Mail Order Prescription Drugs	90 day supply for both eligible maintenance and non-maintenance drugs at two times retail copay

2014
City of Detroit
Retiree Health Care Plan