2022

City of Detroit
Health Care Plan Options
for Active Employees

MEDICAL | DENTAL | VISION | LIFE INSURANCE
FLEXIBLE SPENDING ACCOUNTS

To All City of Detroit Employees

Welcome to your City of Detroit Employee Health Care Plan Options Booklet. This booklet outlines the City of Detroit's medical, prescription drug, dental, vision, flexible spending and life insurance plans and all associated eligibility requirements and notices. It is designed for current employees who wish to change his or her health, dental, vision or life insurance coverage during the annual open enrollment period; for new employees enrolling in City benefits for the first time; and for any employee who experiences a qualified life event that requires a change to his or her dependent's coverage outside of the annual open enrollment period*.

It is important that you read your new booklet in its entirety and that you keep it with your other important papers, so you can reference it as needed throughout the year. You should also:

- **Review** the booklet to familiarize yourself with the health care plan options and other benefits that are available. These include:
  - Medical
  - Dental
  - Vision
  - Pre-tax Flexible Spending Accounts
  - Life Insurance
- **Determine** which health care plans best meet your needs and the needs of your eligible family members. If you have a spouse, it is a good idea to review your plan choices together and discuss the health care needs of any dependent children. Under no circumstances shall the City be obligated to provide more than one health policy or plan, or duplicate coverage for any employee, spouse or dependent.
- **Sign up** for your benefits using the **Enrollment Process** described on page 2.
- **Choose carefully.** Once you have chosen your benefit plan options for calendar year 2022, you will not be able to make changes to your benefit plans until the next open enrollment period (fall of 2022).
- **If you would like more information** about specific providers, services, or facilities for the benefit plans described in the booklet, you may contact them directly at the telephone numbers and websites listed on the back cover of this booklet.
- **If you have questions** about this booklet, call the Benefits Administration Customer Service Line toll-free at **(855) 224-6200**. Representatives are available to take calls Monday – Friday, from 8:30 a.m. – 7:00 p.m. Eastern. If you prefer, you can email the Benefits Administration Customer Service Center at **help@mybenefitexpress.com**
- **The City of Detroit Employee Health Care Plan Options Booklet is intended to be an easy-to-read summary guide. It is not a contract.** The statements contained in this booklet regarding eligibility coverage apply generally to all City employees. However, these statements are not intended to replace or supercede any City Code provisions, City Council resolutions or language in labor agreements governing health care or life insurance benefits.

Thank you,

City of Detroit Benefits Administration

*Plan options for Administrative Special Services Employees are outlined in a separate booklet.

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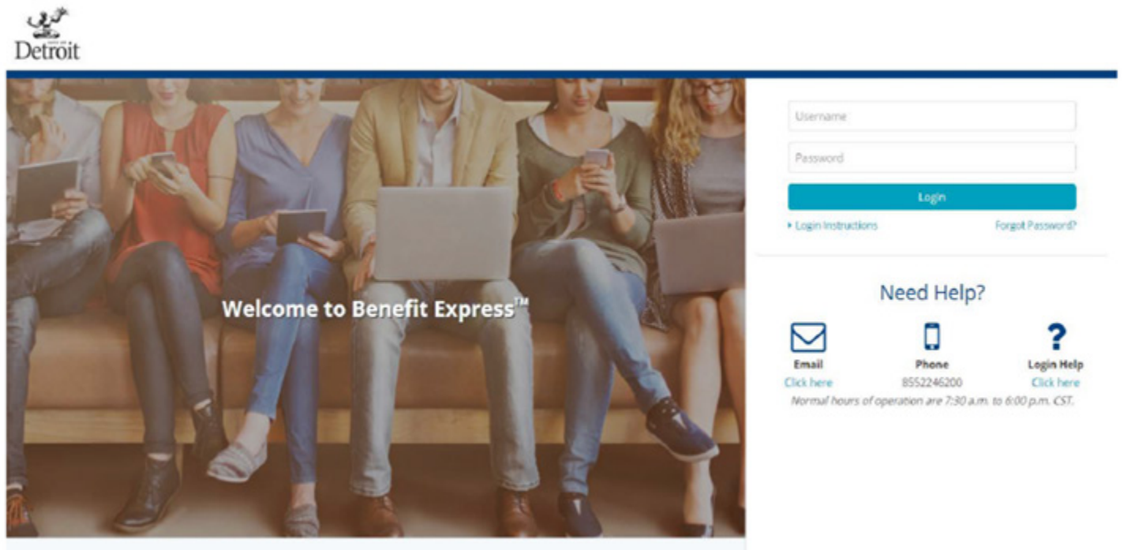
How To Complete The Open Enrollment Process

Open enrollment is scheduled to begin on October 26, 2021. All changes will be effective January 1, 2022.

- **The City of Detroit highly recommends that ALL employees complete the open enrollment process to ensure that your benefit elections for you and your dependents are correct and best meet your needs. Please note the following:**
  - During the enrollment period, you will be able to review your current plans, and employee contributions, select/change your benefit plan options, add or remove dependents, or report other changes affecting your coverage.
  - Please log-in to review any dependent information to ensure it is accurate and complete.
  - Dependents with missing or invalid Social Security Numbers (SSN) will be removed from coverage.
  - You have the option of completing this process online or by phone.
- **To complete your enrollment online, complete the following steps:**

IMPORTANT
ALL PASSWORDS HAVE BEEN RESET.
PLEASE FOLLOW THE DIRECTIONS BELOW TO LOG ON.



- **Step 1 – Log on to the website www.mydetroitbenefits.com**
  - Your username is **DET + the first 5 letters of your last name + the last 4 digits of your SSN**
  - Your initial password is the **first 4 digits of your SSN + the month and day of your birthday in the format MMDD**. Note that if you previously created a password, it has been reset and you must use this format to log-in.
  - Example: If your name is William Johnson, your Date of Birth is 12/01/1964, and your SSN is 123456789, your log-in information would be as follows:
    - Username: DETjohns6789
    - Password: 12341201
  - Upon entering the site, you will be immediately prompted to create your own, unique password, which will be case-sensitive.
- **Step 2 – Click the gold "Enroll Now" Button** to show the Annual Open Enrollment Window.
- **Step 3 – Click the blue "Enroll" button** under Available Enrollments and the system will walk you through the easy process of adding/updating dependents and enrolling in your benefits.
- **Step 4 - Complete the Employee Attestation by checking the box and clicking "Save and Continue"**
- **Step 5 - Verify your Phone Number and E-mail Address and click "Save and Continue"**
- **Step 6 - Verify your Demographic Information and Communication Preference and click "Save and Continue"**
- **Step 7 – Identify any dependents who are also COD Employee and verify no duplicate coverage and click 'Save and Continue.'**
- **Step 8 – Update your dependents** The next page allows you to add new dependents or update their information. All dependents must have valid SSNs to be enrolled in coverage. Please review and, if necessary, update invalid SSNs of your dependents. If you have a dependent who is totally and permanently disabled, you must select the "disabled" indicator and provide the required documentation to the Benefits Administration Office. As you proceed through the enrollment, the coverage levels you are offered are based on the number and type of dependents you elect to cover. Please be sure to read the pages carefully as you may be required to certify your dependents by sending in certain documents before they become eligible for benefits.
- **Step 9 – Make your elections.** The next step allows you to begin picking your elections and,dependent coverage for your benefits. Each page will display your plan choices and will prompt you for additional information where needed. Please make sure you choose all dependents that you want to be covered by verifying they are included under 'Covered Dependents' under the selected Plan Name. All deductions are shown on a per pay basis. If you would like to skip around or go directly to your confirmation statement, just simply click on the drop down box named '2. CHOICES' or '3. CONFIRMATION' the top of the page.
- **Step 10 – Update beneficiaries.** You will be directed to the Beneficiary Designations page displaying all of your dependents and beneficiaries currently in the system. Here you can add new beneficiaries, update their information and assign beneficiary percentages. Any plans requiring a beneficiary designation will be listed on this page.
- **Step 11 – You have completed the enrollment process!** The last page is your confirmation statement. From this page, you can print or email a copy of this confirmation statement for your records. The system will automatically save a copy in your file drawer, which is accessible on the home page, for your future reference. If you need to change any of the plan selections you have made, you can go back into the enrollment and make those changes, but only through the end of the enrollment period. Once the enrollment period ends, you will not be able to make any additional changes to your enrollment unless you experience a qualifying life event.

If you do not have access to a computer

You may also call toll-free (855) 224-6200 to complete your enrollment over the phone with a representative. Note that call volumes are heavy during the open enrollment period and you may be asked to leave a voicemail message. ALL VOICEMAIL MESSAGES WILL BE RETURNED. If you leave a message prior to 11:59 p.m. on the last day of the open enrollment period, you will receive a call back and your enrollment will be processed. Please be sure to enter your **direct call-back number** when prompted.

- Review your benefit plan elections carefully. Upon completing the enrollment process, you will be able to print or email a confirmation statement showing all of your elections. A copy of the confirmation statement will remain on the site for you to access at any time.
- My Benefit Express™ Mobile App – View your benefit elections, find contact information and view educational videos with the My Benefit Express™ mobile app. The mobile app is available for iPhone and Android mobile devices.

Eligibility For Benefits

Employee

Full-time employees are eligible for enrollment in medical, dental, vision, flexible spending accounts and life insurance plans. An employee enrolled in the plan is the subscriber or contract holder. The employee shall remit any required employee contributions (based on the plan selected) and payments for additional dependent coverage to the City through payroll deductions. These elections are applicable for the entire plan year. Employees are not allowed to change their coverage unless they experience a qualifying life event.

Note: The employee must notify the Benefits Administration Customer Service Line at (855) 224-6200 or **www.mydetroitbenefits.com** of any change in health care coverage affecting the employee or any of his or her dependents. The employee must contact the payroll department to report any change of address.

IMPORTANT: Your dependents are only entitled to City medical, dental, vision and life insurance coverage if they meet the eligibility requirements, you have submitted the appropriate documentation and form(s) to the Benefits Administration Office within the appropriate time period and it is approved, and you have submitted a request to enroll them online at www.mydetroitbenefits.com. You must specifically add each eligible dependent to your medical, dental, vision and/or life insurance coverage when completing the enrollment process.

Part-Time and Variable Hour Employees

Certain part-time and variable hour employees may be eligible for coverage under the medical plan if they work, on average, more than 30 hours per week. As permitted under Health Care Reform and detailed in the City's written policies, the City will use the Measurement Period/Stability Period Safe Harbor method to determine the eligibility of an employee who does not work in full-time employment or a part-time position to participate in the Plan. Please contact the Benefits Administration Office at (855) 224-6200 for more information.

Spouse

The legal spouse of an employee is eligible for dependent medical, dental, vision and life insurance coverage. Required documentation is a Social Security Card and a Marriage Certificate that has been properly filed in the County Clerk's office. The Marriage Certificate must show that it was filed in the clerk office in the county that you were married. Active Employees married to a City of Detroit Retiree are eligible to enroll their spouse for health care coverage. Documentation is required.

Divorced Spouses

Divorced spouses are not eligible to be continued as dependents on the City's benefit plans even if the divorce decree mandates that coverage be provided. They may be eligible to purchase health care coverage under COBRA guidelines. Under these guidelines, the divorced spouse may qualify to keep the group health plan benefits for a set period of time. Individuals subject to COBRA coverage may be responsible for paying all costs related to premiums and deductibles.

In order to remove a spouse from your coverage due to divorce or legal separation, you must visit **www.mydetroitbenefits.com** to report the divorce or legal separation and upload a copy of your divorce decree or separation agreement within **30 days** of the event. Coverage termination for an ex-spouse is effective as of the date of the divorce decree. If you fail to remove these ineligible dependents by the deadline, they may lose their rights under COBRA and you will be liable for medical claims and/or premiums incurred from the date of the divorce, as well as subject to disciplinary action up to and including discharge.

Spouses with Other Available Coverage

For employees whose spouse has medical coverage available under a plan offered by his/her employer other than the City of Detroit, said spouse must enroll in their employer's medical plan in order for the spouse to be eligible for coverage through the City of Detroit. You are required to disclose information about any other source of benefits to the Benefits Administration Office. In such cases, if you also enroll your spouse in the City health care plan as described in this booklet, the City's benefit plans will be the secondary insurer/payer.

NO DUPLICATE MEDICAL COVERAGE FOR ANY DEPENDENT OR SPOUSE

Under no circumstances shall the City be obligated to provide more than one medical policy or plan, or duplicate coverage for any employee, spouse or dependent.

For example, if the City employs more than one member of a family unit, the spouse and eligible dependents of that family shall only be covered by one City employee — no duplicate coverage will be permitted. It is the responsibility of the family to select a single medical plan.

Active Employees married to a City of Detroit Retiree are eligible to enroll their spouse for health care coverage. Documentation is required.

Dependent Children

The following types of dependent children are eligible for dependent medical, dental, vision and life insurance coverage until the end of the month in which they reach age 26.

- Natural children
- Stepchildren
- Adopted children
- Children under full legal guardianship

Required documentation for dependent children is a copy of the dependent's Social Security Card and a Birth Certificate or an order or ruling by a court demonstrating legal guardianship. For a newborn infant, a Verification of Birth naming the employee as a parent will be initially accepted, but the Birth Certificate and Social Security Card must be presented within 90 calendar days. Other documents or proof may also be required.

Grandchildren are not eligible for coverage unless the employee has been granted full legal guardianship.

Disabled Dependent Children

Totally and permanently disabled children may be covered to any age provided the disability was medically certified and the employee has submitted the required medical documentation and application for continued coverage (Form No. PA 275) to the Benefits Administration Office BEFORE the end of the month in which the dependent became 26 years of age. Failure to meet these requirements will result in disqualification for coverage as a disabled child.

NOTE: Your dependents are only entitled to City health care, dental, vision and life insurance coverage if they meet the eligibility requirements, you have submitted the proper documentation and form(s) to the Benefits Administration Office within the appropriate time period and it is approved, and you have submitted a request to enroll them at **www.mydetroitbenefits.com**.

IMPORTANT — DEPENDENT SOCIAL SECURITY NUMBERS

In order for the City of Detroit to complete reporting required by the Patient Protection and Affordable Care Act (PPACA), all dependents added to coverage MUST have a valid Social Security Number. If your dependent has an invalid Social Security Number in the eligibility system and/or is added to coverage with an invalid Social Security Number, the enrollment will not be processed and the dependent will be removed from coverage.

Dependent Enrollment Documentation Requirements

	Dependent Classification & Eligible Plan		
	Legal Spouse	**Dependent Child**	**Dependent Continuation****
Eligibility Guidelines		**Medical, Dental and Vision:** Eligible until the end of the month in which the dependent turns 26. **Life Insurance:** Eligible from 14 days old until end of the month in which the dependent turns 26.	
Marriage Certificate Note: A Marriage License will not be accepted as sufficient documentation. An IRS Tax Transcript may be required during dependent audits.	**Yes**	**No**	**No**
Birth Certificate Note: For a newborn infant, a Verification of Birth, naming the employee as the parent will be initially accepted, but the Birth Certificate must be presented within 90 calendar days.	**No**	**Yes**	**Yes**
A copy of the dependent's Social Security Card Note: For a newborn infant, the Social Security Card must be presented within 90 calendar days.	**Yes**	**Yes**	**Yes**
A copy of the dependent's Medicare card Note: If the dependent is permanently disabled or age 65 and older and not eligible for Medicare, you must provide documentation from the Social Security Administration that the dependent is not eligible for Medicare.	**Yes**, if eligible for Medicare due to age or disability	**Yes**, if eligible for Medicare	**Yes**, if eligible for Medicare

Reminder: Spouses and dependent children who are also City employees as well as dependent children of two City employees can only be enrolled under one medical plan (no dual coverage).

IMPORTANT: Active Employees married to a City of Detroit Retiree are eligible to enroll their spouse for health care coverage. Documentation is required.

Please retain photo copies of all health care forms and documents submitted for your personal records.

Time limits for submission of enrollment information and documentation are strictly enforced!

*Go online to **www.mydetroitbenefits.com** to make updates and upload supporting documents.*

New Hires: 30 calendar days from hire. **Life Events*:** 30 calendar days from the life event. **Open Enrollment:** Designated Dates.
Notification that a child is totally and permanently disabled: Before the end of the month in which the child is age 26.
*Examples of life events include marriage, birth of a child, or loss of coverage for a reason you did not cause or could not prevent.

Your Benefit Plan Options

On the following pages, you will find information on the medical, dental, vision, flexible spending and life insurance plans available to City of Detroit employees and their eligible spouses and dependents.

Plan options for Administrative Special Services Employees are outlined in a separate booklet.

Important Reminders:

- **Selections made for medical and dental plans stay in place for one full calendar year. Vision plans stay in place for two full calendar years. You cannot make changes to your benefit elections mid-year unless you experience a qualifying life event. Please see the "Qualifying Life Events and Mid-Year Enrollments" section on page 35 for information about qualifying life events.**

- **Under no circumstances shall the City be obligated to provide more than one medical policy or plan, or duplicate coverage for an employee, spouse or dependent.**

  For example, if the City employs more than one member of a family unit, the spouse and eligible dependents of that family unit shall only be covered by one City employee — no duplicate coverage will be permitted. It is the responsibility of the family to select a single medical plan.

- **Your current coverage for your Flexible Spending Account, commuter benefit, or medical plan opt-out credit will NOT automatically continue for 2022. You must complete the enrollment process if you want to maintain these benefits for 2022.**

- **The health care plan options described in this booklet provide protection against a wide range of health care expenses. While coverage is broad and comprehensive, plans vary in the benefits they offer and will not cover all health care services and expenses under all circumstances. Therefore, contact your health care provider if you have questions regarding whether a particular health care service or expense is covered and whenever possible, obtain pre-approval before having services performed. A telephone number for each medical, dental and vision plan carrier is listed on the back cover of this booklet.**

- **For employees enrolled in the BCN Healthy Blue Living with PCP Focus plan Only: Your prescription drug vendor is changing from Express Scripts to OptumRx. The following will occur:**
  - **You will receive a new ID card showing OptumRx as the new prescription drug vendor. Please begin to show this new ID card to your pharmacies when filling a new script January 1, 2022.**
  - **Your mail order scripts will be transferred automatically unless it is expired as of December 31, 2021, is a controlled substance or has no refills remaining. In these instances, you will need to submit a new script to OptumRx.**

  BCN will be sending you communications about these changes and how you can effectively manage your prescription drug plan.

  NOTE: Employees enrolled in the BCBSM PPO or HAP HMO plans are not affected by this change.

Medical and Prescription Drug Plans

	BCBSM Community Blue PPO	
	This PPO plan does not require referrals. You may see any provider, including specialists, in the BCBSM PPO network and receive the In-Network level of benefits described in the chart below. If you use a non-PPO provider, you will be subject to the Out-of-Network cost sharing described in the chart below, plus any differences between the provider's charge and the BCBSM approved amount.	
	In-Network	**Out-of-Network**
Deductibles		
Annual Deductible	$750 Single $1,500 Family	$1,500 Single $3,000 Family
Coinsurance		
Coinsurance	20% for most services	40% for most services
Out-of-Pocket-Maximums (OOPM)		
Coinsurance OOPM	$1,500 Single $3,000 Family (Not including Deductible)	$4,500 Single $9,000 Family (Not including Deductible) Note: Out of network cost sharing amounts count toward the in-network coinsurance maximum.
Medical and Prescription OOPM (including Deductible)	$6,350 Single $12,700 Family (including Deductible)	$12,700 Single $25,400 Family Note: Out of network cost sharing amounts count toward the in-network out-of-pocket maximum.
Physician Office Services		
Primary Care Physician (PCP) Office Visits	$25 copay	Plan Pays 60% after Deductible
Online Visits	$25 copay	Plan Pays 60% after Deductible
Specialist Care	$25 copay	Plan Pays 60% after Deductible
Preventive Services		
Health Maintenance Exam	Plan Pays 100%	Not Covered
Annual Gynecological Exam	Plan Pays 100%	Not Covered
Mammography Screening	Plan Pays 100%	Plan Pays 60% after Deductible
All other preventive services *Please log in to **www.mydetroitbenefits.com** for a sample listing of preventive services.	Plan Pays 100%	Not Covered
Hearing	Hearing covered once every 36 months	Hearing covered once every 36 months

	BCN Healthy *Blue* Living with PCP Focus Network HMO		HAP HMO
	This HMO plan requires you to select a Primary Care Physician (PCP) that participates with BCN's PCP Focus Network. This PCP will coordinate your care. If you need to see a specialist, you will need a referral from your PCP. This plan also has wellness requirements. You must complete these wellness requirements in order to receive the Enhanced Benefits described in the chart below. Please see details on the network and wellness requirements beginning on page 18.		This HMO plan requires you to select a Primary Care Physician (PCP) who will coordinate your care. Depending on the PCP you choose, you may not need a referral to see a specialist. Please contact HAP for more details.
	Enhanced Benefits In-Network Only*	**Standard Benefits In-Network Only***	**In-Network Only***
$250 Single $500 Family	$750 Single $1,500 Family	$750 Single $1,500 Family
20% for most services	20% for most services	20% for select services
$1,000 Single $2,000 Family	$1,500 Single $3,000 Family	$1,500 Single $4,500 Family These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, deductibles, and copays.
$6,600 Single $13,200 Family (including Deductible)	$6,600 Single $13,200 Family (including Deductible)	$6,350 Single $12,700 Family These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
$20 copay	$30 copay	$25 Copay
$20 copay	$30 copay	Online Visits - $25 copay
$30 copay after deductible	$40 copay after deductible	$25 Copay
Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Hearing covered once every 36 months	Hearing covered once every 36 months	When medically necessary

*The BCN and HAP plans have no out of network coverage.

Important health care notices are included in the "Important Notices" section beginning on page 40.

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

Note: Out-of-pocket maximum and coinsurance may be applied to certain services.

Important health care notices are included in the "Important Notices" section beginning on page 40.

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Note: Out-of-pocket maximum and coinsurance may be applied to certain services.

	BCBSM Community Blue PPO	
	In-Network	**Out-of-Network**
Hospital Care		
Number of days of care	Unlimited Days	Unlimited Days
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Plan Pays 80% after Deductible and $100 Copay	Plan Pays 60% after Deductible
Outpatient Surgery	Plan Pays 80% after Deductible and $100 Copay	Plan Pays 60% after Deductible
Emergency Care		
Hospital Emergency Room	$100 Copay (copay waived if admitted or for accidental injury)	$100 Copay (copay waived if admitted or for accidental injury)
Urgent Care	$25 Copay	Plan Pays 60% after Deductible
Ambulance - medically necessary	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible
Diagnostic Services		
Laboratory and pathology tests	Plan Pays 80% after Deductible	Plan Pays 60% after Deductible
Diagnostic tests and X-rays	Plan Pays 80% after Deductible	Plan Pays 60% after Deductible
Alternatives to Hospital Care		
Skilled Nursing Care in a nursing home	Plan Pays 80% after Deductible. Limited to a maximum of 120 days	Plan Pays 80% after Deductible. Limited to a maximum of 120 days
Mental Health Care		
Inpatient mental health care	Plan Pays 80% after Deductible and $100 Copay	Plan Pays 60% after Deductible
Outpatient mental health care	80% after Deductible	Plan Pays 60% after Deductible
Appliances & Prosthetic Devices		
Prosthetics & Orthotics and Durable Medical Equipment	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible
Chiropractic Services		
Chiropractic Care	$25 Copay - Deductible does not apply	Plan Pays 60% after deductible

BCN Healthy *Blue* Living with PCP Focus Network HMO		HAP HMO
Enhanced Benefits In-Network Only*	**Standard Benefits In-Network Only***	**In-Network Only***
Unlimited Days	Unlimited Days	Unlimited Days
Plan Pays 80% after Deductible	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible and $100 Copay per admission, after deductible
Plan Pays 80% after Deductible	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible
$150 Copay (copay waived if admitted)	$150 Copay (copay waived if admitted)	$100 Copay - Deductible does not apply (copay waived if admitted)
$35 Copay	$35 Copay	$25 Copay - Deductible does not apply
Plan Pays 80% after Deductible	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible (emergency transport only)
Plan Pays 100%	Plan Pays 100%	Plan Pays 80% after Deductible
Plan Pays 80% after Deductible	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible
Plan Pays 80% after Deductible. Limited to a maximum of 45 days per calendar year	Plan Pays 80% after Deductible. Limited to a maximum of 45 days per calendar year	Plan Pays 80% after Deductible (up to 730 days; renew after 60)
Plan Pays 80% after Deductible	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible and $100 Copay per admission
Plan Pays 80%	Plan Pays 80%	$25 Copay - Deductible does not apply
Plan Pays 80% after Deductible	Plan Pays 80% after Deductible	Plan Pays 80% after Deductible for approved equipment based on HAP guidelines
$30 Copay; up to 30 visits per calendar year	$40 Copay; up to 30 visits per calendar year	Not Covered

Tobacco Coaching through BCBSM

If you're a tobacco user who's ready to quit, the Tobacco Coaching program, powered by WebMD, may be right for you.

To qualify for this 12-week program, you must be ready to set a quit date within the next 30 days, and you must have used tobacco within seven days of your initial call to a health coach.

You'll receive five calls from a specially trained health coach over 12 weeks, where you'll work toward your goal of quitting tobacco. If you need additional support, you can call a health coach at any time.

Health coaches are available for calls, Monday through Thursday 9 am to 11:30 pm, Friday 9 am to 8 pm, Saturday 9:30 am to 6 pm and on Sunday 1 to 11:30 pm.

Call WebMD to schedule your first call at **1-855-326-5102.**

Important health care notices are included in the "Important Notices" section beginning on page 40.

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Note: Out-of-pocket maximum and coinsurance may be applied to certain services.

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Note: Out-of-pocket maximum and coinsurance may be applied to certain services.

Medical and Prescription Drug Plans *continued*

	BCBSM Community Blue PPO	
	In-Network	**Out-of-Network**
Prescription Drugs		
Certain drugs require prior authorization and have quantity restrictions.		
Retail Generic (30 day)	$10 Copay	
Retail Formulary Drug – Brand Name (30 day)	$35 Copay	
Retail Formulary Drug – Non-Preferred Brand Name (30 day)	$50 Copay	
Eligible Retail 90 day maintenance	Two times the applicable generic and brand copay for a 90-day supply	
Lifestyle Drugs	Not covered	
Mail Order Prescription Drugs	Two times the applicable generic and brand copay for a 90-day supply	
Prescription Drug Provider	BCBSM Community Blue PPO plan prescription drug benefit is administered by CVS Caremark. See more information on page 20 concerning CVS Caremark.	

Note: The BCBSM plan will include the High Cost Drug Optimization Program administered through PrudentRx covering specialty medications.

What is a Preferred Provider Organization (PPO) plan?

PPO plans consist of a network of independent physicians, hospitals and other health care providers who have agreed to accept a pre-approved amount as full payment for services provided to members of the plan. Under this arrangement, your out-of-pocket expenses will usually be lower for covered benefits if you use network health care providers rather than out-of-network providers. Annual deductibles and copays are required for certain services.

Important health care notices are included in the "Important Notices" section beginning on page 40.

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Note: Out-of-pocket maximum and coinsurance may be applied to certain services.

	BCN Healthy *Blue* Living with PCP Focus Network HMO		HAP HMO
	Enhanced Benefits — In-Network Only*	**Standard Benefits — In-Network Only***	**In-Network Only**
Certain drugs require prior authorization and have quantity restrictions.**			
Tier 1 $10 copay	Tier 1 $10 copay		Generics $10 Copay - Deductible does not apply
Tier 2 $35 copay	Tier 2 $40 copay		Preferred Brands $35 Copay - Deductible does not apply
Tier 3 $50 copay	Tier 3 $80 copay		Non-Preferred Brands and Specialty $50 Copay - Deductible does not apply
90 Day Retail: 84-90 day supply: Two times the tiered copayments defined above	90 Day Retail: 84-90 day supply: Two times the tiered copayments defined above		30 day supply for non-maintenance drugs at 1 copay, 90 day supply for eligible maintenance drugs at two times retail copay
Covered**	Covered**		Covered at applicable tier copay.
Mail Order Prescription Drugs 31-90 day supply: Two times the tiered copayments defined above	Mail Order Prescription Drugs 31-90 day supply: Two times the tiered copayments defined above		90 day supply for both eligible maintenance and non-maintenance drugs at two times retail copay
Blue Care Network	Blue Care Network		HAP plan prescription drug benefit is administered by HAP

***The BCN and HAP plans have no out of network coverage.**

**Lifestyle Drugs - BCN Healthy Blue Living Plan: The BCN plan covers lifestyle drugs at 50% coinsurance, weight management drugs at the applicable tier copay; smoking cessation drugs are fully covered.

**Lifestyle Drugs - HAP Plan: The HAP plan covers lifestyle drugs at the applicable tier copay.

Note: The BCN plan will include the High Cost Drug Optimization Program administered through PillarRx covering specialty and other high-cost medications.

What is a Health Maintenance Organization (HMO) plan?

HMO plans manage and coordinate medical care. You must select a primary care physician from the HMO's provider directory who will provide the majority of your medical services and coordinate other services such as specialty care, hospital services and diagnostic testing. Because you are required to use network providers, out-of-pocket expenses for covered benefits are usually lower than with other types of plans. It is important to note that employees who select an HMO plan must reside in the network service area of the HMO plan for six months of the year. 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 copays are required for certain services.

Important health care notices are included in the "Important Notices" section beginning on page 40.

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

Note: Out-of-pocket maximum and coinsurance may be applied to certain services.

Blue Care Network Healthy *Blue* Living with PCP Focus Network

This plan provides you with the opportunity to receive an **enhanced level of benefits** and **pay less out of your paycheck** for your medical plan. If you decide to enroll in this plan, there are two important components to consider and understand. These components are the **PCP Focus Network** and the **Wellness Requirements**. **You must take action on these items if you decide to enroll in this plan.**

1. The PCP Focus Network

You MUST select a Primary Care Physician (PCP) from BCN's PCP Focus network. This PCP will coordinate all of your care. This means that if you need to see a specialist, you must request a referral from your PCP. The PCP Focus network has over 3,300 PCPs and over 25,000 specialists around the state.

Note that the network changes each year as quality and cost metrics are reviewed. If your PCP is removed from the network, BCN will notify you. You will have the option to select another PCP or one will be assigned to you.

If you have a referral from your in-network Primary Care Physician (PCP), the specialists and facilities that participate in BCN's overall network are available to you. **There is no coverage if you visit a non-network provider.**

Important Prescription Drug Information

The Blue Care Network Healthy *Blue* Living plan uses the Blue Care Network prescription drug formulary. If you enroll in this plan, coverage for your prescription drugs may change. Please contact Blue Care Network for more information.

To check if your doctor is in the PCP Focus Network, visit **www.bcbsm.com** and click on "Find a Doctor"; then click "Search Without Logging In."

Women do not need a referral to see their OB/GYN for routine women's health services. However, the OB/GYN must participate with the BCN network.*

2. Wellness Requirements — Healthy *Blue* Living

What is Healthy *Blue* Living?

It's a wellness plan that puts a spotlight on healthy lifestyles and encourages you to take charge of your health. As a result, you'll have a better understanding of your current health status and you'll receive lower out-of-pocket costs for the whole benefit year when you complete plan requirements.

Healthy *Blue* Living has two levels:

- **Enhanced level** = You met the plan requirements and, as a result, everyone on your contract has lower out-of-pocket costs.
- **Standard level** = You didn't meet the plan requirements. You're still covered, but everyone on your contract has higher out-of-pocket costs.

*Some women's health services may require a referral. Please contact BCN for more details.

How do I earn the enhanced level?*

When you first become a Healthy *Blue* Living member, you'll automatically start in the enhanced level. To stay here, you have a to-do list with plan requirements. **You'll need to complete the first two steps below within the first 90 days of your plan year.** You may also have more requirements. **Depending on your current health status, you may need to also complete steps 3 and 4 within the first 120 days of your plan year.**

Check your personal to-do list online and see the deadline of each task when you create an account and sign in as a member at bcbsm.com.

You must complete these requirements within the first 90 days of the plan year:

1. See your primary care physician for a visit to complete your Blue Care Network Qualification form.

   After your exam, your doctor needs to electronically submit your qualification form to BCN.

2. Complete a health assessment by logging in to your account at bcbsm.com. It takes about 10 minutes. If you don't have internet access, a paper copy is also available. The welcome materials BCN will send to you will have information for how to request a paper copy.

You must complete these requirements within the first 120 days of the plan year:

3. Enroll in the tobacco cessation coaching program. If your qualification form shows you use tobacco, enroll and participate in this program for the rest of your plan year or until your doctor submits a new qualification form that shows you no longer use tobacco. There's no extra cost for this program.

4. Sign up for a BCN-sponsored weight-management program option. If your qualification form shows you have a body mass index of 30 or more, enroll and participate in one of BCN's weight-management program options for the rest of your plan year or until your doctor submits a new qualification form that shows your BMI is below 30.

If you have a tobacco-cessation or weight-management requirement, you'll receive more details about the programs in the mail.

Renewing employees (employees currently enrolled in the Healthy *Blue* Living Plan) start the new year at the level they had in the previous plan year. If you were most recently at the enhanced level, you will stay there as long as you complete all necessary requirements noted above. If you were at the standard level, you will start the new plan year at the standard level, but you can still work to meet the enhanced requirements during the first 90 to 120 days of the new plan year.

Who has to complete the requirements?

The employee, or contract holder, is the only member on a contract who needs to complete the plan requirements to keep or earn the enhanced level for everyone on his or her contract.

What is the Blue Care Network Qualification Form?

It's a form that helps you and your doctor get a snapshot of your health based on the six high-impact health measures below. When you score A's and B's on these health measures. This means you're meeting the wellness targets or you've committed to treatment to improve a particular health measure. Once you enroll, BCN will include a sample qualification form in your welcome kit. Your doctor will submit your qualification form for you after your appointment.

TOBACCO	**Target:** Doesn't use (confirmed by primary care physician through blood or urine cotinine testing)	WEIGHT	**Target:** Body mass index below 30
BLOOD PRESSURE	**Target:** Below 140/90	CHOLESTEROL	**Target:** LDL-C below target (based on risk factors: <100, <130 or <160)
BLOOD SUGAR	**Target:** At or below target (fasting blood sugar or A1c)	DEPRESSION	**Target:** Any depression is in full remission

What will I receive from Blue Care Network to keep me on track?

When you enroll in Healthy *Blue* Living, you'll receive a Member Handbook in the mail. This booklet will include Instructions on how you can activate your online member account, where to access your digital Member Handbook within your member account, and key steps to get started using your health plan.

BCN will send you letters during the beginning of your plan year with reminders about the requirements you already completed and those you still need to do.

Blue Care Network is committed to helping you achieve your best health status. Rewards for participating in our wellness program, Healthy *Blue* Living, are available to all contract holders who meet all qualification requirements. If you think you might be unable to meet a standard or requirement for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. You can work with your BCN primary care physician to find an alternative that's right for you in light of your health status.

Medical Plan Opt-Out Program

City employees who are covered under the medical plan of an employer other than the City of Detroit (e.g. through a spouse or other relative) may choose not to enroll in the City's medical plan and instead receive a cash payment from the City through payroll deduction. City employees may opt out of medical and prescription drug coverage only if the employee and his or her tax dependents are enrolled in another employer health plan that provides minimum essential coverage. If the employee and his or her tax dependents are not enrolled in minimum essential coverage, the employee will be required to enroll in one of the City of Detroit's medical plans as it provides minimum value and is considered affordable under the provisions of the Patient Protection and Affordable Care Act (PPACA).

Important: The following employee groups are NOT eligible to receive Opt-Out program payments:

- **Employees with minimum essential medical coverage through another City of Detroit employee.**
- **Employees in the COPS Trust medical plan**
- **Employees enrolled in another plan that does not provide minimum essential coverage.**

Employees may only exercise the Opt-Out option during the open enrollment period and are required to re-elect the Opt-Out benefit annually and resubmit their supporting documentation to continue to receive any eligible payments. Enrollment in the Opt-Out program is for one full year, unless you experience a qualifying event.

If you elect the Opt-Out program because you are enrolled in other employer group health insurance coverage, you may be able to enroll yourself and your dependents in one of the City's medical plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Please see page 35 for more information.

Generally, the Opt-Out program provides you with a cash payment of $950.00 annually through payroll deduction. Most employees will receive a credit of $36.54 in their bi-weekly payroll check. Employees paid through the PDS system receive a credit of $237.50 in the last payroll check in January, April, July and October of each year. Employees who opt-out of the City's medical plan may continue to participate in the City's dental or vision plans.

Employees must enroll in the Opt Out Program online at **www.mydetroitbenefits.com**. You must also submit an Opt-Out application form and proof of other medical coverage to receive your Opt-Out payment. Proof of medical coverage includes the following:

- A letter or other documentation from the employer or employee group health plan which confirms that you are being carried as an employee/dependent on their medical plan. This coverage must demonstrate that you and your tax dependents are enrolled in a plan that provides minimum essential coverage.

Employees who opt-out of the City's medical plan may continue to participate in the City's dental and/or vision plan.

If you fail to enroll in the Opt Out plan through the online system or neglect to attach proof of coverage, your request for Opt Out will not be processed for January 1, 2022 through December 31, 2022.

If you have questions regarding the Opt-Out program, please call the Benefits Administration Customer Service Line at (855) 224-6200 or online at **www.mydetroitbenefits.com**.

CVS Caremark Prescription Drug Benefit Information

(BCBSM Community Blue Medical Plan Participants Plan Only)

If you enroll in the BCBSM Community Blue PPO plan, your prescription drug benefit will be administered by CVS Caremark. Your prescription plan through CVS Caremark offers two ways to get your medication:

- **Retail network (short-term medications)**
  Use a CVS Caremark participating retail pharmacy when filling short-term prescriptions for medications such as antibiotics. The CVS Caremark network includes more than 64,000 pharmacies nationwide, including chain pharmacies, 20,000 independent pharmacies and 9,500+ CVS/pharmacy stores. You may also use a CVS retail pharmacy to fill prescriptions for long-term medications through the Maintenance Choice program. Through this program, you can receive a 90-day supply of your long term medication at a retail CVS Pharmacy at the same copay as through the CVS mail pharmacy.
- **Mail service pharmacy (long-term medications)**
  Use the CVS Caremark Mail Service Pharmacy or a CVS Retail Pharmacy to fill your long-term prescriptions. Mail service or a CVS Retail Pharmacy is a cost-effective choice for long-term medications because you can get up to a 90-day supply for less than what you would pay for the same supply at retail. **As noted above, you may also fill prescriptions for long-term medications at a CVS Retail Pharmacy through the Maintenance Choice program. Just have your physician write your prescription for a 90-day supply.**

The CVS Caremark plan requires the use of generics first, mail order or CVS Retail for maintenance medications, step therapy and prior approval for certain medications. For more information on these programs go to **www.mydetroitbenefits.com**.

Members can manage prescriptions according to their schedule and preferences

- Transfer a 90 day prescription from mail service to a local CVS Pharmacy
- Refill an existing prescription
- Transfer a 30-day retail prescription at mail service of CVS Pharmacy (using FastStart)
- Search for a Maintenance Choice pharmacy with the Find a Pharmacy tool
- See Maintenance Choice pricing with the Check Drug Cost tool
- Find Maintenance Choice savings opportunities with the Savings and Opportunities tab
- Ask a pharmacist questions through email (Caremark.com only)

Important Information For Mail Service Program Users

Q. What should I do if I have existing refills with another vendor?

A. You will need to ask your doctor for a new prescription and mail it to CVS Caremark or have it transferred to a local CVS Retail pharmacy. For maintenance medications, ask your doctor to write two prescriptions:

- The **first** for up to a 90-day supply plus any appropriate refills to fill through the CVS Caremark Mail Service Pharmacy, or through a local CVS retail pharmacy. You can expect to get your prescription up to 10 days from the time your order is placed if you use CVS Caremark Mail Service.
- The **second** for up to a 30-day supply, which you can fill at a participating retail network pharmacy to use until your mail service prescription arrives.

Q. Where do I send my prescription order?

A. All prescription orders must be submitted to CVS Caremark. Send your order and the appropriate copayment to the preprinted mailing address on the mail service order form, which is available at **www.mydetroitbenefits.com**. You will receive a mail order form in your CVS Caremark new member welcome kit. You will also receive a new mail order kit with each prescription order. Note that your doctor may also be able to submit your script directly to CVS Caremark.

Q. How do I pay for my prescriptions?

A. CVS Caremark prefers payment by credit card, but you can also pay by check or money order. For credit card payments, include your VISA®, Discover®, MasterCard®, or American Express® number and expiration date in the space provided on the order form.

Dental Plans

Benefits	Blue Cross Dental Plan	Golden Dental Plans	DENCAP Dental Plans*
Annual Dollar Maximum			
Maximum annual amount per covered person including diagnostic, restorative, etc.	$1,000	$3,500	$3,300 per member
Diagnostic			
Oral examinations	100% (twice per year)	100%	100%
Emergency treatment for pain	100%	100%	100%
X-rays	100% (limitations depending on type of x-ray)	100%	100%
Prophylaxis – teeth cleaning	100% (twice per year)	100%	Twice Per Year: 100%
Fluoride application	100% (twice per year)	100% up to age 19	Twice Per Year: 100%
Space maintainers	100% (Once per quadrant per lifetime, under age 19)	100% up to age 19	85%
Restorative			
Fillings: Amalgam, Composite	80%	100%	85%
Crowns: Porcelains or Metal	50%	80%	80%
Endodontics			
Root canal therapy	80%	70%	85%
Periodontics			
Treatment for gum disease and tissue of the mouth	80%	70%	80%
Oral Surgery			
Extractions – simple and surgical	50%	70%	85%
Prosthodontics			
Complete dentures	50%	80%	85%
Partial dentures – chrome acrylic	50%	80%	80%
Fixed bridges – full cast	50%	80%	80%
Orthodontics			
Orthodontics (includes over age 19)	50%	$3,000 up to age 19, Member and Spouse	$1,800 under age 19 $1,200 over age 19
Orthodontics – lifetime maximum per covered person	$1,000	$3,000	$1,800 under age 19 $1,200 over age 19 per member
Service Provider			
	Must use an provider in the BCBSM network. Out of network benefits are covered at 50%.	Must use a provider in the Golden Dental Plans Network.	Must use a provider in the DENCAP Dental Plan Network
	For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination before treatment begins.		

*Flat copays are charged for all dental services. The percentages shown in the chart are the approximate percentage of the copays to actual cost for the service.

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

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Vision Plans

The summary below is for your reference only. Vision is a two-year enrollment.

City of Detroit - Active Plan Options	Basic Plan Two-Year Plan	
Description	This is the City's current two year plan, which offers an exam and one pair of glasses or contacts once every two years.	
Frequency of Services	**Adults & Dependents to age 26****	
Exams	24 Months	
Lenses	24 Months	
Frames	24 Months	
Co-pays	**In-Network**	**Non-Network**
Exams	$0 copay	N/A
Lenses	$0 copay	N/A
Frames	$0 copay	N/A
Allowances	**In-Network**	**Non-Network**
Exams	100% Covered	N/A
Lenses - Standard		
Single	100% Covered	N/A
Bifocal	100% Covered	N/A
Trifocal	100% Covered	N/A
Progressive	Not Covered	N/A
Frames [1]	$100 Allowance	N/A
Lens Options	**In-Network**	**Non-Network**
Solid Tint	100% Covered	N/A
Anti-Reflective Coating	Not Covered	N/A
Scratch Coating	100% Covered	N/A
Prism	100% Covered	N/A
Photochromic Lenses	Not Covered	N/A
Contacts (In Lieu of Glasses)	**In-Network**	**Non-Network**
Elective Contacts [2,3]	$45 Allowance	N/A
Medically Necessary	Not Covered	N/A
Network	Heritage Select Network	

[1] Program frames include 6 month manufacturer warranty. 20% off remaining balance.
[2] Member responsible for contact fitting fees.
[3] 10% off remaining balance, excludes disposable contacts.
20% discount for lens options and upgrades not covered by the plan.
Minimum 20% discount for additional prescription Eyeglass or Sunglass purchase. Some restrictions may apply.
15% Discount off Retail Price (or 5% off Promotional Pricing) on Lasik Refractive Surgery through the LCAV nationwide network of providers.

****Progressive Myopic Children** (under age 19) receive an exam and new lenses once every 12 months with a prescription change of ± .50 diopters or more.

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

Enhanced Plan Annual Calendar Year Plan		Premier Plan Annual Two-Pair Calendar Year Plan	
This plan mirrors the Basic plan but offers annual service for the exam and **one pair of glasses** OR contact lenses once every year.		This plan mirrors the Basic plan but offers annual services for the exam and **two pairs of glasses**, OR one pair of glasses and one pair of contact lenses once every year.	
Adults & Dependents to age 26		**Adults & Dependents to age 26**	
12 Months		12 Months	
12 Months		12 Months	
12 Months		12 Months	
In-Network	**Non-Network**	**In-Network**	**Non-Network**
$0 copay	N/A	$0 copay	N/A
$0 copay	N/A	$0 copay	N/A
$0 copay	N/A	$0 copay	N/A
In-Network	**Non-Network**	**In-Network**	**Non-Network**
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
$130 Allowance[4]	N/A	$130 Allowance[4]	N/A
In-Network	**Non-Network**	**In-Network**	**Non-Network**
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
100% Covered	N/A	100% Covered	N/A
In-Network	**Non-Network**	**In-Network**	**Non-Network**
$130 Allowance	N/A	$130 Allowance	N/A
Not Covered	N/A	Not Covered	N/A
Heritage National Network			

[1] Program frames include 6 month manufacturer warranty. 20% off remaining balance.
[2] Member responsible for contact fitting fees.
[3] 10% off remaining balance, excludes disposable contacts.
[4] $75 allowance for Sam's Club and Walmart.
20% discount for lens options and upgrades not covered by the plan.
Minimum 20% discount for additional prescription Eyeglass or Sunglass purchase. Some restrictions may apply.
15% Discount off Retail Price (or 5% off Promotional Pricing) on Lasik Refractive Surgery through the LCAV nationwide network of providers.

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

Life Insurance Plan

A group life insurance program for the employee and their dependents is available to eligible City employees on an optional basis as follows:

- For General City Employees: The City will pay approximately sixty percent (60%) of the premiums for life insurance coverage up to and including $12,500. The employee would pay the remaining portion of the premiums. Each dependent can be insured for $5,000 at the employee's expense.
- For Non-Civilian Employees of the Police and Fire Department: The City will pay one hundred percent (100%) of the premiums for insurance up to and including $35,000 for the employee and $5,000 for each dependent, if applicable.

Both groups of employees can purchase additional group life insurance at their own expense. Under Option 1, you can purchase an amount of life insurance approximately equal to your annual salary based upon a published schedule of salary ranges. Under Option 2, you can purchase an amount of life insurance approximately equal to twice your annual salary, based upon a published schedule of salary ranges. A change from Option 1 to Option 2, or an increase in salary, is not subject to Evidence of Insurability provisions.

The current life insurance carrier for the group life insurance available to City employees is MetLife. The toll-free number is listed on the back cover of this booklet.

If you wish to participate in the life insurance program, go to **www.mydetroitbenefits.com** during open enrollment to enroll. The amount of any required employee insurance payments will be deducted from your paycheck. You should also read the "Eligibility for Health Care and Life Insurance Benefits" section of this booklet for rules regarding dependent life insurance coverage.

Employees should visit **www.mydetroitbenefits.com** to review their life insurance beneficiary designations. Life insurance beneficiaries can be updated at any time during the year. If an employee does not designate a life insurance beneficiary, the benefit will be paid according to the plan document.

Important: Employees who do not enroll in group life insurance when originally eligible upon hire are considered "late entrants". Enrollment after the original eligibility period is subject to Evidence of Insurability provisions, including enrollment during the annual open enrollment period unless otherwise specified.

City Death Benefit Program

Apart from the optional life insurance programs described above, the City has a Death Benefit program, administered by the Finance Department, which is mandatory for all regular City employees. An amount of 40¢ is automatically deducted from the employee's paycheck on a biweekly basis. The current benefit payment on the employee's death is $10,000.

Flexible Spending Accounts

Flexible Spending Arrangements (FSAs) help you save money on health, day care and commuter expenses. FSAs will have the whole family cheering!

Tax Benefits

The federal government takes about 30% of each dollar you earn in FICA and federal income taxes, and you take home the remaining 70% to use for your living expenses. When you use an FSA, you set aside money before it is taxed, so you spend the entire 100% of your earned income on your health and day care expenses.

Here's an example of the potential tax savings by enrolling in a HCFSA.

Health Care FSA Savings Example	Without HCFSA	With HCFSA
Gross Annual Salary	$36,000	$36,000
Pre-Tax Health Care Costs	-	$2,500
Taxable Income	$36,000	$33.500
Federal Income Tax (15%)	$5,400	$5,025
State Income Tax (4.25%)	$1,530	$1,424
FICA (7.65%)	$2,754	$2,563
After-tax Health Care Costs	$2,500	-
Net Annual Salary	$23,816	$24,488
Annual Savings	**-**	**$672**

Enrolling in the Health Care FSA would save the above employee over $672 per year in tax savings!

How does it work?

- During your open enrollment estimate your eligible expenses for the plan year and enroll in the plan.
- Your annual election amount will be evenly deducted pre-tax from your paycheck throughout the plan year.
- You cannot change your annual election amount after the plan start unless you have a qualified change in status. For example, birth, death, marriage or divorce.
- Check out your Navigate My Benefits and Pre-Tax Solutions pages for more details on how your plan works.

Visit or contact us:

www.naviabenefits.com or **customerservice@naviabenefits.com** or by phone at (800) 669-3539.

How do I access my benefits?

Accessing your benefits couldn't be easier. Just swipe your Navia Benefit Card to pay for eligible health care expenses. Funds come directly out of your Health FSA and are paid to the provider. Some swipes require Navia to verify the expense, so hang on to your receipts! If they are needed, Navia will send you an email or notification via Navia's smartphone app.

You can also submit Health Care FSA and Day Care FSA claims online, through our smartphone app for Android and iPhone, email, fax or mail. Claims are processed within a few days and reimbursements are issued according to the City of Detroit's benefit plans.

Submitting claims is easier than ever using FlexConnect

The FlexConnect feature connects your FSA to your insurance plans and seamlessly creates a claim with proper documentation direct from your insurance carrier! All you have to do is click "reimburse me" and the claim is expedited for payment. Sign up for FlexConnect today!

Get more with the MyNavia mobile app

The MyNavia app is free to download on both iPhone and Android. You can manage your benefits and view important details right from the convenience of your phone.

Benefits made so simple... anyone can do it!

Health Care FSA

The Health Care FSA (HCFSA) allows you to pay for out-of-pocket medical expenses with tax-free dollars. Think of the HCFSA as a tool to pay for all your regular medical expenses throughout the plan year.

- Expenses for you, your spouse and tax-dependents are eligible for reimbursement. It does not matter if they are covered on your medical plan.
- The Health Care FSA is a pre-funded benefit.
- This means you have access to your full annual election amount at any time during the plan year.
- Estimating future expenses is an important step as you prepare to enroll in an FSA. The more accurate you are in estimating your expenses the better the plan will work for you!

Common Eligible Expenses

- Prescription drugs
- Copays and coinsurance
- Deductibles
- Office visits
- Dental work
- Orthodontia
- Glasses
- Contacts
- Chiropractic
- Massage

NOTE: Expenses that are cosmetic in nature are not eligible

Day Care FSA

Child care can be one of the single largest expenses for a family with children. A Day Care FSA (DCFSA) can be used to pay for your qualified day care expenses with pre-tax dollars which can save you up to $1,700 per year!!

- The DCFSA limit is set by the IRS and is a calendar year limit of $5,000 per household, $2,500 if married and filing separately. The funds must be available in the account before you use them.
- Expenses can be for your dependent children 12 and under, and in some cases elder care, and must be enabling you to work, actively look for work or be a full-time student.
- Some types of expenses are not eligible. These include tuition for school at the kindergarten level or above, overnight camp, nursing home expenses, meals, activity/supply fees and transportation costs.

Common Eligible Expenses

- Child Care
- Preschool
- Before and after school care
- Day Camps

NOTE: Expenses for school tuition and overnight camps are not eligible

Election and Claim Filing Period

Open Enrollment period is a great time to look at your benefits and estimate your out-of-pocket expenses. Be sure to only elect an amount that you know you will use during your plan year.

At the end of the plan year you will have a claim filing period to turn in any leftover claims for your benefits. Money left in the plan after the end of the claim filing period and 2 ½ month Grace Period is subject to the Use-or-Lose rule and cannot be refunded to you.

Grace Period

Your plan also has a special 2 ½ month Grace Period after the end of the plan year. This feature gives you an additional 2 ½ months to incur expenses against your Health Care and Day Care arrangements. All expenses incurred during the grace period will automatically deduct out of the prior year's arrangement, and any remaining balance will then be applied to the current plan year.

Navia Benefits Card

Rather than filing a claim and waiting for reimbursement, you can use the debit card to pay your provider directly for qualified health care expenses. The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at medical care merchants using the Master-Card® system. Be sure to hang on to your receipts in case Navia needs to see them to verify the expense eligibility. If Navia needs to see a receipt, you will notice an alert on your mobile app and Navia will send you an email reminder.

What happens to my day care FSA if I terminate employment?

If you terminate employment during the plan year, you can still access the funds in your DCFSA through the end of the plan year (even if the dates of service are after your termination date), as long as the expenses for care allow you to look for work or work full-time. However, you must submit your claims before the 90-day claim filing period that begins after your termination date.

Commuter Benefit

How Does It Work?

A Commuter Benefit Flexible Spending Account allows you to use pre-tax contributions to pay for eligible parking/transit expenses. The Commuter benefit, administered by Navia Benefit Solutions, allows you to pay for work related travel and parking costs with pre-tax dollars. Pre-tax means no federal income tax or FICA tax. The funds you allocate for your transportation and parking needs will be loaded onto a special debit card. You can then use your card to purchase services at any transportation or parking facility that accepts MasterCard™.*

If you already have a debit card for your City of Detroit Health Care FSA, your transit and/or parking funds will be loaded to your current card—there's no need to wait for a new one. If you don't have a card, you will receive one once you submit your first order.

The maximum allowable pre-tax contribution for the Commuter Benefit is $255 per month for mass transit expenses and $255 per month for parking expenses. In the event your merchant does not accept the debit card, you may be able to utilize the Pay Me Directly option. Log on to **www.mydetroitbenefits.com** for a link to find more information on the commuter benefit.

Mass Transit Eligible Expenses

- Bus vouchers and passes used to commute to and from work.
- Vanpooling in a "commuter highway vehicle" to and from work so long as 80% of mileage is for transportation of employees between work/home and the vehicle is at half the maximum adult seating.
- Ferry passes used to commute to and from work.

Mass Transit Non-Allowable Expenses

- Mass transit costs not associated with the commute to work.
- Toll fares used to commute to and from work.
- Mass transit costs from an employee bought voucher or bus pass when a voucher system is already sponsored or available by the Employer.

Parking Eligible Expenses

- Parking costs associated with a lot at or near the place of business.
- Parking costs from a lot that is at or near the place of commute (i.e. rideshare, carpool, vanpool)

Parking Non-Allowable Expenses

- Parking costs incurred at your residence
- Parking costs at a lot that is owned or sponsored by the Employer.

Accessing Your FSA Benefits

Navia wants to make accessing your benefits as simple and efficient as possible.

- Online Account Access: Order additional debit cards, update bank and address information and see up to date details of your benefits.
- Online Claims Submission: Upload your documentation, complete the online wizard, and voila! a reimbursement will be on its way within a few days!
- Mobile App: MyNavia allows you to simply snap a photo and submit for reimbursement direct from your mobile device.
- Flexconnect: Sync your various medical, dental and vision benefits with your FSA plan for a quick and easy reimbursement. No need to submit documentation, we'll get it from the insurance carrier!

What happens to my health care FSA if I terminate employment?

If you cease employment during the plan year, you have some options.

- **STOP** (default) – Your final paycheck will have the normal deduction and your participation will cease. You may be reimbursed only for services incurred on or before the termination date.
- **ACCELERATE** – You can authorize your employer to take the remaining FSA deductions from your final paycheck. This final deduction will be pre-tax and allows you to participate in the plan for the remainder of the plan year.
- **COBRA** – If your HCFSA balance is positive at the time of termination, then you will receive COBRA continuation paperwork to continue participation on a self-pay basis to the end of the FSA plan year.

How to Get the Most Out of Your Benefits

Here are some tips to help you make sure you are getting the right care at the right cost.

- First, remember to **go to an in-network provider or facility**. It can cost you and the City a lot more when you go out of network.
- **If you need medical care quickly but it's not an emergency, don't waste your hard-earned money.** Try these options instead:
  - **Go to your primary care physician.** Your doctor is generally the best option. He or she already knows you and understands your medical history. Just call your doctor, explain your condition and see if you can schedule a same-day appointment. If you do not have a personal doctor, you can find an in-network provider at **www.bcbsm.com**. if you are enrolled in the Blue Cross or BCN plan. Visit www.hap.org if you are enrolled in the HAP plan.
  - **Give telemedicine a try.** Online Visits provide 24/7 health care from board-certified doctors to treat minor health issues via tablet, smart phone, or computer. You can get help whenever you need it, wherever you are. If you are enrolled in the Blue Cross or BCN plans, visit bcbsm.com to manage your costs and care. Once you register for an online member account, nearly everything you can do on the website you can also do on your smartphone or tablet. To get our app, search BCBSM in the App Store or on Google Play. For HAP members, visit hap.amwell.com or visit the iTunes or Google Play app store to download the Amwell app. When prompted use the service key: HAPMi.
  - If your injury or illness isn't life threatening, but it's after hours or on a weekend when your doctor's office is closed—but you need care as soon as possible—you can **go to an urgent care center**. You don't need an appointment. You'll probably have a shorter wait time than the emergency room.
  - If you are enrolled in the Blue Cross or BCN plan, call Blue Cross Blue Shield's **24-Hour Nurse Line** at 855-624-5214 for a **free** service, to talk to a registered nurse. The nurse can answer general medical questions, help you determine whether your symptoms require a visit to the doctor's office, urgent care or the ER, and more.
- **Go to the emergency room for life-threatening medical conditions.** Go to the ER for heavy bleeding, serious head injuries, difficulty breathing, sudden chest pain, severe burns, neck/spine injuries and major broken bones.

Benefit Plan Defaults

The City of Detroit highly recommends that ALL eligible employees complete the open enrollment process to ensure that the benefit elections for you and your dependents are correct and best meet your needs. If you do not complete the enrollment process, your benefits will continue as shown in the chart below. Please note the following:

- **You are responsible** for viewing your enrollments on the **www.mydetroitbenefits.com** site to make sure your current elections are correct and best meet your needs. Changes to your elections can not be made after open enrollment closes unless you experience a qualifying life event.
- If you are enrolled in the Health or Dependent Care Flexible Spending Account or Commuter Plan, you must log on to **www.mydetroitbenefits.com** during the open enrollment period to re-elect your contribution for 2022. If you make no election during the open enrollment period, you will be defaulted to an election of $0.
- If you receive the medical opt-out credit and would like to continue to receive the payments in 2021, you must log on to **www.mydetroitbenefits.com** and complete the Opt-Out Credit Request form. If you make no election to continue this benefit during the open enrollment period, you will not receive the $950 credit for the 2022 plan year.

2021 Plan	2022 Plan
Blue Cross Blue Shield Community Blue PPO	Blue Cross Blue Shield Community Blue PPO
Blue Care Network Healthy Blue Living HMO	Blue Care Network Healthy Blue Living HMO
HAP HMO	HAP HMO
Blue Cross Blue Shield Dental	Blue Cross Blue Shield Dental
Golden Dental	Golden Dental
Dencap Dental	Dencap Dental
Heritage Vision – Basic Plan	Heritage Vision – Basic Plan
Heritage Vision – Enhanced Plan	Heritage Vision – Enhanced Plan
Heritage Vision – Premier Plan	Heritage Vision – Premier Plan
Employee Basic Life Insurance	Employee Basic Life Insurance
Optional Employee Life Insurance	Optional Employee Life Insurance
Optional Dependent Life Insurance	Optional Dependent Life Insurance
Health Care Flexible Spending Account	None
Day Care Flexible Spending Account	None
Commuter Plan	None
Medical Opt-Out Credit	None
No Coverage	No Coverage

Protecting Your Benefits While On Unpaid Leave

What You Need To Do

When you are off the active payroll (i.e., have exhausted all sick leave, vacation, “c-time”) and are placed on an approved unpaid Family and Medical Leave (FMLA), Workers’ Compensation, Long Term Disability or City Leave of Absence for health reasons, and you wish to continue medical, dental, vision, flexible spending accounts, and/or life and death benefits, **you must immediately contact the Benefits Administration Office at (855) 224-6200 to determine eligibility, complete the necessary forms and make arrangements to pay for such continued benefits**.

Payment Information

The amount you will be required to pay to continue coverage for these benefits will depend on the plan(s), the number of dependents covered and the type of unpaid leave for which you are approved. An employee placed on an approved FMLA is required to pay the employee cost sharing contribution amount that would be deducted from his/her payroll check if he/she were on the active payroll. Those on an approved leave of absence are required to pay the full premium amount (100% of the cost for the benefit). These payments must be made monthly via money order or certified check, and must be received in full at the Benefits Administration Office by the due date.

Failure To Provide Notification

Failure to notify the Benefits Administration Office to make arrangements for continued coverage, complete the required forms or make full and timely payments will result in a lapse of coverage or termination of benefits for the employee and his/her dependents. In such cases, neither the City nor the insurance carrier will be responsible for any claims filed, including but not limited to prescription drug coverage and medical and life insurance.

Reinstating Coverage Upon Return To Work

If your health care benefits or life insurance are terminated while you are off the active payroll, you must complete the health care and life insurance enrollment online at **www.mydetroitbenefits.com** and submit any necessary documentation to the Benefits Administration Office immediately upon your return to reactivate your health care benefits.

Enrollment Deadlines And Reporting Qualifying Life Events

Open Enrollment

A designated open enrollment period is generally scheduled each year for medical, dental, flexible spending accounts, life insurance plans and every other year for vision plans. Unless otherwise posted, changes in health care and life insurance coverage made during the Open Enrollment period will become effective January 1 of the following year.

Qualifying Life Events And Mid-Year Enrollments

Requests to add new benefit eligible dependents to coverage must be submitted **within 30 calendar days** of a life event, such as marriage, loss of coverage, or the birth or adoption of a child. Requests must be completed online at **www.mydetroitbenefits.com** or by calling (855) 224-6200 and by submitting the required documentation outlined on page 8. Coverage will be made retroactive to the date of the event after the online enrollment has been completed and the required documentation has been provided to and approved by the Benefits Administration Office. If you do not meet this mid-year enrollment deadline, you will not be able to add the new dependent until the next annual open enrollment period. (Note: You are required to submit documentation to substantiate the event and prove that the dependent is eligible for coverage).

Coverage Effective Dates

Requests for enrollment in the City's medical, dental, vision and life insurance for new hires, persons returning from a leave of absence and persons recalled from layoff are due **within thirty (30) calendar days** of the date of hire or return to work. New hires are generally eligible for medical and flexible spending account coverage after you complete 90 days of employment. New hires become eligible for dental and vision coverage after you complete 6 months of employment. Special rules may apply to employees returning to active employment.

Declining Coverage

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the City of Detroit plans if you or your dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your dependent’s other coverage. However, you must request coverage **within 30 days** after your or your dependent’s other coverage ends or after the employer stops contributing toward the other coverage. To request special enrollment or obtain more information, contact the Benefits Administration Customer Service Line at (855) 224-6200 or visit **www.mydetroitbenefits.com**.

Coverage Terminations

Employees are responsible for notifying the City of any event that makes a dependent ineligible for continued health care coverage. Disqualifying events that can make a dependent ineligible include, but are not limited to, marriage, divorce, death and age. You must go online to **www.mydetroitbenefits.com** to make this change. There are specific rules governing termination dates in cases of divorce and death.

- **Divorce:** In order to remove a spouse from your coverage due to divorce or legal separation, you must visit www.mydetroitbenefits.com to report the divorce or legal separation and upload a copy of your divorce decree or separation agreement within 30 days of the event. Coverage termination for an ex-spouse is effective as of the date of the divorce decree. If you should get a divorce, your ex-spouse and his/her dependent(s) have different coverage rights after the date of the divorce. Such ex-spouse will be eligible for COBRA continuation coverage. It is your responsibility to provide notification and submit a copy of your divorce decree online at www.mydetroitbenefits.com within 30 days of the disqualifying event. If you fail to remove these ineligible dependents by the deadline, they may lose their rights under COBRA and you will be liable for medical claims and/or premiums incurred from the date of the divorce, as well as subject to disciplinary action up to and including discharge.
- **Death:** In the case of a deceased spouse/dependent, employees must visit www.mydetroitbenefits.com to report the death and upload a copy of the death certificate within 30 days of the event. Coverage termination for a deceased spouse/dependent is effective as of the date of death.

Coverage termination for other cases of loss of eligibility is effective on the last day of the month in which the disqualifying event occurs. To stop applicable payroll deductions and avoid personal liability for health care provided after the effective termination date, the employee must take action promptly to remove the ineligible dependent from his or her medical, dental, vision and life insurance contract(s) **within thirty (30) days** following the disqualifying event. Once a dependent is terminated from coverage, the employee must wait until the next open enrollment period to add the dependent to his or her medical, dental, vision and/or life insurance coverage. **If you fail to submit the required documentation to remove the ineligible dependent, you WILL be liable for expenses incurred as a result of his/her continued health care and/or life insurance coverage. You may also be subject to discipline up to and including discharge.**

Deadlines

Deadlines for the open enrollment period, mid-year enrollment for life events and all eligibility audits are strictly enforced. If you fail to meet the required time limits you will have to wait until the next annual open enrollment period to add or reactivate the coverage for your dependents.

Employee Responsibilities For Maintaining Coverage

Please review the following items carefully. Failure to respond in a timely manner to the items listed below could result in termination of your coverage and/or discipline up to and including termination.

Proper Notification

The City is not responsible for any excess contributions made because the employee failed to provide proper notification of ineligibility of a dependent. This notification of ineligibility for health care and life insurance benefits must be submitted online at **www.mydetroitbenefits.com** or via phone at (855) 224-6200 **within 30 calendar days** of the disqualifying event. Failure to do so can subject you to discipline up to and including discharge. Also, you WILL be responsible for expenses incurred as a result of continued coverage after the disqualifying event. You are urged to keep a copy of all City of Detroit health care documents.

Providing False Information

Employees, who submit false information to provide health care and life insurance coverage for alleged dependents not eligible for such coverage may be subject to discipline up to and including discharge. Such employee will also be held financially responsible for all claims filed, and will be required to reimburse the City for any payments made on behalf of or for the benefit of an ineligible person claimed as a dependent.

Notification Of Address Change

We must have your correct address to send you information regarding your benefits. It is your responsibility to provide notification of any address change to the payroll department. Failure on your part to do so may result in delayed notification, excessive out-of-pocket expenses or loss of continued coverage opportunity. You should also monitor your payroll check to verify that your address is correct. If there is a discrepancy, provide notification to the payroll department.

Coordination of Benefits

If you or a covered family member are entitled to benefits from a source other than your City of Detroit's health plan, such as a spouse's health insurance coverage, Medicare or Medicaid, coordination of benefits will take place. You are required to disclose information about any other source of benefits to the Benefits Administration Office. In order to be eligible for coverage under all City of Detroit's health care plans, employees and covered family members who are eligible for Medicare due to End-Stage Renal Disease (permanent kidney failure) must enroll in Medicare Parts A and B. The medical conditions for required enrollment in Medicare are based on the Center for Medicare and Medicaid Services coordination of benefit rules which determine the conditions under which Medicare will be the primary payer for persons covered by employer group insurance. Such enrollment in Medicare shall not result in any reduction in benefits or additional cost to the employee, in that the employee shall be reimbursed the amount paid for Medicare after submission of required proof of enrollment and monthly payments.

Monitoring Payroll Deductions

Neither you nor the City should continue paying for medical, dental, vision and/or life insurance that you no longer require or for dependents that are no longer eligible for coverage. You, as the employee, are responsible for providing notification to terminate the coverage for your dependents that are no longer eligible for benefits. You can provide notification to terminate online at **www.mydetroitbenefits.com**. You, as the employee, have a responsibility to periodically review your dependent coverage and to timely submit the necessary form to immediately terminate coverage for ineligible dependents. You will be financially responsible for all claims and premiums paid by the City of Detroit for any dependents enrolled in your health care and life insurance plans who do not meet the eligibility requirements. You are also responsible for reviewing your paycheck stubs each pay period to verify that the proper amount of money for your payroll deductions for medical, dental, vision, flexible spending account and life insurance are being deducted from your pay. Your payroll deduction for medical insurance is listed on your paycheck stub next to the word "Hospital." If an incorrect amount is being deducted, you must immediately report these errors to the Benefits Administration Office. You may contact the Benefits Administration Office to report changes in dependent coverage either online at **www.mydetroitbenefits.com** or by telephone (855) 224-6200.

Notice Of Coverage Termination

If you receive a Notice of Coverage Termination from the Benefits Administration Office or a health care provider, do not ignore it! It does not matter that you are on a Family and Medical Leave, Workers' Compensation, Leave of Absence, or off the active payroll for a temporary period of time for any reason, and believe your health care coverage should be continued. The Notice of Coverage Termination is official notification that your health care and life insurance coverage with the City of Detroit has been terminated and you are no longer insured. It is strongly recommended that you designate a trusted and responsible family member to monitor your mail and handle your business affairs when you are sick or otherwise incapacitated and unable to attend to such matters. This is important because the health care providers have strict rules regarding reinstating insurance after the coverage has been terminated. If you believe the Notice of Coverage Termination was sent to you in error, you must immediately contact the Benefits Administration Office either on-line **www.mydetroitbenefits.com** or by telephone (855) 224-6200. The same rule applies if you should receive a Notice of Coverage Termination for your dependent and you believe the notice was sent in error.

Notice of Health Care Dependent Audits

The City of Detroit may conduct eligibility audits at any time for any dependent that is covered under City insurance plans. If you receive a notice of audit, you must provide the documentation within the time period specified in the notice or the coverage for your dependent will be terminated. If you recently added or provided documentation for that dependent, you are still obligated to comply with the audit requirements and submit this documentation again. Failure to provide documentation that substantiates the eligibility of any dependent will result in termination of the dependent's medical, dental, vision and life insurance coverage. If the coverage is terminated, your dependent cannot be reinstated until the next open enrollment period (usually offered in the fall of the year, with a January 1st or later effective date). If you apply to reinstate the dependent's coverage during open enrollment, you will be required to provide required documentation in respect to the dependent.

Important Notices

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

NOTICE REGARDING WELLNESS PROGRAM

Blue Care Network's Healthy *Blue* Living℠ plan is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for high cholesterol and diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of an enhanced level of benefits. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the enhanced level of benefits.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Blue Care Network at (800) 662-6667.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as weigh-management or tobacco cessation programs. You also are encouraged to share your concerns with your own doctor.

Blue Care Network is committed to helping you achieve your best health status. Rewards for participating in our wellness program, Healthy *Blue* Living, are available to all contract holders who meet all qualification requirements. If you think you might be unable to meet a standard or requirement for a reward under this program, you might qualify for an opportunity to earn the same reward by different means. You can work with your BCN primary care physician to find an alternative that's right for you in light of your health status. Consult with your BCN primary care physician before starting any exercise or weight-management program.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City of Detroit may use aggregate information it collects to design a program based on identified health risks in the workplace, Blue Care Network of Michigan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only entity who will receive your personally identifiable health information is Blue Care Network of Michigan in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact City of Detroit Benefit Administration Customer Service at (855) 224-6200.

Patient Protection And Affordable Care Act

The newly enacted federal health reform laws provided under the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act, require that the employer provide you with certain notices. These important notices are found below.

General Information

Key parts of the health care law effective in 2014 provide a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find and acquire health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins on November 1, 2021 and runs through December 15, 2021.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if the coverage offered by the City and described in this booklet doesn't meet certain standards. The savings on your premium for insurance that you acquire on the Marketplace depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

Yes. If the health coverage that the City offers you and is described in this booklet meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in the City's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing for you, if the coverage that the City offers and which is described in this booklet would cost you more than 9.5% of your household income for the year, or if the coverage the City provides does not meet the "minimum value" standard set by the Affordable Care Act.[1]

Note: If you purchase a health plan through the Marketplace instead of enrolling in and accepting health coverage offered by the City, then you will lose the amount that the City pays toward the cost of its employer-offered coverage. Also, the amount that the City pays toward the cost of the coverage described in this booklet — as well as your employee contribution to such employer-offered coverage — is excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Does Coverage Provided by the City Meet the Minimum Value Standard? Is the Coverage Provided by the City Affordable?

Coverage provided by the City meets the minimum value standard and the cost of the coverage to you is intended to be affordable, based on the wages paid to most active City employees. However, depending on your particular wages and household income, you may still be eligible for a premium discount for a health care plan you purchase through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week.

How Can I Get More Information About the Marketplace?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide information regarding your employer. This information can be obtained by calling the City of Detroit Benefits Administration Office at **(855) 224-6200**.

Notice of Patient Protections

The City of Detroit's HMO options require the designation of a primary care physician (PCP). Individuals have the right to designate any primary care provider who participates in the or Blue Care Network (BCN) PCP Focus networks and who are available to accept you or your family members. Individuals do not need prior authorization from the City's medical plan providers or from any other person in order to obtain access to obstetrical or gynecological care for routine services. For children, individuals may designate a pediatrician as the primary care provider. The health care plan professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a listing of participating health care providers, please contact HAP or BCN at the customer service numbers provided on the back cover of this booklet or call the number on the back of your medical plan identification card or visit the carrier's website. The carrier information is listed on the back cover of this booklet.

Women's Health Initiatives

As mandated by the federal Patient Protection and Affordable Care Act (PPACA), Blue Cross Blue Shield of Michigan, Blue Care Network PCP Focus and Health Alliance Plan are covering some additional preventive services for women with no cost sharing (copay/deductible/coinsurance) when administered by a network provider during a visit with preventive care as the primary reason for the appointment. Out-of-pocket costs, such as deductibles, copays and coinsurance, will still apply if services are provided to reach a diagnosis, monitor or treat an illness, injury or health problem. These services may have additional restrictions. Employees/dependents are encouraged to call the Customer Service number at BCBSM, BCN or HAP for more specific information. Under the CVS Caremark prescription drug plan, the HAP prescription drug plan, or the BCN prescription drug plan, some contraceptives may still require cost-sharing. Only those contraceptive services and contraceptive drugs that are performed or provided by a medical provider or require a doctor's prescription will be covered with no cost-sharing. Over the counter contraceptives such as condoms and foams that do not require a prescription will not be covered. Male sterilization may require cost-sharing if covered under the member's plan. The City encourages employees/dependents to contact BCBSM, BCN, HAP, or CVS Caremark Customer Service for more specific information before incurring an expense to ensure you understand the benefits available at no cost to you.

This Health Plan Covers Medically Necessary Services

This health plan covers medically necessary services. Transgender benefits including related medical visits and laboratory services are standard provisions in the health insurance policy. This is inclusive of surgery for gender reassignment which is payable for reconstructive procedures of the genitalia. The surgery is offered as a treatment for gender dysphoria.

In addition to current coverage for genitalia surgery, hormonal therapy, psychological testing, assessment and counseling, mastectomy for female to male transitions were added as covered services effective January 1, 2019.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hippPages/TPLRD_CAU_cont.aspx

Phone: 916-445-8322

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711

CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/ hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp

Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/

Phone: 1-877-438-4479

All other Medicaid

Website: https://www.in.gov/medicaid/

Phone: 1-800-457-4584

IOWA – Medicaid

Medicaid Website: https://dhs.iowa.gov/ime/members

Medicaid Phone: 1-800-338-8366

Hawki Website: http://dhs.iowa.gov/Hawki

Hawki Phone: 1-800-257-8563

HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP

Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740.

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-payment-program-hipp premium-assistance-pa

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

Lincoln: 1-402-473-7000

Omaha: 1-402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm

Phone: 1-603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx

http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/ HIPP-Program.aspx

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/

CHIP Website: http://health.utah.gov/chip

Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp

Medicaid Phone: 1-800-432-5924

CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Summary Of Benefits And Coverage

As part of the federal Affordable Care Act, health carriers and group health plans are now required to provide current and prospective members with a Summary of Benefits and Coverage (SBC). The SBC must include Coverage Examples which are intended to show how the plan might cover medical care in a given situation. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. It is important to note that the SBC is not a contract. For a complete description of benefits and terms of coverage, consult the applicable BCBSM, BCN or HAP plan documents. A stand-alone, standard glossary of medical and insurance terms must also be provided. Please note these are federal agency definitions and do not necessarily reflect BCBSM, BCN or HAP definitions of the same terms. You may obtain a copy of the SBC and Uniform Glossary Document from the Benefits Administration Office or at **www.mydetroitbenefits.com**.

Discrimination Is Against the Law

The City of Detroit complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The City of Detroit does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The City of Detroit:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the City of Detroit has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Civil Rights Coordinator, City of Detroit, 2 Woodward Avenue, Suite 304, Detroit, Michigan 48226, Telephone: 1-855-224-6200, E-Mail: *codbenefitenrollment@detroitmi.gov*

You can file a grievance in person or by mail, or e-mail. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Michigan Languages

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-224-6200.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-224-6200.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-224-6200.
Syriac	1-855-224-6200.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-224-6200..
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-224-6200..
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-224-6200.. 번으로 전화해 주십시오.
Bengali	লয্ করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িবনঃখরচায় ভাষা সহায়তা পিরেষবা উপল ওোছ। েফান করন ১-1-810-257-3034.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-224-6200.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-224-6200.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-224-6200.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-224-6200.まで、お電話にてご連絡ください。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-224-6200.
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-224-6200.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-224-6200.

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 reasonably be 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 benefit plan participants. 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 (855) 224-6200 for more information.

Telephone Calls To The Benefits Administration Customer Service Line

If you have questions or concerns regarding your health care or life insurance coverage, please contact the Benefits Administration Customer Service Line at (855) 224-6200. When you call, you will be asked specific questions to verify that we are speaking directly to the employee and contract holder for the City of Detroit health care and life insurance plans. This security procedure is in accordance with the City of Detroit policies and is in place to protect your privacy.

SOCIAL SECURITY NUMBERS AND HEALTH INSURANCE CLAIM NUMBERS:

In order for the City to properly administer the benefit plans, you MUST provide the Social Security Numbers (SSN), and where applicable, the Health Insurance Claim Numbers (HICN), for all dependents covered under City of Detroit health care plans. Benefit elections that do not contain this required information will not be processed.

In order for the City to complete reporting required by the Patient Protection and Affordable Care Act (PPACA), all dependents added to coverage MUST have a valid Social Security Number. Also, the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan administrators to provide SSNs (or HICNs) to the Center for Medicare & Medicaid Services (CMS) in order for Medicare to properly coordinate Medicare payments. If your dependent is added to coverage with an invalid SSN, the enrollment will not be processed and the dependent will be removed from coverage.

For further information on this mandatory reporting requirement under the Mandatory Insurer Reporting Law, please visit the CMS Web site at www.cms.hhs.gov/MandatoryInsRep. Please be assured that your SSN and HICN will only be used for the purpose of required reporting and other plan administration requirements and that we will adhere to all privacy and confidentiality laws.

Notice of Right to Continue Health Care Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the City of Detroit is required to offer the opportunity for a temporary extension of health care coverage (called "Continuation Coverage") at group rates to former employees, spouses, and eligible dependents in certain instances where coverage under the City's plan(s) would otherwise end due to certain qualifying events. *This notice is intended to provide you and any covered dependents with a summary of your rights and obligations under the continuation coverage provisions of the law.*

Qualifying Events for Covered Employees – If you are an employee of the City of Detroit covered by our group benefit plans, you may have the right to choose continued coverage if you lose your group benefit coverage because of the termination of your employment (for reasons other than gross misconduct) or a reduction in your work hours.

Qualifying Events for Covered Spouses – If you are the spouse of an employee of the City of Detroit and are covered by our group benefit plans you may have the right to choose continuation coverage for yourself if you lose group benefit coverage under the plan for any of the following reasons: termination of your spouse's employment (for reasons other than gross misconduct); a reduction of your spouse's hours of employment; the death of your spouse; or divorce or legal separation from your spouse.

Qualifying Events for Covered Dependent Children – If you are the covered dependent child of an employee covered by our group benefit plans you may have the right to continuation coverage for yourself if group benefit coverage under the plan is lost for any of the following reasons: termination of the employee's employment (for reasons other than gross misconduct); a reduction in the employee's hours of employment; the death of the employee; the employee's divorce or legal separation; you no longer meet the eligibility requirements of a "dependent child" under the rules of the City of Detroit's health care plan.

NOTIFICATION INSTRUCTIONS

All notification requirements referred to in this summary must be made via the Benefits Administration Customer Service Line at **(855) 224-6200**
Service Center Hours: 8:30 a.m. – 7:00 p.m. Monday – Friday EST
or online at **www.mydetroitbenefits.com**.

Employee, Spouse, and Dependents Notifications Required – Under the law, the employee, spouse, or other family member has the responsibility to inform the City of Detroit – Benefits Administration Office of a divorce, legal separation, or a child losing dependent status under our group health care plan. This notification must be made within 30 days from the date of the event or the date on which coverage would end, whichever is later. Visit **www.mydetroitbenefits.com** to report these changes.
Note: Required documentation must be submitted to the Benefits Administration Office. *If this notification is NOT completed in a timely manner, rights to continue coverage may be forfeited.*

Election Period and Coverage – Once notification of a qualifying event has occurred, covered individuals (also referred to as qualified beneficiaries) will be notified of their right to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days from the date coverage is lost under the City's health care plan or the date of notification, whichever is later, to elect continuation coverage. *If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue insurance under the City's group health care plan will end.*

If a qualified beneficiary elects continuation coverage and pays the applicable premium, the City of Detroit is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated employees and/or covered dependents.

Length of Continuation Coverage – 18 months: If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction of work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

- Social Security Disability – The 18 months of continuation coverage can be extended to 29 months if the Social Security Administration determines that a qualified beneficiary was disabled at any time within the first 60 days of continuation coverage according to Title II or XVI of the Social Security Act. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and notify the City of Detroit – Benefits Administration Customer Service (855) 224-6200 or www.mydetroitbenefits.com within 60 days of the date of determination and before the original 18 month period expires. It is also the qualified beneficiary's responsibility to notify within 30 days that a final determination has been made that they are no longer disabled.
- Secondary Events – An extension of the 18 months of continuation coverage can occur if, during the initial 18 months of continuation coverage, a second event takes place (divorce, legal separation, death, or a dependent child ceasing to be a dependent). If a second event does take place, then the 18 month of continuation coverage can be extended to 36 months from the date of the original qualifying event date for the qualified beneficiary spouse and/or dependent children. If a second event occurs, it is the qualified beneficiary's responsibility to notify the City of Detroit – Benefits Administration Customer Service at (855) 224-6200 or www.mydetroitbenefits.com. In no event, however, will continuation coverage last beyond three years from the date of the original qualifying event.

Length of Continuation Coverage – 36 Months: If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, or a dependent child ceasing to meet the eligibility requirements for coverage under the City of Detroit health care plan rules, each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility, Premiums, and Potential Conversion Rights – A qualified beneficiary does not have to show that he/she is insurable to elect continuation coverage. The City of Detroit, however, reserves the right to verify eligibility status and terminate continuation coverage retroactively if the person is determined to be ineligible or if there has been a material misrepresentation of the facts. A qualified beneficiary will have to pay all of the applicable premiums plus a 2% administration charge for continuation coverage. These premiums may be adjusted in the future if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the City of Detroit can charge up to 150% of the applicable premium during the extended coverage period. There is a grace period of 30 days for the regularly scheduled monthly premiums. At the end of the 18 months or 36 months of continuation coverage, a qualified beneficiary must be allowed to enroll in a conversion plan.

Notification of Address Change – To insure that all covered individuals receive all required information, it is important that you immediately provide notification of any address change online at **www.mydetroitbenefits.com**

Cancellation of Continuation Coverage – The law provides that if elected and paid for, continuation coverage may end prior to the maximum continuation period for any of the following reasons:

1. The City of Detroit ceases to provide group health care coverage to all City of Detroit employees;
2. The total monthly cost for continuation coverage is not paid on a timely basis;
3. The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation which does not apply to (or satisfied by) such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996;
4. A qualified beneficiary becomes eligible for Medicare;
5. A qualified beneficiary has extended coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies the City of Detroit – Benefits Administration Customer Service (855) 224-6200 that he/she wishes to cancel continuation coverage.

The qualified beneficiary is required to notify the City of Detroit – Benefits Administration Customer Service (855) 224-6200 if event # 3, 4, 5, or 6 occurs. If continuation coverage is terminated for any of the above reasons, it cannot be reinstated.

A Check List of Important Items to Remember

Employees must provide notification online at www.mydetroitbenefits.com within 30 days of the event if…

- You get married or divorced
- Your dependents change (e.g., birth or adoption of child)
- Your spouse or a dependent dies
- You, your spouse or a dependent becomes eligible for Medicare due to age or disability

Note that you must provide documentation (marriage certificate, divorce decree, Medicare ID card) to the Benefits Administration Office online at **www.mydetroitbenefits.com**

Contact the Benefits Administration Office if…

- You are laid off
- You are placed on an unpaid Family and Medical Leave, Workers' Compensation, Long Term Disability or City Leave of Absence
- You return to work after being off the active payroll for 30 or more calendar days
- You elected to participate in the City's Opt-Out program and you lose your other medical coverage for a reason that you did not cause or could not prevent

Be sure to include your Social Security number in all communications to the Benefits Administration Office.

Contact the health care provider if…

- You have questions regarding services and expenses covered under the health care plan you selected
- You have questions regarding a bill you received for services
- You wish to verify providers that are available under the plan you selected

Contact your local Social Security Office if...

- You have questions regarding Social Security or Medicare
- You or one of your dependents has a severe long-term disability, end-stage renal disease, or is undergoing a kidney transplant because 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 have your case evaluated by the Social Security Administration.

Contact the Flexible Spending Account provider if….

- You have questions about your flexible spending account or eligible/ineligible services
- You need assistance to submit a claim for services
- You want to know if your claim has been processed.

Notes

Important Phone Numbers

City of Detroit – Benefits Administration Customer Service

www.mydetroitbenefits.com
Toll-free (855) 224-6200

Health Carriers

Blue Cross Blue Shield Community Blue PPO ..... (877) 354-2583
Web site: **www.bcbsm.com**

BCBSM 24-hour Nurse Line ..... (800) 775-BLUE (2583)

CVS Caremark ..... (855) 467-8417

Health Alliance Plan (HAP) ..... (313) 872-8100 or (800) 422-4641
Web site: **www.hap.org**

PCP Focus (Blue Care Network) Customer Service ..... (800) 662-6667
Web site: **bcbsm.com**

Dental Carrier

BCBSM Blue Dental PPO ..... (888) 826-8152
Web site: **www.bcbsm.com/bluedental**

DENCAP Dental Plans ..... (313) 972-1400
Web site: **www.dencap.net/**

Golden Dental Plans ..... (800) 451-5918
Web site: **www.goldendentalplans.com/**

Vision Carrier

Heritage Vision Plans, Membership Department ..... (800) 252-2053
Web site: **www.heritagevisionplans.com**

Life Insurance

MetLife Claims ..... (800) 638-6420

Flexible Spending Account

Navia Benefit Solutions ..... (800) 669-3539
Web site: **www.naviabenefits.com**

City of Detroit Health Care Plan Options for Active Employees