

2018

**City of Detroit
General Retiree Healthcare Trust
Open Enrollment Information**



**MEDICAL | DENTAL | VISION
HEALTH REIMBURSEMENT ACCOUNT**



City of Detroit General Retiree Healthcare Trust

IMPORTANT INFORMATION ABOUT YOUR 2018 OPEN ENROLLMENT

October 30, 2017

Dear City of Detroit General Retiree:

It's time for your 2018 Open Enrollment. This is the time to review your current healthcare coverage, review what has changed for 2018, and make elections or changes for the 2018 Plan Year, if desired. Prior to making this important decision we encourage you to carefully read through this book and the attached rate sheet so you will be aware of the healthcare options and benefits that are available to eligible General City retirees through the VEBA and the cost of that coverage for the 2018 Plan Year. If after review, you find you are satisfied with your current medical, dental, vision or HRA elections and you do not wish to make any changes, there is no need to take any action. Your current elections will automatically continue and the amount you are required to pay will be adjusted to the 2018 rate. However, if you wish to change your coverage you must do so during the Open Enrollment period. Open Enrollment begins on **October 30, 2017** and ends on **November 17, 2017**. New enrollments, benefit changes, the 2018 rates, and any changes you choose to make to your current coverage will be effective January 1, 2018.

BeneSys, Inc. will process your 2018 enrollment requests, manage the HRA program, and deal with the day-to-day activities related to the administration of all VEBA healthcare plans. If you have questions, we encourage you to contact the BeneSys staff at (844) 563-8911. BeneSys is available to assist you during open enrollment and throughout the year.

IMPORTANT NOTICE REGARDING VEBA BENEFIT CHANGES

The current projected liabilities of the VEBA are significantly greater than its assets. More specifically, as of January 1, 2017, the market value of the VEBA's assets was \$94,717,802, compared to its future liability which is estimated to be \$275,849,019. This means that the VEBA is only 34.3% funded and, at its current pace, is estimated to run out of money in 2028. Accordingly, as the Board has forewarned in the past, changes to the healthcare plan design, including reducing benefits, are necessary in order to preserve the solvency of the VEBA and protect the benefits for you as participants of the City of Detroit General Retiree Healthcare Trust.

To that end, the Board has made the difficult decision to reduce the monthly premium subsidy and HRA benefit provided by the VEBA by \$15 a month effective January 1, 2018. This \$15 monthly reduction will not be enough to bring the VEBA's expenses in line with its annual income. However, the losses sustained by the VEBA will be less than in previous years and will allow the Board to transition to a more sustainable funding model. Once the VEBA's financial situation is stabilized, the Board's long-term goal is to establish an appropriate reserve account which would allow it to provide periodic increases in benefits to help defray the impact of rising health care costs.

Sincerely,

City of Detroit General Retiree Healthcare Trust
Thomas Sheehan, Trustee
Chairman, Board of Trustees

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General Information

When is open enrollment?

Open enrollment for medical, dental and vision starts on **October 30, 2017** and continues through November 17, 2017. The deadline for submission of all enrollment changes is **November 17, 2017**. Enrollment changes received after November 17, 2017 will not be processed.

What changes will be made to retiree healthcare in 2018?

Medical benefits under the Medicare Advantage Plans provided by Blue Cross Blue Shield of Michigan (BCBSM), Blue Care Network of Michigan (BCN), and Health Alliance Plan (HAP) will remain the same. Likewise, the prescription drug coverage for all three Medicare Advantage Plans is the same; however, BCBSM and BCN have each added a Preferred Pharmacy Network. The Preferred Pharmacy Network is designed to reduce prescription drug copays when preferred pharmacies are used and will be available effective January 1, 2018.

The monthly premiums for Medicare Advantage Plans provided by BCBSM, BCN and HAP will increase in 2018. In addition, as previously noted, the monthly premium subsidy provided by the VEBA will be reduced by \$15.00 a month. As a result, your retiree monthly contribution (the amount deducted from your pension check each month) for medical and prescription drug coverage will increase effective January 1, 2018. If you receive benefits from the VEBA's Health Reimbursement Arrangement (HRA) program, the monthly credit to your account will be reduced by \$15.00 effective January 1, 2018.

Dental and vision coverage will continue to be available, with retirees paying the full cost for such coverage. The dental and vision benefits will remain the same. Monthly premiums for Blue Cross Blue Shield Dental and Delta Dental's High and Low plans will decrease. These rate changes are effective January 1, 2018. The monthly premium for all other dental and vision plans will remain the same.

A summary of benefits and the amount retirees will have to pay for all medical, dental and vision plans are included in this open enrollment package. The summary is presented in a format that permits easy comparison of the main features or benefits of the plans; it contains general information only. We urge you to read this information and share it with your family members, caregivers, and others, as needed. If you are enrolled in a Medicare Advantage Plan you may also receive additional information from the carrier that describes the details of your current plan. To review the full benefits for all plans visit www.ourbenefitoffice.com/mydetroitretireebenefits.

Do I need to enroll or make changes during open enrollment?

If you are currently enrolled in a Medicare Advantage Plan, dental and/or vision plan offered through the VEBA and you do NOT want to switch to a different medical/prescription drug, dental or vision plan, or add or remove any dependents, you do NOT have to take any action during the open enrollment period. Your current healthcare elections will automatically continue for the 2018 Plan Year, and the amount you are required to pay for that coverage will be adjusted to the 2018 rate.

You only have to take action during this open enrollment period if you

- are NOT currently enrolled and wish to enroll in a Medical Advantage Plan, dental and/or vision plan offered through the VEBA;
- are currently enrolled, but want to switch to a different medical/prescription drug, dental, and/or vision plan;

- are currently enrolled and want to add or remove dependent coverage from your Medicare Advantage, dental and/or vision coverage;
- are currently enrolled and want to terminate or stop your Medicare Advantage, dental or vision coverage; and
- wish to opt-out from coverage under the VEBA's Medicare Advantage program and enroll in the VEBA's Health Reimbursement Arrangement (HRA) program.

Note: Vision plans are two-year plans, so if you enrolled in a vision plan in 2017 you cannot switch to another vision plan until the 2019 open enrollment period.

If you are unsure of your current coverage please contact BeneSys at 1-844-563-8911.

How do I enroll or make changes?

If you wish to enroll or make changes to your plans, or add or remove dependents' coverage, you may do so online at www.ourbenefitoffice.com/mydetroitretireebenefits. This website will be available 24 hours a day, 7 days a week beginning October 30 through November 17, 2017. Please see page 22 of this booklet for instructions on how to register online. If you need help with online registration, please contact BeneSys at (844) 563-8911.

If you do not have access to the internet, you may complete the enclosed enrollment form and return it to BeneSys at P.O. Box 4955, Troy, MI 48099-4955. For your convenience, enclosed is a self-addressed envelope you can use. Be sure to place the appropriate postage on the envelope before mailing. If you require additional assistance, please contact a BeneSys Member Services Representative at (844) 563-8911.

When will the 2018 open enrollment changes be effective?

If you elected a new medical, dental and/or vision plan during the open enrollment, the coverage for your new plan will start on January 1, 2018. If you added a dependent to your medical, dental and/or vision plan, that dependent's coverage will start on January 1, 2018. If you elected to terminate coverage during the open enrollment the coverage will end on December 31, 2017. All benefit and rate changes for the 2018 Plan Year are effective January 1, 2018.

Can I make changes to my medical coverage during the year?

As is common in most group insurance plans, once the coverage period begins, you cannot switch to another plan, terminate coverage, add or remove dependents or otherwise make changes during the coverage year unless a verifiable qualifying life event occurs. (Examples of qualifying life events include, death, marriage, divorce, enrollment in Medicare Part A and Part B, loss of coverage, eligibility for coverage as an early retiree or resulting from new employment, permanent address change in instances where your current healthcare plan is not available in the new area.) Qualifying life events must be reported to BeneSys within thirty (30) days of the event. Notification beyond thirty (30) days of the event will delay the effective date of the coverage change to the first day of the calendar month following the date on which notification was made. If failure to report a qualifying life event within thirty (30) days results in additional benefit costs to the VEBA due to non-termination of benefits, you may be held responsible for such additional costs.

Can I enroll in another prescription drug or medical plan during the year?

No. All Medicare Advantage Plans offered through the VEBA include hospital, medical and prescription drug coverage. Medicare will only allow you to be enrolled in one Medicare Advantage Plan (Medicare Part C) and one Medicare Prescription Drug Plan (Medicare Part D). If you are

enrolled in BCBSM Medicare Plus Blue Group PPO, BCN Advantage HMO-POS, or HAP Senior Plus HMO offered through the VEBA, you must take the medical and prescription drug coverage that is offered by that plan. If you join another medical and/or prescription drug plan (this includes coverage you may have through another family member or one that is purchased through an individual health insurance plan), your medical and prescription drug coverage (and your spouse's medical and prescription drug coverage, if enrolled) under the VEBA's Medicare Advantage Plan will be automatically terminated. If coverage is terminated due to enrolling in another medical and/or prescription drug plan during the coverage year, you (and your spouse) will not be eligible to reenroll in the VEBA's Medicare Advantage Plans during the 2018 coverage period; you (and your spouse) will have to wait until the next Open Enrollment period. If you are enrolled in the VEBA's Medicare Advantage Plan and decide you want to join another medical or prescription drug plan during the coverage year, please call BeneSys at (844) 563-8911 **BEFORE** you enroll in the other plan. Again, if you enroll in another medical and/or prescription drug plan during the coverage year your coverage (and your spouse's coverage) under the VEBA Medicare Advantage Plan will be terminated; and you (and your spouse) will not be able to reenroll in the VEBA's Medicare Advantage Plan until the next open enrollment period.

Can I make changes to my dental and/or vision coverage during the year?

You cannot switch to another dental or vision plan during the coverage year. But, if you wish to terminate your dental or vision plan during the coverage year you may be permitted to do so. However, please note, if you terminate your dental and/or vision coverage during the 2018 plan year, you will not be eligible to re-enroll for dental/vision coverage until the 2020 open enrollment period.

Am I required to be enrolled in Medicare to qualify for VEBA medical coverage?

Yes, all persons enrolled in the Medicare Advantage Plans offered through the VEBA must be enrolled in Medicare Part A and Part B, and continue paying their Medicare Part B premiums.

When should I enroll in Medicare?

You, your spouse and other eligible dependents seeking VEBA medical coverage should enroll in Medicare Part A and Part B as soon as you become eligible. Most people become eligible for Medicare at age 65. It is your responsibility to contact the local Social Security Administration (SSA) office to apply for Medicare. To allow sufficient time to process your application it is recommended that you apply three (3) months prior to reaching age 65. Please note if you fail to enroll in Medicare Part B when first eligible you may have to pay a late enrollment penalty which will increase your monthly Medicare Part B premiums. Also note, if you are entitled to Social Security disability benefits, have end-stage renal disease, or undergo a kidney transplant, you may be eligible for Medicare coverage prior to age 65, and should contact your local SSA office to have your case evaluated for Medicare eligibility.

Note: When you receive your Medicare Card, you **MUST** notify BeneSys, call (844) 563-8911.

Is documentation required when adding a dependent?

Yes, when adding dependents to your healthcare coverage you will be required to submit documentation to substantiate eligibility for coverage. Examples of documentation that may be required include, but are not limited to: birth certificate, marriage certificate (a marriage license is not accepted), legal guardianship papers (stating full and permanent custody), proof of residency, and the last Federal 1040 filed.

Providing False Information:

Retirees who submit false information intended to provide health care coverage for alleged dependents not eligible for such coverage will be held financially responsible for all claims filed, and will be required to reimburse the VEBA for any payments made on behalf of or for the benefit of an ineligible person claimed as a dependent. Also, be aware that even if you had been in a long period of marriage while you were actively employed, if that former marital partner is now divorced from you (*is your ex-spouse*) then he/she is NOT eligible for our retiree healthcare benefits even though you are.

Audits:

Periodic audits will be conducted to ensure that retirees, spouses and dependents currently enrolled in VEBA healthcare plans are eligible for coverage. During these audits, the terms and conditions of your retirement will be examined. In addition, retirees will be required to provide documentation to substantiate that their covered dependents continue to be eligible for coverage. 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 it is determined that a retiree and/or his/her dependent is not eligible for healthcare the coverage will be immediately terminated.

Note: It is the responsibility of the retiree/beneficiary to notify BeneSys when covered dependents are no longer eligible for healthcare coverage. Events that can make a dependent ineligible for coverage include, but are not limited to, marriage, divorce, age or no longer being a dependent of the retiree/beneficiary (i.e., can no longer be claimed as a dependent on his/her federal income tax return). In general, the termination of coverage becomes effective at the end of the month in which the disqualifying event occurs. However, the coverage termination date for an ex-spouse is the date of the divorce decree. Please note that you will be financially responsible for all claims and premiums associated with an ineligible dependent.

How do I pay for my healthcare plans?

The required monthly payment for your medical, dental and/or vision plan will be automatically deducted from your monthly pension check. The amount being deducted appears on your pension check stub. You are responsible for monitoring your pension check stubs to verify that the deductions are proper. If an incorrect amount is being deducted, you must immediately report it to BeneSys.

My pension will not cover the cost for my healthcare, how do I pay?

If you are eligible for healthcare, but do not receive a pension check or the amount of your pension is insufficient to cover the cost of the monthly premium(s), you will need to contact BeneSys to set up a direct payment plan. If you are on a direct pay plan but fail to submit your payments in accordance with the pay schedule, your coverage will be terminated.

Who do I contact to change my address?

It is important to keep your address updated in two places, the City of Detroit Pension Office and BeneSys.

You are required to notify BeneSys of your address change so that you will continue to receive information from the VEBA and other mailings regarding healthcare benefits. To change your address for healthcare purposes please contact BeneSys at (844) 563-8911.

Health Reimbursement Arrangement (HRA) FAQ's

What is the HRA Account?

The *Health Reimbursement Arrangement* (HRA) is a bookkeeping account that will be established for any Medicare Retiree who retired on or before December 31, 2014 and has elected to opt out of the Medicare Advantage Plans provided through the VEBA. Additionally, Non-Medicare eligible Retirees who retired on or before December 31, 2014, and who have obtained health insurance via the Health Insurance Marketplaces – also known as Exchanges, are also eligible to receive a monthly HRA benefit.

Please note, this is a bookkeeping account only – it cannot be cashed out by participants at any time, and it does not “vest” – the Board may terminate the account at any time.

What can I use the HRA account for?

The HRA may be used for all “qualified medical expenses.” Unfortunately, we cannot provide an exhaustive list of all possible “qualified medical expenses.” A partial list is provided in IRS Pub 502 (available at www.irs.gov).

Where do I obtain HRA Claim Forms?

You may call BeneSys at (844) 563-8911 to have a Claim Form mailed to you or you may obtain a form by visiting our website at www.ourbenefitoffice.com/mydetroitretireebenefits

Is there a time limit to file for HRA Benefits?

Yes, HRA Claims must be filed by March 31st of the year following the Plan Year in which the expense was incurred.

Where do I send my HRA reimbursement request?

Send your HRA reimbursement requests to: City of Detroit General Retiree Healthcare Trust, P.O. Box 4955, Troy, Michigan 48099-4955

What if my total household income is \$75,000 or less?

If your total household income is \$75,000 or less and you purchased health insurance through a policy purchased on a public exchange you may be eligible to receive an additional monthly HRA benefit. You will be required to provide verification of coverage purchased through a public exchange along with a copy of your tax return from the previous year.

If I opt out can my spouse stay in the VEBA's Medicare Advantage Plan?

No. When you opt out of the VEBA's Medicare Advantage Plan you and your spouse will no longer have medical/prescription drug coverage under the VEBA's Medicare Advantage Plan.

What if I'm already receiving a tax credit?

Please be advised that HRA coverage through the VEBA will be considered “other health coverage” and may result in your ineligibility for federal tax credits on the public exchanges. Therefore, if you are currently receiving federal tax credits through the public exchanges, you may elect to opt-out of coverage via the VEBA's Open Enrollment in order to preserve your eligibility for such tax credits on the public health exchanges. You may need to contact your accountant for additional information regarding your eligibility.



2018 VEBA Healthcare Options

Enrollment options for retirees who qualify for healthcare and retired on or **BEFORE** December 31, 2014

Medicare-Eligible Retiree Options

Medical and Prescription Drug Plan Options: All medical plans offered through the VEBA are Medicare Advantage Plans that include prescription drug coverage. You must be enrolled in Medicare Part A and Part B and continue to pay your Medicare Part B premium to enroll and maintain coverage in Medicare Advantage Plans.

- BCBSM Medicare Plus Blue Group PPO (available anywhere in the U.S.A.)
- BCN Advantage HMO-POS (available in Michigan only)
- HAP Senior Plus HMO (available in Michigan only)

Health Reimbursement Account (HRA): Medicare eligible retirees and retiree spouses who meet the below criteria, who do not wish to enroll in the Medicare Advantage Plans offered through the VEBA, can opt-out of the VEBA's medical coverage and establish an HRA. See FAQ's on page 8 for additional HRA information.

- Medicare-eligible Retiree (Post-65) \$100.00
- Medicare-eligible Retiree Spouse who is Non-Medicare-eligible, insured through a Public Exchange and whose household income is less than \$75k..... \$110.00
- Medicare Eligible Surviving Spouse married to retiree at time of retirement..... \$100.00

Dental Plan Options:

- Blue Cross Blue Shield Dental PPO
- Delta Dental High Plan
- Delta Dental Low Plan
- DENCAP Dental DHMO
- Golden Dental DHMO

Vision Plan Options:

- Heritage Vision Standard Plan
- Heritage Vision National Plan
- Vision Service Plan (VSP)

Non Medicare-eligible Retiree Options

Health Reimbursement Account (HRA):

- Non Medicare-eligible Retiree (Pre-65) \$110.00
- Non Medicare-eligible Retiree Spouse who is also Non Medicare-eligible, insured through a Public Exchange and whose household income is less than \$75k \$110.00
- Non Medicare-eligible Retiree, insured through a Public Exchange and whose household income is less than \$75k..... \$160.00
- Non Medicare-eligible Retiree Duty Disabled \$285.00
- Non Medicare Eligible Surviving Spouse married to retiree at time of retirement \$110.00

Dental Plan Options:

- Blue Cross Blue Shield Dental PPO
- Delta Dental High Plan
- Delta Dental Low Plan
- DENCAP Dental DHMO
- Golden Dental DHMO

Vision Plan Options:

- Heritage Vision Standard Plan
- Heritage Vision National Plan
- Vision Service Plan (VSP)

Enrollment options for retirees who qualify for healthcare and retired on or **AFTER** January 1, 2015

Medicare and Non Medicare-eligible Retiree Options

Retirees who retired on or after January 1, 2015 are not participants in the VEBA and accordingly are not eligible for the VEBA's medical coverage or Health Reimbursement Arrangement (HRA) benefits offered in this enrollment package. If you have questions regarding the HRA program that has been established for retirees who retired on or after January 1, 2015, contact BeneSys at (248) 641-4989.

Although you are not eligible for medical or HRA benefits provided in this Plan, the VEBA Board of Trustees has extended the opportunity for you and your eligible dependents to enroll in the VEBA's optional dental and vision plans: Accordingly, your dental and vision plan options are as follows:

Dental Plan Options:

- Blue Cross Blue Shield Dental PPO
- Delta Dental High Plan
- Delta Dental Low Plan
- DENCAP Dental DHMO
- Golden Dental DHMO

Vision Plan Options:

- Heritage Vision Standard Plan
- Heritage Vision National Plan
- Vision Service Plan (VSP)

Benefit Summary Comparison Charts

The benefit summaries presented on the following pages are intended to be easy-to-read summaries and provide a general overview of your medical, dental and vision benefits. **They are not contracts. Additional limitations and exclusions may apply.** For a complete description of benefits, please see the Evidence of Coverage documents provided at www.ourbenefitoffice.com/mydetroitretireebenefits. If there is a discrepancy between the enclosed summaries and the Evidence of Coverage, the Evidence of Coverage will control.

**Medical and Prescription Drug Plan Options
for Medicare-eligible retirees who qualify for healthcare and retired on or BEFORE December 31, 2014**

Benefits	BCBSM Medicare Plus Blue Group		BCN Advantage HMO-POS	HAP Senior Plus HMO
	In-network	Out-of-network		
Deductibles, copays and dollar maximum				
Annual deductible	\$750 per member per calendar year	\$500 per member per calendar year	\$500 per member per calendar year	\$500 individual, per calendar year. Copays apply to the deductible
Percent copayments	20% for select services	20% for select services	20% for select services	10% for select services
Annual coinsurance maximum (percentage copayment)	N/A	N/A	\$1,500 per member per calendar year	\$2,700 individual, per calendar year
Maximum out-of-pocket (For covered medical services)	\$2,500 per member per calendar year	\$5,000 per member per calendar year (combined in and out-of-network)	\$2,500 per member per calendar year	\$3,200 individual, per calendar year.
Routine office visits				
Office visits	\$25 copay	\$50 copay	\$25 copay	\$20 copay
Specialist care (includes GYN, eye exams and hearing exams)	\$25 copay	\$50 copay	\$25 copay after deductible	\$40 copay
Preventive services				
Annual wellness visit	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Annual cervical and cancer screening	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Mammography screening	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Pap smear screening	Plan pays 100% (lab only)	Plan pays 100% (lab only)	Plan pays 100% (lab only)	Plan pays 100%
Immunizations	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Prostate Specific Antigen (PSA) screening – laboratory services only	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%

Benefits	BCBSM Medicare Plus Blue Group		BCN Advantage	HAP Senior Plus HMO
	In-network	Out-of-network	HMO-POS	
Hospital services				
Number of days of care	Unlimited days	Unlimited days	Unlimited days	Unlimited days
Inpatient physician care, general nursing care, hospital services and supplies	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan pays 90% after deductible
Outpatient surgery	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan pays 90% after deductible
Emergency care				
Hospital emergency room	\$65 copay after deductible (copay waived if admitted within 3 days)	\$65 copay after deductible (copay waived if admitted within 3 days)	\$65 copay after deductible (copay waived if admitted)	\$65 copay, applies to deductible (copay waived if admitted)
Urgent care	\$25 copay	\$25 copay	\$25 copay	\$40 copay - Applies to the Deductible
Ambulance – medically necessary	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays, 80% after deductible, ground and air service, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan pays 90% after deductible
Diagnostic Services				
Laboratory and pathology tests	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 100%	Plan pays 90% after deductible
Diagnostic tests and X-rays	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible, with a 20% coinsurance up to \$1,500 per member per calendar year	Plan pays 90% after deductible
Alternatives to hospital care				
Skilled nursing care in a nursing home	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 90% after deductible up to 730 days per benefit period. Hospital stay not required

Benefits	BCBSM Medicare Plus Blue Group		BCN Advantage HMO-POS	HAP Senior Plus HMO
	In-network	Out-of-network		
Mental health care				
Inpatient mental health care and outpatient facility mental health care	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 100% when authorized by BCN	Plan pays 90% after deductible
Outpatient mental health care rendered in a provider's office	\$25 copay	\$50 copay	Plan pays 100% when authorized by BCN	\$20 copay
Appliances & prosthetic devices				
Prosthetics & orthotics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 100%	Plan pays 90% after deductible, coverage for approved equipment based on Medicare guidelines
Durable medical equipment	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 100%	Plan pays 90% after deductible, coverage for approved equipment based on Medicare guidelines
Chiropractic services				
Chiropractic care	\$20 copay	\$40 copay	Chiropractic spinal manipulation when referred by PCP – \$20 copay after deductible	\$20 copay (manipulation of spine for subluxation only)
Prescription drugs				
Certain drugs require prior authorization and have quantity restrictions.				
Prescription drug deductible	None	None	None	\$0 Generic deductible plus generic drug coverage through the coverage gap \$100 brand/specialty tier deductible applies.
Retail preferred generic	PPN: \$10 copay SP: \$20 copay up to 31 day supply. Coverage gap does not apply.	PPN: \$10 copay SP: \$20 copay up to 31 day supply. Coverage gap does not apply.	PPN: \$10 copay SP: \$20 copay up to a 34 day supply. Coverage gap does not apply.	\$3 copay up to a 30 day supply. Coverage gap does not apply.

Benefits	BCBSM Medicare Plus Blue Group		BCN Advantage HMO-POS	HAP Senior Plus HMO
	In-network	Out-of-network		
Prescription drugs <i>continued</i>	Preferred Pharmacy Network (PPN) Standard Pharmacy (SP)		Preferred Pharmacy Network (PPN) Standard Pharmacy (SP)	
Retail non-preferred generic	PPN: \$10 copay SP: \$20 copay up to 31 day supply. Coverage gap does not apply.	PPN: \$10 copay SP: \$20 copay up to a 34 day supply. Coverage gap does not apply.	PPN: \$10 copay SP: \$20 copay up to a 34 day supply. Coverage gap does not apply.	\$15 copay up to a 30 day supply. Coverage gap does not apply.
Retail preferred brand name	PPN: \$45 copay SP: \$60 copay up to 31 day supply. Coverage gap does not apply.	PPN: \$45 copay SP: \$60 copay up to a 34 day supply. Coverage gap does not apply.	PPN: \$45 copay SP: \$60 copay up to a 34 day supply. Coverage gap does not apply.	\$45 copay up to a 30 day supply. Coverage gap applies.
Retail non-preferred brand name	50% coinsurance with \$60 minimum copay and \$120 maximum copay up to a 31 day supply. Coverage gap does not apply.	50% coinsurance with \$80 minimum copay and \$100 maximum copay up to a 34 day supply. Coverage gap does not apply.	50% coinsurance with \$80 minimum copay and \$100 maximum copay up to a 34 day supply. Coverage gap does not apply.	30% coinsurance up to a 30 day supply. Coverage gap applies.
Retail specialty drugs	50% coinsurance with \$300 minimum copay and \$600 maximum copay up to a 31 day supply. Coverage gap does not apply.	50% coinsurance with \$160 minimum copay and \$200 maximum copay up to a 34 day supply. Coverage gap does not apply.	50% coinsurance with \$160 minimum copay and \$200 maximum copay up to a 34 day supply. Coverage gap does not apply.	30% coinsurance up to a 30 day supply. Coverage gap applies.
Mail order prescription drugs	Two times the applicable generic and brand copay for a 90-day supply; (Specialty drugs cannot be filled for a 90 day supply)	Two times the applicable generic and brand copay for a 90-day supply; (Specialty drugs cannot be filled for a 90 day supply)	Two times the applicable generic and brand copay for a 90-day supply	Two times the applicable generic and brand copay for a 90-day supply
Part D – catastrophic coverage	Once member's out of pocket costs reach over \$5,000, the copay is the greater of 5% or \$3.35 generics and \$8.34 for all others	Once member's out of pocket costs reach over \$5,000, the copay is the greater of 5% or \$3.35 generics and \$8.34 for all others	Once member's out of pocket costs reach over \$5,000, the copay is the greater of 5% or \$3.35 generics and \$8.34 for all others	Once member's out of pocket costs reach over \$5,000, the copay is the greater of 5% or \$3.35 generics and \$8.34 brands
Prescription drug coverage gap (donut hole)	Coverage gap does <u>not</u> apply to this plan.	Coverage gap does <u>not</u> apply to this plan	Coverage gap does <u>not</u> apply to this plan	In 2018, the coverage gap begins when the total cost of your prescription drugs (both what you and the plan have paid) reaches \$3,750 and ends when your out-of-pocket costs reach \$5,000.

Dental Plan Options for Medicare and non-Medicare eligible retirees

Benefits	Blue Cross Dental Plan	Delta Dental High Plan	Delta Dental Low Plan	DENCAP Dental (DHMO)	Golden Dental Plan (DHMO)
Maximum annual amount	\$1,000 per member	\$1,000 per member	\$800 per member	\$3,300 per member	\$1,600 per member
Diagnostic					
Oral examinations	Twice per year: 100% In-network 50% Out-of-network	Twice per year: 100% In-network 100% Out-of-network	Twice per year: 100% In-network 75% Out-of-network	Twice Per Year 100%	Once every six months: 100%
Emergency treatment for pain	100% In-network 50% Out-of-network	100% In-network 100% Out-of-network	100% In-network 50% Out-of-network	100%	100%
X-rays	100% In-network 50% Out-of-network Limitations depending on type of x-ray	100% In-network 100% Out-of-network Limitations depending on type of x-ray	100% In-network 75% Out-of-network Limitations depending on type of x-ray	100%	100%
Prophylaxis – teeth cleaning	Twice per year: 100% In-network 50% Out-of-network	Twice per year: 100% In-network 100% Out-of-network	Twice per year: 100% In-network 75% Out-of-network	Twice Per Year: 100%	Once every six months: 100%
Fluoride application	Twice per year: 100% In-network 50% Out-of-network	Twice per year: 100% In-network 100% Out-of-network	Twice per year: 100% In-network 75% Out-of-network	Twice Per Year: 100%	Once every six months – up to age 19: 100%
Space maintainers	Twice per quadrant: 100% In-network 50% Out-of-network	100% In-network 100% Out-of-network	100% In-network 75% Out-of-network	85%	Primary teeth only – up to age 19: 100%
Restorative					
Fillings: amalgam, composite	80% In-network 50% Out-of-network	80% In-network 50% Out-of-network	50% In-network 50% Out-of-network	85%	100%
Crowns: porcelain or metal	80% In-network 50% Out-of-network	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	80%	80%
Root canal therapy	80% In-network 50% Out-of-network	80% In-network 50% Out-of-network	50% In-network 50% Out-of-network	85%	100% general provider 70% speciality provider
Periodontics					
Treatment for gum disease of the mouth	80% In-network 50% Out-of-network	80% In-network 50% Out-of-network	50% In-network 50% Out-of-network	80%	70%

Benefits	Blue Cross Dental Plan	Delta Dental High Plan	Delta Dental Low Plan	DENCAP Dental (DHMO)	Golden Dental Plan (DHMO)
Oral Surgery					
Extractions – simple and surgical	80% In-network 50% Out-of-network	80% In-network 50% Out-of-network	50% In-network 50% Out-of-network	85%	100% general provider 70% speciality provider
Prosthodontics					
Complete dentures	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	85%	80%
Partial dentures – chrome acrylic	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	80%	80%
Fixed Bridges	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	80%	80%
Orthodontics					
Orthodontics – teeth straightening (Includes over age 19)	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	50% In-network 50% Out-of-network	\$1,800 up to age 19 \$1,200 over age 19 per member	\$3,000 up to age 19 \$3,000 retiree and spouse
Orthodontics – lifetime maximum	\$1,000 per member	\$1,000 per member	\$800 per member	\$1,800 up to age 19 \$1,200 over age 19 per member	\$3,000 up to age 19 \$3,000 retiree and spouse
Service provider					
	If you receive care from a nonparticipating dentist , you may be billed for the difference between the approved amount and the dentist charge.	If you receive care from a nonparticipating dentist , you may be billed for the difference between the approved amount and the dentist charge.	If you receive care from a nonparticipating dentist , you may be billed for the difference between the approved amount and the dentist charge.	Must use a provider in the DENCAP Dental Plan Network	Must use a provider in the Golden Dental Plan Network
Service area	Nationwide plan	Nationwide plan	Nationwide plan	South East Michigan	South East Michigan

Vision Plan Options for Medicare and non-Medicare eligible retirees

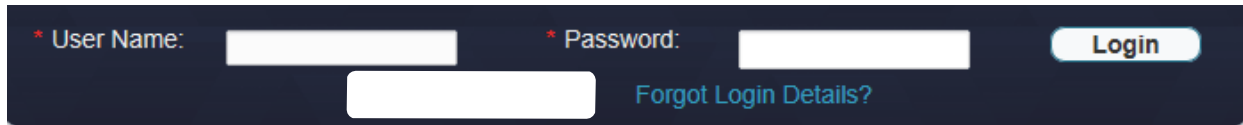
Benefits	Heritage Local Vision Plan	Heritage National Vision Plan	Vision Service Plan (VSP)
Frequency			
Applies to all listed benefits, unless otherwise noted.	Once every 24 months from date of last service	Once every 12 months from date of last service	Once every plan year
Exams for glasses			
Comprehensive exam for eyeglasses (does not apply to contact lens exam)	In-network: 100% no copay Out-of-network: reimbursed up to \$25.00	In-network: 100%, \$5.00 copay Out-of-network: reimbursed up to \$45.00	100% with \$5.00 copay
Frames			
Frames	In-network: \$100.00 retail allowance no copay Out-of-network: reimbursed up to \$30.00	In-network: \$130.00 retail allowance no copay (20% discount will be applied to member's balance for frame amount exceeding \$130.00 allowance) Out-of-network: reimbursed up to \$70.00	Benefit renews once every two years. \$130 allowance for a wide selection of frames, \$150 allowance for featured frame brands, 20% off amount over your allowance Out-of-network: reimbursed \$70
Frame warranty	In-network: 100% no copay (6 month U & C manufacturer's warranty) Out-of-network: N/A	In-network: 20% discount (where applicable) Out-of-network: N/A	In-network: 20% discount (where applicable) Out-of-network: NA
Lenses			
Single vision	In-network: 100% no copay Out-of-network: reimbursed up to \$30.00	In-network: 100%, \$10.00 copay Out-of-network: reimbursed up to \$30.00	100% (included in prescription glasses).
Lined bifocal	In-network: 100% no copay Out-of-network: reimbursed up to \$35.00	In-network: 100%, \$10.00 copay Out-of-network: reimbursed up to \$50.00	100% (included in prescription glasses).
Lined trifocal	In-network: 100% no copay Out-of-network: reimbursed up to \$40.00	In-network: 100%, \$10.00 copay Out-of-network: reimbursed up to \$65.00	100% (included in prescription glasses).

Benefits	Heritage Local Vision Plan	Heritage National Vision Plan	Vision Service Plan (VSP)
Lens options			
Tint (one solid color tint)	In-network: 100% no copay Out-of-network: N/A	In-network: 20% discount Out-of-network: N/A	Average 20-25% discount Out-of-network: NA
Scratch resistant coating	In-network: 100% no copay Out-of-network: N/A	In-network: 20% discount Out-of-network: N/A	Average 20-25% discount Out-of-network: NA
Progressive (standard)	In-network: covered to trifocal lens Member pays retail upgrade expense Out-of-network: reimbursed up to \$40.00	In-network: 100%, \$55.00 copay Out-of-network: reimbursed up to \$65.00	In-network: 100%, \$55 copay Out-of-network: NA
Prism	In-network: 100% no copay Out-of-network: N/A	In-network: 20% discount Out-of-network: N/A	Average 20-25% discount Out-of-network: NA
Contact lenses (instead of glasses)			
Comprehensive eye exam for contact lenses (applies to contact lens exam and fitting)	In-network: \$45.00 retail allowance Out-of-network: reimbursed up to \$25.00	In-network: 100%, \$5.00 copay (15% discount on fitting and follow-up) Out-of-network: reimbursed up to \$45.00	In-network: 100%, up to \$60 copay
Contact lenses elective (includes disposables)	In-network: \$45.00 retail allowance Out-of-network: reimbursed up to \$40.00	In-network: \$130.00 retail allowance Out-of-network: reimbursed up to \$105.00	In-network: \$130 allowance copay does not apply Out-of-network: reimbursed up to \$105
Contact lenses medically necessary	In-network: \$45.00 retail allowance Out-of-network: reimbursed up to \$40.00	In-network: 100%, \$10.00 copay Out-of-network: reimbursed up to \$210.00	In network: 100%, \$10 copay Out-of-network: reimbursed up to \$210 (\$105 per eye)
Progressive myopic			
Progressive myopic – rapidly changing near-sighted vision	Children (under age 19) may receive an annual exam and new lenses with a prescription change of plus or minus .50 diopters or more.	NA – annual services available to all members.	No interim benefit
Service area			
	Southeastern Michigan region.	National network (includes locations in Hawaii and Puerto Rico).	National network
Note: Vision plans are two year plans.			

How to Register on the Website

When registering for the first time, please follow these instructions:

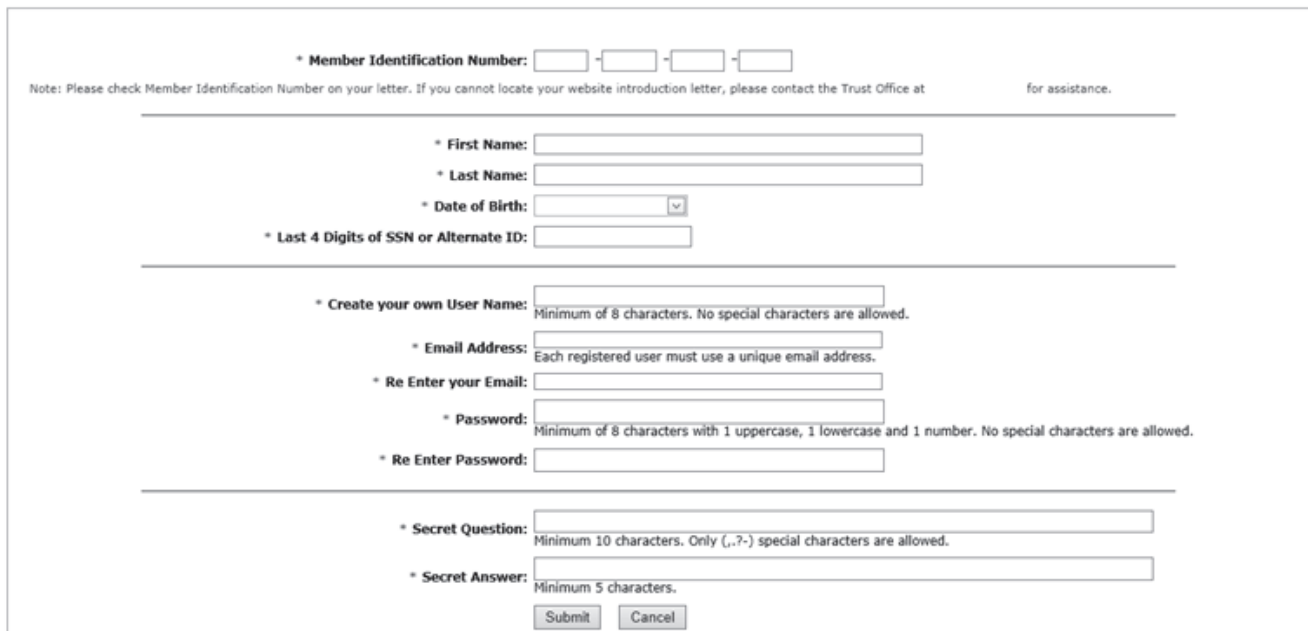
1. From your computer, www.ourbenefitoffice.com/mydetroitretireebenefits to connect to the website.
2. Locate the Login box in the upper right hand corner of the screen.
3. Click on *Create an Account* to get started.



A dark blue rectangular box containing login fields. On the left, there is a label '* User Name:' followed by a white input field. To its right is a label '* Password:' followed by another white input field. On the far right, there is a white button with the text 'Login'. Below the password field, there is a link that says 'Forgot Login Details?' in blue text.

4. The Registration Screen will display next. You will be required to enter a Member Identification Number. If you created an account during last year's Open Enrollment, please login using your User Name and Password. If you did not create an account and do not have your Member Identification Number provided last year please contact BeneSys at 1-844-563-8911 to resend one to you.
5. Your email address will be used to send you notification in the event you forget your user name and password. Once all information has been entered, please click "Submit" on the bottom of the screen.

All fields listed on the Registration Screen are required and must be completed in order to complete website registration.



A registration form with several sections. At the top, there is a field for '* Member Identification Number:' with four separate input boxes. Below this is a note: 'Note: Please check Member Identification Number on your letter. If you cannot locate your website introduction letter, please contact the Trust Office at [redacted] for assistance.' The form is divided into sections by horizontal lines. The first section contains: '* First Name:', '* Last Name:', '* Date of Birth:' (with a dropdown arrow), and '* Last 4 Digits of SSN or Alternate ID:'. The second section contains: '* Create your own User Name:' (with a note: 'Minimum of 8 characters. No special characters are allowed.'), '* Email Address:' (with a note: 'Each registered user must use a unique email address.'), '* Re Enter your Email:', '* Password:' (with a note: 'Minimum of 8 characters with 1 uppercase, 1 lowercase and 1 number. No special characters are allowed.'), and '* Re Enter Password:'. The third section contains: '* Secret Question:' (with a note: 'Minimum 10 characters. Only (.,-;) special characters are allowed.') and '* Secret Answer:' (with a note: 'Minimum 5 characters.'). At the bottom of the form are two buttons: 'Submit' and 'Cancel'.



City of Detroit General Retiree Healthcare Trust

SUMMARY ANNUAL **REPORT**

For the Fiscal Year Ending
December 31, 2016

CITY OF DETROIT GENERAL RETIREE HEALTH CARE TRUST
700 Tower Drive, Suite 300
Troy, MI 48098-2808

www.ourbenefitoffice.com/Mydetroitretireebenefits/Benefits/

BOARD OF TRUSTEES

Trustee	Term Expires
Tom Sheehan, Chair	12/31/2018
Roger Cheek, Vice Chair	12/31/2018
Doris Ewing, Secretary	12/31/2018
Floyd Allen	12/31/2018
Charles Gayney	12/31/2018
Shirley Lightsey	12/31/2018
Barbara Wise Johnson	12/31/2018

ACTUARY

Conduent Inc.

AUDITOR

Plante & Moran, PLLC

CUSTODIAL BANK

Fifth Third Bank, N.A.

GENERAL COUNSEL

VanOverbeke, Michaud & Timmony, P.C.

INVESTMENT CONSULTANT

NEPC, LLC

THIRD PARTY ADMINISTRATOR

BeneSys, Inc.

SUMMARY FACT SHEET

Member Data	December 31, 2016	December 31, 2015	Increase/(Decrease)
Benefit			
BCBS Medicare Plus Group PPO	4,607	4,932	(325)
BCN Advantage HMO-POS	646	685	(39)
HAP Senior Plus	1,717	1,842	(125)
Medicare Opt-Out HRA	941	614	327
Non-Medicare HRA	1,305	1,890	(585)
No Benefit Election	643	423	220
Totals	9,859	10,386	(527)

Expenditures	2016	2015
Net Benefits Paid	\$10,654,061	\$12,774,607
Administrative Expenses	\$1,461,921	\$1,091,545
Investment Expenses	\$0	\$0
Education/Travel Expenses	\$0	\$0
Totals	\$12,115,982	\$13,866,152

Key Figures (Projected – Next 2 Years)	Projected Market Value of Assets	Projected Net Benefits Payable¹	Projected Cost of Future Benefits	Projected Funded Ratio
Year Ended 12/31/2017	\$90,717,802	\$13,809,859	\$273,537,075	33.1%
Year Ended 12/31/2018	\$85,606,322	\$14,249,986	\$270,668,699	31.6%

¹ These figures include all projected benefit payments including Dental and Vision insurance premiums which are fully-funded through Participant contributions and do not result in a net cost to the RHC Trust.

CITY OF DETROIT GENERAL RETIREE HEALTH CARE TRUST

FREQUENTLY ASKED QUESTIONS (FAQs)

Q: I thought the VEBA received almost \$240 Million dollars under the City of Detroit's bankruptcy plan. Why are the assets so much less than that?

A: All contributions from the City of Detroit to the General Retiree Health Care Trust ("VEBA") were made in the form of new "B-Notes" issued by the City under the bankruptcy Plan of Adjustment. The B-Notes were issued to the VEBA on December 10, 2014 in the aggregate principal amount of \$238,780,159. Upon their issuance the B-Notes were valued at approximately 60% of face value (i.e., \$143,268,095). Throughout the 2015 and 2016 calendar years the market value of the B-Notes gradually decreased to approximately 40% of face value as of December 31, 2016 (i.e., \$90,736,460).

Various external factors outside the control of the VEBA Board are believed to have negatively impacted the market value of the B-Notes. Such factors include: (1) the rating of the B-Notes as highest risk/at or near default; (2) trading of the B-Notes is occurring at extremely discounted rates, in low volumes, and in odd lots; (3) uncertainty regarding the principal repayment process as provided in the B-Notes; and (4) uncertainty regarding the City's ability to repay the principal amount of the B-Notes.

That being said, there is evidence to suggest that the value of the B-Notes has increased in recent months. In light of this the Board has retained a municipal bond expert to advise on the possible sale of some of the VEBA's B-Notes, with the ultimate goal of strengthening the funded status of the VEBA.

Q: Why have my benefit costs increased in 2018?

A: In short, the VEBA's long-term liabilities are significantly greater than its assets. The VEBA's annual net benefit expenses have exceeded the income received from the interest payments on the B-Notes in each year since the VEBA's formation in 2015. Accordingly, as the Board has forewarned in years past, it has become necessary to reduce benefits in order to extend the life of the VEBA and protect the future benefits of all VEBA participants moving forward. Notably, the \$15 monthly reduction implemented in 2018 is still not enough to bring the VEBA's expenses in line with its annual income. However, the losses sustained by the VEBA will be less than in previous years and will allow the Board to transition to a more sustainable funding model.

Q: What impact do the uncertainties surrounding the repeal and replacement of the Affordable Care Act (ACA) have on the VEBA?

A: While it is impossible to predict what changes might be enacted with any degree of certainty, the most impactful changes are the potential:

- (1) implementation of the Health Insurer Fee; and
- (2) removal of the federal tax subsidies available to individuals through the public marketplace.

More specifically, the ACA's Health Insurer Fee, which was suspended in 2017 but is currently scheduled to be implemented in 2018, serves as an additional tax on insurance providers that they have not previously had to pay. As a result, health insurance premiums are expected to meaningfully increase in 2018 if the ACA's Health Insurer Fee is not repealed or suspended. Additionally, it is likely that many of the VEBA's non-Medicare population are entitled to larger federal tax subsidies than the HRA benefit offered by the VEBA. As a result, it is believed that many of the VEBA's non-Medicare eligible Participants do not utilize the VEBA's HRA benefit as it would make them ineligible to receive the federal subsidies provided under the ACA. Should the federal subsidies go away under a repeal and replacement or amendment of the ACA, it is likely that utilization of the VEBA's HRA benefit would increase, thus increasing the VEBA's annual liabilities and administrative expenses.

Q: What accounts for the VEBA's General and Administrative expenses in 2016?

A: The VEBA's general and administrative expenses includes all costs incurred in the administration of benefits and management of assets of the VEBA, including, but not limited to: administrative fees paid to the VEBA's Third Party Administrator, actuarial fees and expenses, legal fees and expenses, consulting fees and expenses, all other expenses contemplated under the Retiree Health Care Trust Agreement, and all fees and interest incurred on a short-term loan from Citibank, which allowed the VEBA to maintain existing benefit levels through the 2016 calendar year.

Q: What will the VEBA's benefit levels and coverage options be in 2019?

A: The level of benefits that the VEBA is able to provide is highly dependent on many of the questions and factors raised above, which are uncertain at this time. The Board is continuously evaluating numerous options in an effort to provide more cost-effective and efficient coverage options for the VEBA's Participants, while at the same time seeking to improve the financial solvency of the VEBA. Once the VEBA's financial situation is stabilized, the Board's long-term goal is to establish an appropriate reserve account which would allow it to provide periodic increases in benefits to help defray the impact of rising health care costs. As indicated above, the Board's ability to accomplish this goal is highly dependent on the market value of the B-Notes and any future investment returns.

Important Phone Numbers

If You Have a Question About

You Should Contact

Eligibility for coverage for you or your dependents, the amount being deducted from your pension check for medical, dental, or vision coverage, the HRA program, Open Enrollment, or Online Enrollment call BeneSys.

(Do NOT call the City of Detroit Benefits Administration Office or Benefits Express.)

BeneSys (Third Party Administrator) at:
(844) 563-8911

Hours: 7:30 a.m. – 4:30 p.m. Eastern Time,
Monday – Friday

You can also leave a message and your call will be returned, during regular business hours, in the order in which it was received.

Blue Cross Blue Shield of MI

(866) 684-8216

TTY (800) 579-0235

Locating a Provider that Participates in the Blue Cross Blue Shield PPO Network

(800) 810-2583

Blue Care Network

(866) 966-2583

HAP

(800) 801-1770

Delta Dental PPO

(800) 524-0149

Golden Dental DMO

(800) 451-5918

DENCAP Dental DMO

(888) 988-3384

Blue Cross Blue Shield of MI Dental PPO

(888) 826-8152

Vision Service Plan (VSP)

(800) 877-7195

Heritage Vision

(800) 252-2053

2018

**City of Detroit
General Retiree
Healthcare Trust Open
Enrollment Information**

