Section Name:	Human Resources	Effective Date:	June 2, 2008
Section Number:	400	Date of Revision:	7/7/08, 12/19/11, 2/21/12
Policy Number:	001		
Page:	1 of 5		

Subject: Health Care Benefits

1. Purpose: The purpose of this policy is to provide health care benefits for all regular full-time non-union employees, regular full-time Appointed Officials, and regular full-time Elected Officials of the City of Monroe.

2. Statement of Policy:

2.1. Regular full-time non-union employees, regular full-time Appointed Officials, and regular full-time Elected Officials shall be entitled to the following health care benefits commencing on their 91st day of continuous employment

A. Employees Hired Prior to December 19, 2011. Subject to the provisions of Section 2.1 B below, effective January 1, 2012, each regular full-time employee hired prior to December 19, 2011, who desires health care benefits through the Employer shall have his choice of coverage under one of the following plans:

(1) A Blue Cross/Blue Shield of Michigan Community Blue (90/10) PP0 Plan, (See Attachment 1), and Rx generic mandate $10 co-pay, brand name $60 co-pay; and mandatory purchase of all maintenance drugs through mail order with Rx generic mandate $20 co-pay and brand name $120 co-pay. Employees may select coverage for employee, employee and spouse, employee and child(ren), or family. [1]

(2) A Blue Cross/Blue Shield of Michigan Community Blue (80/20) PP0 Plan, (See Attachment 2) and Rx generic mandate $10 co-pay, brand name $60 co-pay; and mandatory purchase of all maintenance drugs through mail order with Rx generic mandate $20 co-pay, and brand name $120 co-pay. Employees may select coverage for employee, employee and spouse, employee and child(ren), or family.[1]

(3) A Blue Cross/Blue Shield of Michigan Flexible Blue PP0 High Deductible Health Care Plan with a Health Savings Account and Rx generic mandate $10 co-pay and brand name $60 co-pay after the annual deductible has been met; and mandatory purchase of all maintenance drugs through mail order Rx generic mandate $20 co-pay and brand name $120 co-pay after

[1] Eligible participants include the employee, the employee's legal spouse, and the employee's unmarried children to age 26 if they meet the requirements as defined and provided for in the respective plan documents.

the annual deductible has been met. This Plan shall include a $2,000 individual and a $4,000 family in-network deductible and a $4,000 individual, $8,000 family out-of-network deductible. (See Attachment 3)

Except as above provided, after payment of the applicable in-network deductible in each calendar year, the Plan shall cover 100% of all eligible in-network expenses for the balance of that calendar year. Except as above provided, after payment of the applicable out-of-network deductible in each calendar year, the Plan shall cover 80% of all eligible out-of-network expenses for the balance of that calendar year.

Unless modified pursuant to the provisions of Section 2.1 B below, for employees covered under this Plan during the period January 1, 2012 – December 31, 2014, the Employer shall pay the illustrated premium cost of the health plan and make a contribution to the employee's HSA in an annual amount of $350 for those who select employee only coverage, $800 for employee/spouse or employee/child(ren) coverage, and $1,000 for family coverage.[2]

Employees may make contributions to their Health Savings Accounts on a bi-weekly basis, through automatic payroll withholding, in accordance with the provisions of the Internal Revenue Code and the related regulations, and the Employer's administrative procedures.

Notwithstanding the foregoing, employees commencing their employment with the Employer after January 1 of any calendar year shall receive prorated contributions to their Health Savings Account in their first calendar year of employment. Such proration shall be based upon the number of days between the employee's date of hire and December 31 of the first calendar year of employment divided by 365.

B. Employer Health Care Contributions. The Employer's contribution to the coverage's described in Sections 2.1 A(1), (2) and (3) above shall not exceed the total cost it is permitted to incur under Section 3 of the Publicly Funded Health Insurance Contribution Act, Act. No. 152 of the Michigan Public Acts of 2011 (the "Act"). The Employer will annually compare the total cost it is allowed to incur according to the Act to its actual cost if each employee were to select the plan in Section 2.1 A (3) above. If the actual cost exceeds the allowed cost, the Employer's total cost will be adjusted to comply with the Act by first reducing the employer's contribution to the HSA referred to in Section 2.1 A (3) until they are eliminated and then, if necessary, adding an employee payment for the cost of the

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plan in Section 2.1 A (3) until the calculation is brought into compliance with Section 3 of the Act. The employee's payment for the plans in Sections 2.1 A (1) and (2) will be adjusted to make the Employer's net cost match the cost for the plan in Section 2.1 A (3) above.

C. Employees Hired On Or After December 19, 2011. Each regular full-time employee hired on or after December 19, 2011, who desires health care benefits through the Employer shall be provided the Blue Cross/Blue Shield of Michigan Community Blue PP0 (80/20) Plan described in Section 2.1 A (2) above or the Blue Cross/Blue Shield of Michigan Community Blue Flexible Blue PP0 High Deductible Health Care Plan with a Health Savings Account as described in Section 2.1 A (3) above. The terms and conditions applicable to these plans shall be as described in Section 2.1 (A) (2) and (3) above, with the following exceptions:

1) those employees choosing the PP0 (80/20) Plan described in Section 2.1 A (2) shall be required to pay 20% of the illustrated premium cost of such Plan or the cost calculated in Section 2.1 B, whichever results in the greater employee payment; and

2) those employees choosing the Flexible Blue PP0 High Deductible Health Care Plan with a Health Savings Account described in Section 2.1 A (3) shall be required to pay the full amount of the annual deductible and any amount by which the annual premium exceeds the Employer's total cost as calculated in Section 2.1 B. (The Employer shall not contribute to the employee's HSA.)

The illustrated premium costs of the foregoing plans are subject to adjustment each calendar year (typically in January of each year). Prior to implementing each such adjustment, the Employer will inform employees of the adjustment and provide an open enrollment period during which time employees will be permitted to change their coverage selections. Eligibility for the medical benefits herein above provided shall be conditioned on the employee authorizing the Employer to deduct the covered employee's portion of the cost of such benefits from compensation due the covered employee.

2.2 Spousal Coverage Limitations. Notwithstanding any other provision of this policy to the contrary, if a regular full-time, non-union employee's spouse works for an employer, other than the City of Monroe, who provides medical coverage, such spouse shall be required to elect employee only medical coverage through his/her employer, so long as the spouse's monthly contribution to the premium does not exceed one-third (1/3) of the total premium cost of employee only coverage. In such circumstance, the City's Plan shall provide secondary coverage. If the spouse's contribution exceeds one-third (1/3) of the total cost of

employee only coverage, the spouse will not be required to participate in his/her employer's plan, in which event the City will provide primary coverage.

2.3 Health Care Waiver Incentives.

A. Total Waiver of Health Care Coverage

(1) Regular full-time, non-union employees who have health care benefits provided through a source other than the City of Monroe may waive their rights to health care benefits provided by the City under this policy. An employee who expressly waives, in writing, all rights to any health care benefits provided through the City of Monroe, including health care benefits provided through a spouse employed by the City, will receive a cash payment (not to be added to base salary) of $1,250 per year, payable in December of each calendar year. Any employee who has waived coverage for a period less than a full calendar year shall receive a prorated amount of such $1,250 payment.

(2) An employee who has waived coverage as hereinabove provided may have such coverage reinstated, provided he/she demonstrates that he/she can no longer receive such benefits from another source.

B. Waiver of Coverage for Employee's Spouse or Spouse and Dependent Children Only

(1) Any regular full-time, non-union employee whose spouse and eligible dependent children can secure health care coverage from a source other than the City of Monroe may waive all coverage for said spouse and and/or dependent children.

(2) An employee who waives all health care coverage for only his/her spouse will receive a cash payment of $750 per year, payable in December of each calendar year. Any employee who has waived coverage under this provision less than a full calendar year shall receive a prorated amount of such $750 payment.

(3) An employee who has waived all coverage for his/her spouse and all dependent children will receive a cash payment of $1,000 per year, payable in December of each calendar year. Any employee who has waived coverage under this provision less than a full calendar year shall receive a prorated amount of such $1,000 payment.

(4) An employee who has waived health care benefits coverage under the City's plan for his spouse, or spouse and dependent children, may apply to have such benefits reinstated, provided he/she demonstrates that his or her spouse, or spouse and dependent children, can no longer receive such benefits from another source.

2.4 Coverage under the above plans is subject to the terms, conditions, exclusions, limitations, deductibles, illustrated premium co-payments and other provisions of such plans, and all applicable provisions of the Internal Revenue Code and related regulations.

2.5 To be eligible for health care benefits, an employee must document all coverage provided under his/her spouse's medical plan and cooperate in the coordination of coverage to limit the City's expense.

2.6 The City reserves the right to change its third party administrator and/or the carrier(s), plan(s), and/or the manner in which it provides the above benefits.

3. Definitions: None.

4. Application: This policy shall apply to all regular full-time non-union employees, regular full-time Appointed Officials and regular full-time Elected Officials in all departments of the City of Monroe and shall supersede and cancel all prior policies and actions of the City Council related to health care benefits for active employees, their spouses and eligible dependents.

5. Responsibility: The Human Resources Director or designee shall have the responsibility of implementing and overseeing the administration of this policy.

6. Administrative Procedure: None

7. Legislative History of Authority for Creation or Revision:

Adopted pursuant to action of the Monroe City Council, dated June 2, 2008.

Revised pursuant to action of the Monroe City Council dated July 7, 2008.

Revised pursuant to action of the Monroe City Council dated December 19, 2011.

Revised pursuant to action of the Monroe City Council dated February 21, 2012.

City of Monroe
38678-671
Community Blue℠ PPO
Benefits-at-a-Glance
Effective January 1, 2011

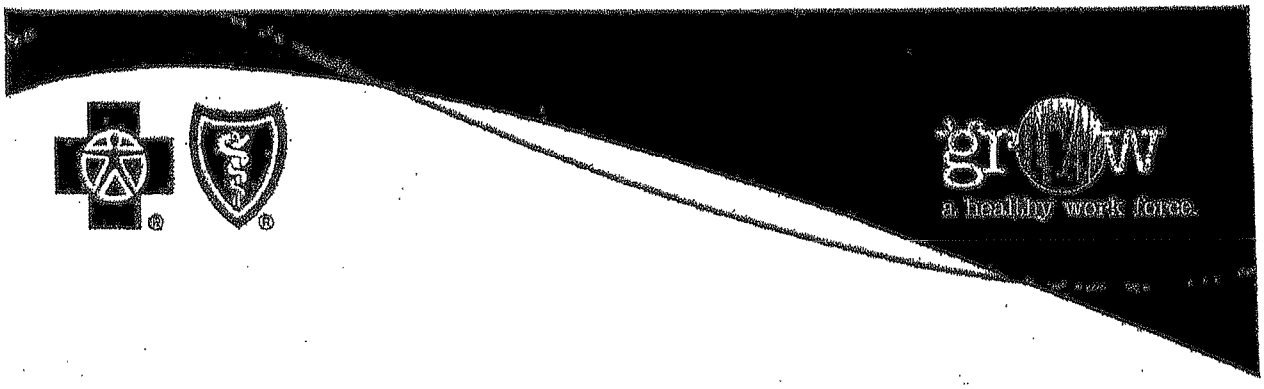
ATTACHMENT 1
PPO PLAN (90/10%)
RX $10/$60

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network*
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived if service is performed in a PPO physician's office.	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	• $20 copay for office visits • $50 copay for emergency room visits	$50 copay for emergency room visits
Percent copays Note: Copays apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 10% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but does not apply to fixed dollar copays and private duty nursing percent copays Note: For groups with 50 or fewer employees or groups that are not subject to the MHP law, mental health care and substance abuse treatment copays do not contribute to the copay dollar maximum.	$1,000 for one member, $2,000 for two or more members each calendar year	$2,000 for one member, $4,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

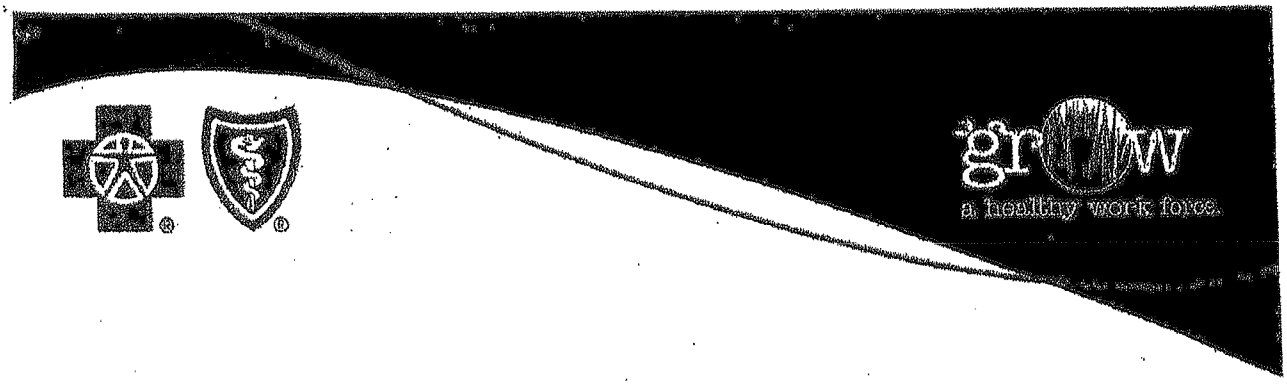
* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



	In-network	Out-of-network*
Preventive care services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay) Note: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible.
	One routine colonoscopy per member per calendar year	

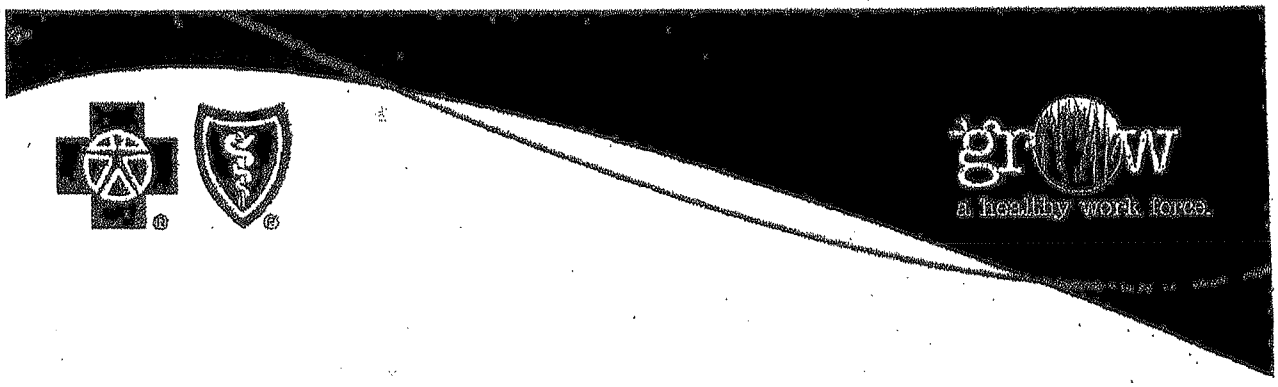
Physician office services		
Office visits	$20 copay per office visit	80% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	80% after out-of-network deductible, must be medically necessary
Office consultations	$20 copay per office visit	80% after out-of-network deductible, must be medically necessary
Urgent care visits	$20 copay per office visit	80% after out-of-network deductible, must be medically necessary

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



	In-network	Out-of-network *
Emergency medical care		
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	90% after in-network deductible	80% after in-network deductible
Diagnostic services		
Laboratory and pathology services	90% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	80% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care	100% (no deductible or copay)	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	90% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	90% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	90% after in-network deductible	80% after out-of-network deductible
Chemotherapy	90% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a participating skilled nursing facility	90% after in-network deductible	90% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care – must be provided through a participating hospice program	100% (no deductible or copay)	100% (no deductible or copay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a participating home health care agency	90% after in-network deductible	90% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	90% after in-network deductible	90% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	90% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	80% after out-of-network deductible
Voluntary sterilization	90% after in-network deductible	80% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



	In-network	Out-of-network*

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	80% after out-of-network deductible

Mental health care and substance abuse treatment

Note: If your employer has 51 or more employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See "Annual copay dollar maximums" section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care	90% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	90% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care		
• Facility and clinic	90% after in-network deductible	90% after in-network deductible
• Physician's office	90% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	90% after in-network deductible	90% after in-network deductible

	In-network	Out-of-network*

Other covered services

Outpatient Diabetes Management Program (ODMP)	90% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	80% after out-of-network deductible
Chiropractic spinal manipulation	$20 copay per visit for specific office services	80% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	90% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

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City of Monroe
38678- 672, 972
Community Blue[SM] PPO – Plan 6
Benefits-at-a-Glance

Effective January 1, 2012

ATTACHMENT 2
PPO PLAN (80/20%)
RX $10/$60

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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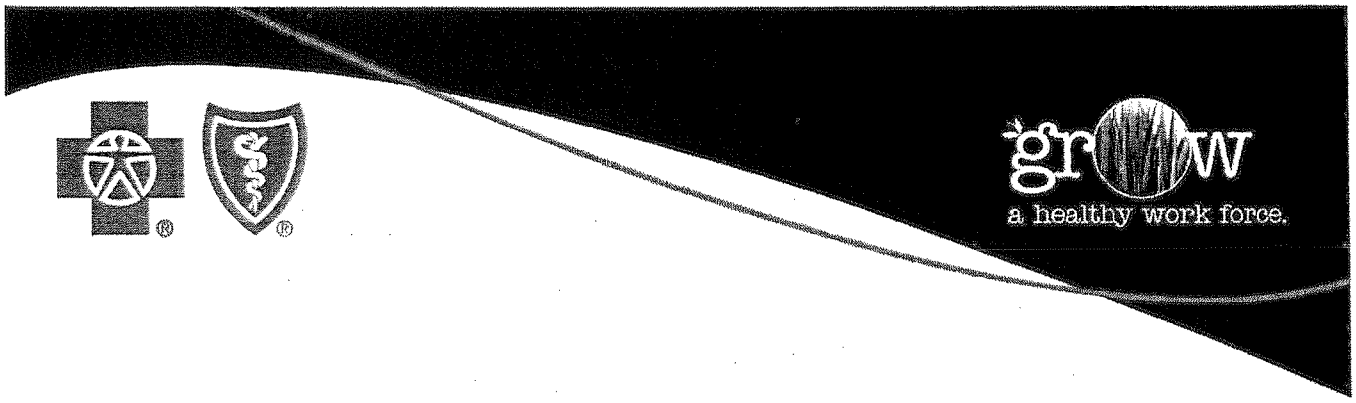
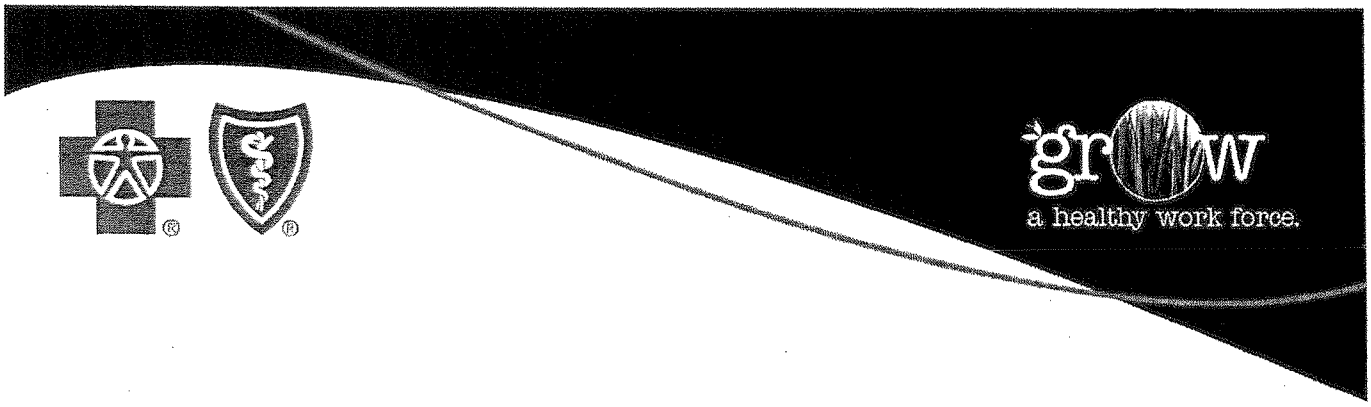
	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived if service is performed in a PPO physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	• $25 copay for office visits • $50 copay for emergency room visits	$50 copay for emergency room visits
Percent copays **Note:** Copays apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing percent copays **Note:** For groups with 50 or fewer employees or groups that are **not** subject to the MHP law, mental health care and substance abuse treatment copays **do not** contribute to the copay dollar maximum.	$1,000 for one member, $2,000 for two or more members each calendar year	$2,000 for one member, $4,000 for two or more members each calendar year **Note:** Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



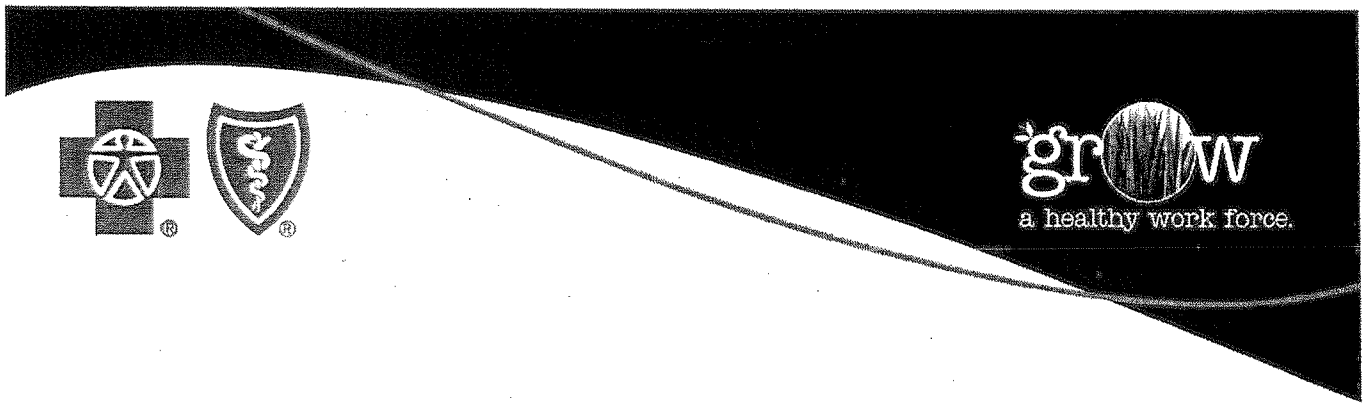
	In-network	Out-of-network *
Preventive care services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	70% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay) **Note:** Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	70% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
Physician office services		
Office visits	$25 copay per office visit	70% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	70% after out-of-network deductible, must be medically necessary
Office consultations	$25 copay per office visit	70% after out-of-network deductible, must be medically necessary
Urgent care visits	$25 copay per office visit	70% after out-of-network deductible, must be medically necessary

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



	In-network	Out-of-network *
Emergency medical care		
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic services		
Laboratory and pathology services	80% after in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	70% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	70% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care	100% (no deductible or copay)	70% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	70% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	70% after out-of-network deductible
Chemotherapy	80% after in-network deductible	70% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care – must be provided through a **participating** hospice program	100% (no deductible or copay)	100% (no deductible or copay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	80% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	70% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	70% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



	In-network	Out-of-network *

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities **only**
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	70% after out-of-network deductible

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See "Annual copay dollar maximums" section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care	80% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	80% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Outpatient mental health care		
• Facility and clinic	80% after in-network deductible	80% after in-network deductible
• Physician's office	80% after in-network deductible	70% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% after in-network deductible	80% after in-network deductible

	In-network	Out-of-network *

Other covered services

Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	70% after out-of-network deductible
Chiropractic spinal manipulation	$25 copay per visit for specific office services	70% after out-of-network deductible
	Limited to a **combined** maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	70% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible

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City of Monroe
38678-681, 981
Flexible Blue℠ Plan 3 Medical Coverage With Flexible Blue℠ RX Prescription Dru Benefits-at-a-Glance

Effective: January 1, 2012

ATTACHMENT 3
PPO FLEXIBLE BLUE
RX $10/$60 after deductible

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	**Out-of-network ***
Member's responsibility (deductibles, copays and dollar maximums)		
Note: If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.		
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Flexible Blue medical coverage **and** your Flexible Blue prescription drug coverage.	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$4,000 for a one-person contract or $8,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)
Note: The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	Deductibles are based on amounts defined annually by the federal government for Flexible Blue-related health plans. Please call your customer service center for an annual update.	
Fixed dollar copays	None	None
Percent copays **Note:** Copays apply once the deductible has been met.	None	20% of approved amount
Annual copay dollar maximums **Note:** Your copay dollar maximum **combines** copay amounts paid under your Flexible Blue medical coverage **and** your Flexible Blue prescription drug coverage.	Not applicable	$1,000 for a one-person contract or $2,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered

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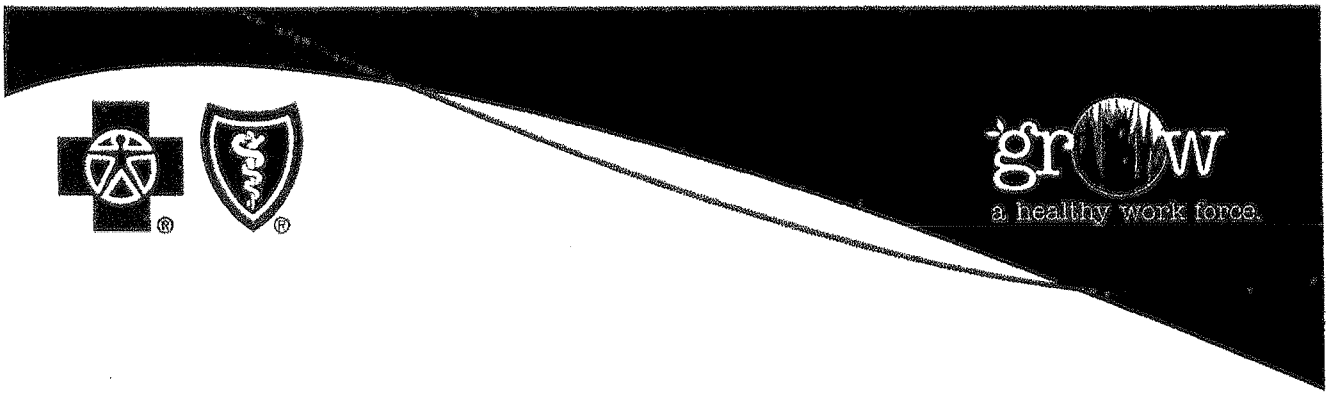

	In-network	Out-of-network *
Preventive care services, *continued*		
Well-baby and child care visits	100% (no deductible or copay) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay) **Note:** Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
Physician office services		
Office visits	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits	100% after in-network deductible	80% after out-of-network deductible
Office consultations	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits	100% after in-network deductible	80% after out-of-network deductible
Emergency medical care		
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

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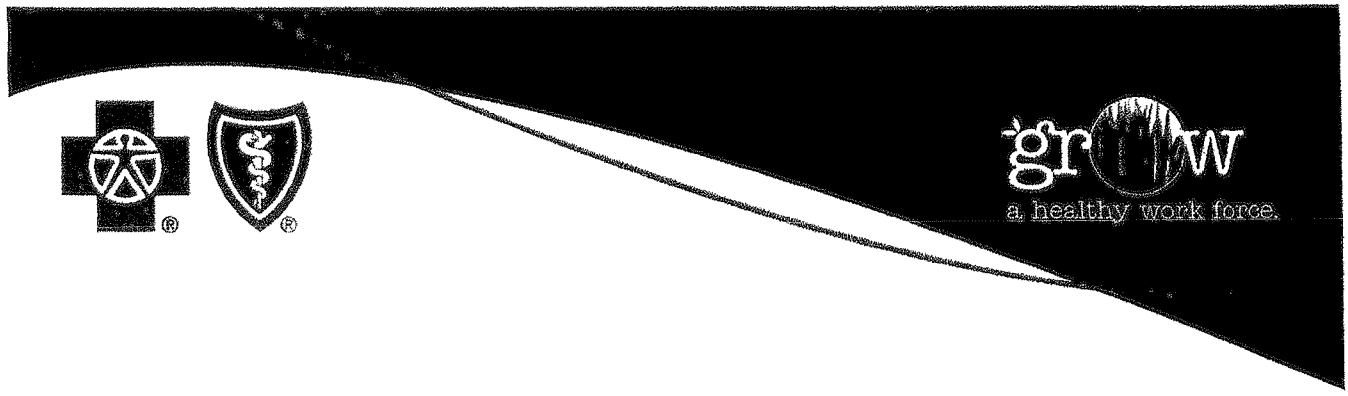

	In-network	Out-of-network *
Maternity services provided by a physician		
Prenatal and postnatal care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care – must be provided through a **participating** hospice program	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	100% after in-network deductible	100% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization	100% after in-network deductible	80% after out-of-network deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible – in designated facilities **only**
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

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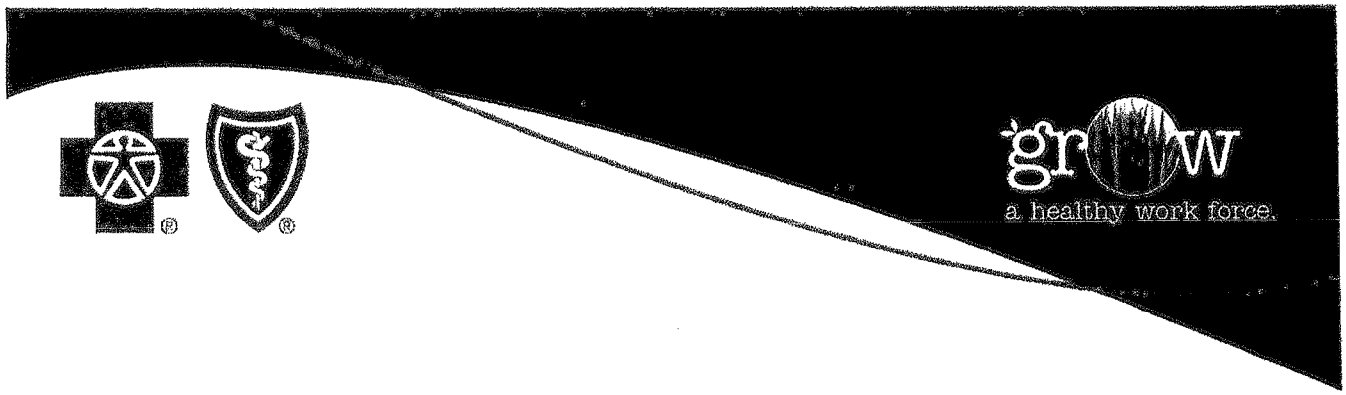

	In-network	Out-of-network *
Mental health care and substance abuse treatment		
Inpatient mental health care and inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic	100% after in-network deductible	100% after in-network deductible, in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible	100% after in-network deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP)	100% (no deductible or copay)	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Osteopathic manipulative therapy Chiropractic spinal manipulation	100% after in-network deductible	80% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing	100% after in-network deductible	100% after in-network deductible

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Flexible Blue℠ RX Prescription Drug Plan

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com**. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

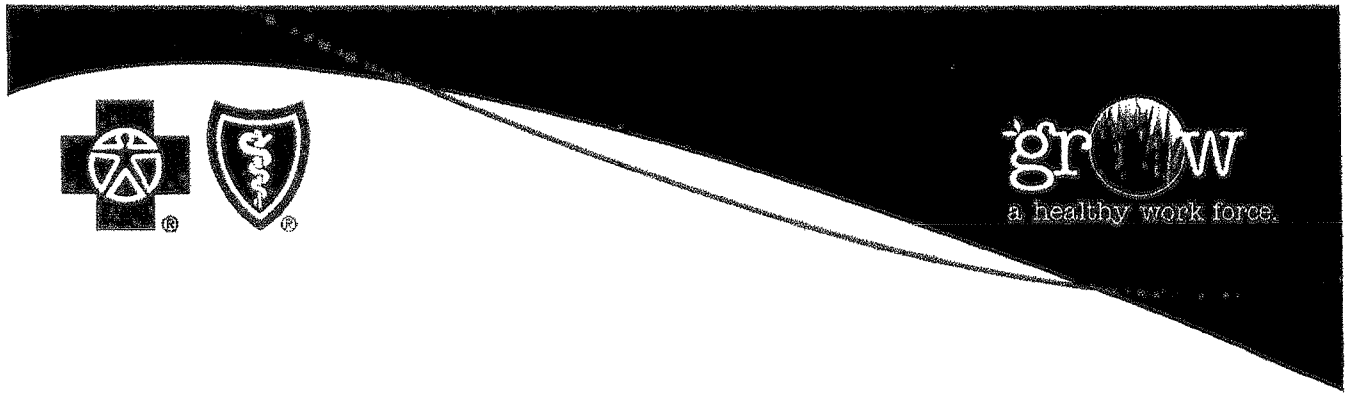
Effective July 1, 2010, BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

	Network pharmacy	**Non-network pharmacy**
Member's responsibility (copays)		
Your Flexible Blue prescription drug benefits, including mail order drugs, are subject to the same deductibles, copays and annual copay dollar maximums required under your Flexible Blue medical coverage.		
Benefits are not payable until after you have met the Flexible Blue annual deductible.		
Retail Pharmacy copays Up to 30 day supply **Note:** Copays apply once the deductible has been met.	$10 for each generic drug $60 for each brand drug, even if the prescription is marked "DAW" or there is no generic equivalent drug available.	Your network pharmacy copay plus 25% of the BCBSM approved amount.
Mail order (home delivery) prescription drugs – up to a 90-day supply of prescribed medication by mail from Medco (BCBSM mail order vendor)	$20 for each generic drug $120 for each brand drug, even if the prescription is marked "DAW" or there is no generic equivalent drug available.	No coverage
Covered services		
FDA-approved drugs	100% of approved amount after Flexible Blue medical coverage deductible	80% of approved amount (20% copay) after Flexible Blue medical coverage deductible ***plus*** an additional 20% of BCBSM approved amount for the drug **
Prescribed over-the-counter drugs – when covered by BCBSM **Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.	100% of approved amount after Flexible Blue medical coverage deductible	80% of approved amount (20% copay) after Flexible Blue medical coverage deductible ***plus*** an additional 20% of BCBSM approved amount for the drug **
State-controlled drugs	100% of approved amount after Flexible Blue medical coverage deductible	80% of approved amount (20% copay) after Flexible Blue medical coverage deductible ***plus*** an additional 20% of BCBSM approved amount for the drug **
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount after Flexible Blue medical coverage deductible	80% of approved amount (20% copay) after Flexible Blue medical coverage deductible ***plus*** an additional 20% of BCBSM approved amount for the drug **

Note: If you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand name drug dispensed and the maximum allowable cost for the generic, ***plus*** your copay, if applicable. This cost difference will **not** be applied toward your in-network deductible, nor your annual copay dollar maximum, if applicable.

* A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

** The 20% prescription drug out-of-network copay will not be applied toward your annual Flexible Blue deductible or annual copay dollar maximum.



Features of your prescription drug plan

Drug interchange and generic copay waiver	Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com**. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com**.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug, it applies only to prescriptions being filed for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com, along with the preferred medications**. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.