

EXHIBIT 3

CITY OF DETROIT
BENEFITS ADMINISTRATION OFFICE
BULLETIN

-IMPORTANT NOTICE-

TO: All City of Detroit Retirees

RE: CHANGES IN HEALTH CARE BENEFITS

This is an official notice to advise you that effective July 15, 2006, there will be changes to the health care design plan for employees and retirees including the contribution structure of the medical plan premium sharing formula.

While we recognize these changes may increase what you are required to pay for your health care, they are necessary in order to manage rising health care costs. Failure to implement changes to employee and retiree health care will adversely impact the City's financial solvency and commitment to provide you and your eligible dependents with quality and affordable health care coverage. We will continue to stand by this commitment, however, it must be balanced with our ability to pay for these benefits while still providing the core services that our citizens need. It is our firm belief that the City's health care plans, with the cost-saving measures in place, are still among the best when compared to those provided by major employers in this area.

Changes to the medical plan design effective July 15, 2006 include:

- **Prescription Drugs:** The new plan design for all Traditional and HMO plans and the LSA-Community Blue PPO plan provides for the following prescription drug co-payments:
 - for prescription medications purchased at retail (up to a 30 day supply), there will be a \$5 co-payment for generic medications, and a \$15 co-payment for brand-name medications; and
 - for prescription medications purchased through mail order (up to a 90-day supply), the co-payment will be \$10 for generic medications, and \$30 for brand-name medications.
 - **Note:** The co-payments for prescription medications for Blue Cross Community Blue PPO remain the same.
- **Emergency Room Services:** The new plan design for all medical plans will require a co-payment of \$75 per emergency room visit. However, this co-payment will be waived, meaning you will not have to pay it, if you are admitted to the hospital.
- **Office and Urgent Care Facility Visits for all PPO, HMO, and Medicare Advantage Plans:** The new plan design will require a co-payment of \$10 per office visit and \$10 per urgent care facility visit.
- **Mental Health and Substance Abuse Visits for all HMO Plans:** The new plan design will require a co-payment of \$10 per office visit.
- **Deductibles for all Traditional, CMM and PPO Plans:** If your coverage is through the Traditional, CMM or PPO plans, the new plan design will require annual deductibles of \$175 for single coverage and \$350 for family coverage. Family for purposes of deductibles is defined as two (2) or more persons on the same contract. The new plan design will require annual out-of-network deductibles of \$425 for single coverage and \$850 for family coverage for covered services conducted by out-of-network providers (Community Blue PPO plan).

The deductible is applied before the health care carrier makes any payment for covered services. Exceptions are for services with a fixed dollar co-payment (e.g., co-payments for office visits, emergency room, prescription medication), services performed in a PPO physician's office, emergency care provided by a physician, chiropractic spinal manipulation, pre- and post-natal care visits, allergy testing and therapy injections, hospice care benefits, and preventive care services.

Amounts applied toward an annual deductible for out-of-network services also count toward the deductible for in-network services. However, deductible amounts for in-network services are not applied toward the deductible for out-of-network services.

- **Co-insurance for all Traditional and PPO Plans and CMM:** After the applicable deductible has been met and until the applicable out-of-pocket maximum is reached, members enrolled in PPO plans will be required to pay 10% of covered charges from in-network providers and 30% from out-of-network providers. This is referred to as "co-insurance." Co-insurance is applied to outpatient professional and hospital services that are not subject to a fixed dollar co-pay. The co-insurance payments are limited to a maximum of \$1,000 for single coverage and \$2,000 for family coverage for services received from in-network providers. Family for purposes of co-insurance payments is defined as two (2) or more persons on the same contract. The required co-insurance for single and family coverage under the PPO plan is two times these amounts for covered services rendered by out-of-network providers. The out-of-pocket maximum includes amounts applied towards the deductible. Fixed dollar co-payments and co-payments for mental health care, substance abuse and private duty nursing cannot be applied toward this maximum. Co-insurance applied toward the annual maximum for out-of-network services also counts towards the maximum for in-network services. However, co-insurance for in-network services is not applied toward the annual maximum for out-of-network services. Inpatient hospital services are not subject to co-insurance (and will be paid at 100%).

Retiree Contribution Structure for New Design Plans

Your monthly contribution for all plans is as follows (for the actual dollar amounts you may be responsible for, please see the attached 2006 Retiree Monthly Contribution Sheet):

- **One Person:** with Medicare: \$7.50; without Medicare: \$15.00
- **Two Persons:** both with Medicare: \$17.50; both without Medicare: \$35.00;
one with Medicare and one without Medicare: \$26.25
- **Family:** one or more with Medicare: \$45.00; without Medicare: \$75.00

Please note that for all plans, you will not pay less than what you are paying today for the same coverage type (one person, two persons, or family) under the same plan.

Eventually, your contribution structure will be 10% of the monthly premium for PPO plans, and 20% of the monthly premium for Traditional, CMM, and HMO plans. This will be phased in over a five year period, beginning in July 2007, by increasing the previous year's contribution by 20% of the difference between that previous year's contribution and the target contribution of either 10% (PPO) or 20% (Traditional, CMM, HMO). In July 2008, your contribution will increase by 40% of the difference between that previous year's contribution and the target contribution, 2009 by 60%, and in 2010 by 80%, so that by July 2011, your contribution will match the target of 10% of the monthly premium for PPO plans and 20% of the monthly premium for Traditional, CMM, and HMO plans.

Family Continuation Dependents

In addition to the existing family continuation requirements, retirees insuring family continuation dependents must also provide proof that the dependent is enrolled in an accredited school as a full-time student in order for that dependent to be eligible for continued coverage. This requirement is effective beginning with the Family Continuation Verification Period for the July 2006 coverage period, conducted in October 2006.

Retirees who are Medicare-eligible (or who will become Medicare-eligible during the 2006 coverage plan year) and who are enrolled in one of the following HMOs:

Blue Care Network (BCN) or Health Alliance Plan (HAP)

Effective with the 2006 Open Enrollment, all retirees and their dependents enrolled in BCN and HAP who are Medicare-eligible and who wish to remain enrolled in an HMO will be automatically transferred to that HMO's Medicare Advantage Plan. For BCN, the plan is called BCN Medicare Advantage. For HAP, it is called HAP Senior Plus. Although less expensive, the benefit levels offered in these Medicare Advantage plans are equal to or better than those offered under the current HMO plan. However, the network providers and service areas may be different. If you do not live in the service area or do not wish to be enrolled in the BCN Medicare Advantage or Senior HAP Plus plans, you must complete an enrollment form during the open enrollment period and select another health care plan. If you do not submit an enrollment form during the open enrollment period requesting to switch to another health care plan, you will be automatically transferred to the Medicare Advantage plan that is offered by your current HMO.

Regardless of the health care plan you select, all Medicare-eligible retirees and Medicare-eligible dependents will continue to be responsible for paying the Medicare Part B premium, which is deducted from your monthly Social Security check.

CITY OF DETROIT
BENEFITS ADMINISTRATION OFFICE
BULLETIN Continued

THE NEW HEALTH CARE RATES ARE EFFECTIVE JULY 1, 2006
NEW HEALTH CARE PLAN DESIGNS ARE EFFECTIVE JULY 15, 2006

To learn more about these important changes to your benefits:

You are invited to attend health care information sessions that will be conducted at the City of Detroit's Benefits Administration Office. Representatives of all health care plans will be present to explain the changes to their health care plan and to respond to your benefit questions. You will receive notice of the dates and times such presentations will be held. You will also receive, by US mail, a new Health Care Plan Option booklet that will contain a summary description of the major health care benefits and comparisons of all new health care plans to assist you and your family in making your health care selection. If you have any questions or concerns at this time regarding benefit design changes, please contact the health care providers at the following Hot Line numbers:

Blue Cross Blue Shield Traditional
Blue Cross Community Blue PPO
Blue Cross Community Blue PPO- the LSA Plan
Blue Cross Comprehensive Master Medical (CMM)
Blue Care Network (HMO)
BCN Medicare Advantage
Call: (800) 470-9633

Health Alliance Plan (HMO)
HAP Senior Plus
Call: (800) 422-4641

US Health - C.O.P.S Trust Traditional
US Health - C.O.P.S. PPO
Call: (800)-255-9674

You may also contact the Benefits Administration Office at (888) 288-2684 or 313-224-2742, and your call will be directed to an appropriate staff member.

Medical and Dental Open Enrollment

The 2006 medical and dental open enrollment will be scheduled within the next few weeks. An open enrollment package will be mailed to your home address of record. This package will contain the specific opening and closing dates, a City of Detroit Health Care Plan Option booklet, the monthly retiree contribution sheets, an enrollment form, and for your convenience a self-addressed return envelope. During the open enrollment period you will have the opportunity to switch to other plans and/or add dependents. If after reviewing the open enrollment material you do not wish to make any changes, you do not have to submit an enrollment form. Your health care coverage will be continued.

Enclosures: 2006 Retiree Monthly Contributions and City Payment Sheets