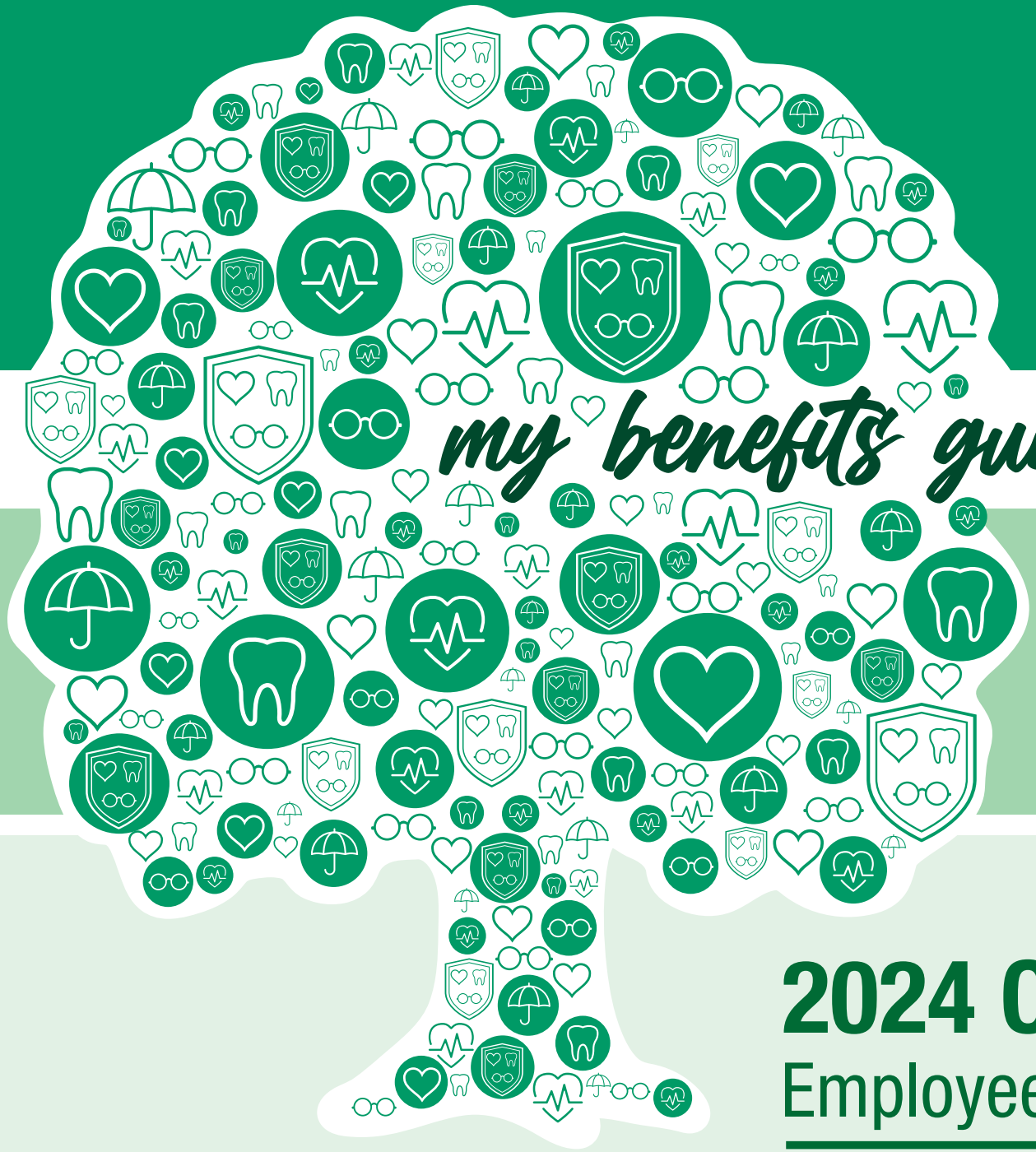

2024 Oakland County
Employee Benefits & Wellness

OAKLAND COUNTY MICHIGAN

All ways, MOVING FORWARD

Dear Colleagues,

A big welcome to the new employees who are joining our Oakland County team and my ongoing thanks to our current employees. In our mission to deliver excellent service to the residents of Oakland County you remain our most valuable asset.

Our goal is to attract and retain talented and dedicated employees and to that end, I am pleased to present the Health and Benefits guidebook. We are proud to offer a comprehensive and competitive benefits package because we recognize and appreciate the importance of your physical and mental health.

With the health enrollment period quickly approaching, please review this guidebook to ensure you sign up for the coverage that best suits your needs. The guidebook also provides information on the wide array of other valuable benefits and programs available to Oakland County employees.

I hope you find it helpful. And thanks again for your service and dedication to Oakland County.

Sincerely,

David Coulter
Oakland County Executive

TABLE OF CONTENTS

Contact Information

MEDICAL	**Blue Cross/Blue Shield of MI** 1-877-790-2583 bcbsm.com	**Blue Care Network** 1-877-790-2583 bcbsm.com	
PRESCRIPTION	**Optum** 1-800-356-3477 optumrx.com	**Optum Mail Order** 1-800-356-3477 optumrx.com	
DENTAL • VISION • FLEXIBLE SPENDING ACCOUNTS • HEALTH SAVINGS ACCOUNT	**Dental** Delta Dental 1-800-524-0149 deltadentalmi.com	**Vision** National Vision Administrators (NVA) 1-800-672-7723 e-nva.com	**Flexible Spending Accounts & Health Savings Account** Health Equity 1-866-346-5800 healthequity.com
LIFE INSURANCE • AD&D • DISABILITY	**Unum** 1-800-445-0402 (Life Insurance/AD&D) 1-888-673-9940 (Disablility) unum.com		
EMPLOYEE ASSISTANCE PROGRAM	**Optum** 1-866-248-4096 liveandworkwell.com (code: Oakgov)		

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Checklist

CHECKLIST FOR A SUCCESSFUL ENROLLMENT

EXPLORE

- ☐ Browse through detailed plan summaries and benefit options enclosed in this booklet and visit OakGov.com/benefits for additional plan documentation.

ENGAGE

- ☐ We're here to help. Contact the Benefits Team at **benefits@oakgov.com** or (248) 452-9189.

PREPARE

- ☐ If adding dependents to coverage, have Social Security numbers and required documentation (such as a marriage or birth certificate) available to upload into Workday.
- ☐ New hires must make enrollment elections **within 14 days** of the date of hire.

ENROLL

- ☐ In Workday, click on your Inbox at the top right corner or middle of the page.
- ☐ Select Benefit Event to begin elections.
- ☐ Benefits are effective the 1st of the month following new hire date.

workday.

NEED HELP IN WORKDAY?

Refer to the Enrollment Instructions by visiting the benefits website at OakGov.com/benefits

Important Information about Default Coverage
If new hire elections are not made within 14 days of hire, employees will be enrolled in employee-only default coverage, shown here.

Plan	Default Coverage
Medical	BCN HMO (employee only)
Dental	Standard Dental (employee only)
Vision	Standard Vision (employee only)

Medical

MEDICAL BENEFITS

Oakland County offers a choice of medical plans, including two Preferred Provider Organization (PPO) plans, a Health Maintenance Organization (HMO) plan, and a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). Although the plans generally cover similar medical services, they are different in three important ways. You will determine the best plan based on your family's health care needs.

1. Provider networks
2. The amount of money spent for services (deductible, co-pays, coinsurance)
3. The amount of money paid in payroll deductions

MEDICAL PLAN CHOICES

- PPO1 Blue Cross/Blue Shield of MI (BCBSM)
- PPO2 Blue Cross/Blue Shield of MI (BCBSM)
- HMO Blue Care Network (BCN)
- HDHP with HSA Blue Cross/Blue Shield of MI (BCBSM)
- Traditional Plan Blue Cross/Blue Shield of MI (BCBSM) *(closed plan for current enrollees only)*
- No Coverage

NOTE: All dependents on your benefit coverage are required to have the same medical, dental and vision coverage you elect.

PPO PLANS

Administered by Blue Cross/Blue Shield of MI (BCBSM)

A PPO plan allows you to pay a percentage of the cost of care. Once the plan-year (Jan. to Dec.) deductible is met, the plan begins to pay a majority share of the cost, and you're responsible for the remaining, smaller percentage. PPO plans allow you to go to any physician (in-network or out of network) at any given time without having to obtain a referral from your primary physician.

Coinsurance is the percent you pay for services not covered at 100%. Once the coinsurance maximum has been reached, the plan will pay 100% of eligible in-network expenses for the rest of the calendar year. However, any copays applicable to certain medical services may apply.

NOTE: Reference the medical plan comparison chart for plan details on deductibles, coinsurance, and covered services.

Medical

HMO PLAN

Administered by Blue Care Network (BCN)

The Blue Care Network (BCN) HMO plan is a Health Maintenance Organization (HMO) plan. This plan has no deductible and requires a copay for certain services. You will need to receive most or all of your health care from a "in-network" provider. HMOs require that you select a primary care physician (PCP) at enrollment who provides routine care and coordinates specialty care. BCN also offers online tools and resources at bcbsm.com to manage your health care and wellness goals wherever you are.

What You Should Know

- When you choose a PCP you're also choosing your network of doctors for any specialty care you may need.
- Emergency coverage is worldwide.
- There is no PCP or specialty coverage for out-of-network benefits.

HDHP / HIGH DEDUCTIBLE HEALTH PLAN

Administered by Blue Cross/Blue Shield of MI (BCBSM)

- The High Deductible Health plan (HDHP) is designed so that you pay for the medical costs up front when visiting the doctor before insurance kicks in (after the deductible is met). With this plan, it allows for lower monthly premiums and enrolling into an HSA to help pay for qualified expenses. This plan works in the same way as a PPO, so a referral from a primary doctor first is not required to see a specialist.
- The plan has a higher deductible than the traditional plans, has lower monthly premiums, and still has the same out of pocket maximum. As with the other plans, all preventive visits/services are covered 100% by the insurance.

TRADITIONAL PLAN

Administered by Blue Cross/Blue Shield of MI (BCBSM)

No new enrollments are allowed in the Traditional plan. Once an employee leaves the Traditional plan, it can't be elected again until retirement.

NOTE: Reference the comparison chart on page 9 for plan details on deductibles, coinsurance maximums, and services covered.

Medical

PREVENTIVE CARE BENEFITS

All medical plans will pay 100% of usual, customary, and reasonable fees for (in-network) recommended preventive care services, including:

- Routine adult preventive visit – one per calendar year
- Immunizations
- Routine GYN exam including pap smear – one per calendar year
- Mammography screening (in accordance with guidelines from American Cancer Society)
- Prostate and colorectal screenings
- Well child care and immunizations
- Routine prenatal maternity services
- And more!

Key Items to Remember:

- Items that may occur during a preventive visit include immunizations, blood pressure and cholesterol measurement, diabetes screening, or counseling on healthy weight.
- Diagnostic care to identify potential health risks are covered according to plan benefits, even if recommended or done during a preventive care visit.
- If your physician finds a specific health risk or new medical condition during your appointment, your doctor may bill those services as diagnostic medicine. These types of diagnostic services may result in out-of-pocket costs for you (i.e., deductibles, coinsurance, or copays) because they are no longer considered preventive care.
- If you use an out-of-network provider, you will be responsible for any additional charges.

PREVENTATIVE CARE COVERAGE

Many preventive care services and tests are covered at 100%.

You can verify covered services by contacting your carrier's customer service line:

BCBS: 1-877-790-2583

BCN: 1-877-790-2583

Medical

FIND A PROVIDER

Visiting in-network providers typically means lower costs for you, as these providers agree to negotiated, discounted rates with the plan. You can receive care from a non-participating provider; however, your out-of-pocket cost will be higher.

PPO1, PPO2, HMO & HDHP Blue Cross/Blue Shield of MI (BCBSM) & Blue Care Network (BCN)
To find in-network providers, visit **bcbsm.com** and click on “Find a Doctor” For additional provider search instructions, contact BCBSM at 1-877-790-2583

COMPARING MEDICAL PLAN OPTIONS

All options provide benefit coverage for preventive, routine, and emergency medical treatments and services. The chart on the following pages helps you compare the features and benefits of the different plans—and choose which one is best for you.

Medical

MEDICAL PLAN OPTIONS COMPARISON

	AVAILABLE TO ALL EMPLOYEES Bi-weekly contributions may differ based on union agreement				ONLY AVAILABLE TO EMPLOYEES WHO ARE CURRENTLY ENROLLED
In-Network Benefits Shown	**PPO1**	**PPO2**	**HMO**	**HDHP**	**TRADITIONAL**
	Blue Cross/Blue Shield of MI (BCBSM)	Blue Cross/Blue Shield of MI (BCBSM)	Blue Care Network	Blue Cross/Blue Shield of MI (BCBSM)	Blue Cross/Blue Shield Traditional Plan (BC/BS)
Plan Website	BCBSM.com				
Bi-Weekly Contributions	Employee **$42** Emp +1 **$75** Family **$85**	Employee **$52** Emp +1 **$80** Family **$95**	Employee **$26** Emp +1 **$45** Family **$55**	Employee **$10** Emp +1 **$15** Family **$25**	Employee **$62** Emp +1 **$99** Family **$104**
No Coverage Option	Refer to benefit elections in Workday				
Network(s)	Blue Cross/Blue Shield	Blue Cross/Blue Shield	Blue Care Network	Blue Cross/Blue Shield	Blue Cross/Blue Shield
Deductible(s)	$200 per person / $400 per family per calendar year	$100 per person / $200 per family per calendar year	No deductible	$1,600 per person / $3,200 per family per calendar year	$200 per person / $400 per family per calendar year
Coinsurance	None for most services; 10% after deductible for durable medical equipment and private duty nursing care	10% after deductible, as noted; 50% after deductible for private duty nursing care	None	None	10% after deductible for most services; 25% after deductible for private duty nursing care
Coinsurance Maximum	$1,000 per person / per calendar year	$500 per person / $1,000 per family per calendar year	N/A	N/A	$1,000 per person / per family per calendar year
Annual Out-of-Pocket Maximum	$4,125 per person / $10,250 per family per calendar year	$4,125 per person / $10,250 per family per calendar year	$6,600 per person / $13,200 per family per calendar year	$4,125 per person / $10,250 per family per calendar year	$4,125 per person / $10,250 per family per calendar year

Medical

In-Network Benefits	PPO1	PPO2	HMO	HDHP	TRADITIONAL
PREVENTIVE CARE					
Annual Physical Exam, Well Baby Exam	100%				
Related Laboratory & Radiology Services	100%				
Annual Gynecological Exam, Pap Smear, Mammogram, Colonoscopy	100%				
Immunization (adult & childcare)	100%				
PHYSICIAN/PROFESSIONAL PROVIDER SERVICES					
Primary Care Physician (PCP) Office Visit	$20 copay	$20 copay	$20 copay	100% after deductible	90% after deductible
Specialty Provider Office Visit	$20 copay	$20 copay	$20 copay *PCP referall may be required*	100% after deductible	90% after deductible
Telehealth Visit	100%	$20 copay	$20 copay *Must be provided through contracted telehealth services provider*	100% after deductible *Online visits by a non-BCBSM selected vendor are not covered*	90% after deductible
Blue Cross/Blue Shield of MI (BCBSM) Online Visits	100%	$20 copay	$20 copay	100% after deductible	90% after deductible
EMERGENCY / URGENT CARE SERVICES					
Urgent Care	$20 copay	$20 copay	$20 copay	100% after deductible	100%
Emergency Room Visits	$100 copay *Copay will be waived if admitted or accidental injury*	$100 copay *Copay will be waived if admitted or accidental injury*	$100 copay *Copay will be waived if admitted or accidental injury*	100% after deductible	$100 copay *Copay will be waived if admitted or accidental injury*
Ambulance Service for Medical Emergencies	90% after deductible	90% after deductible	100%	100% after deductible	90% after deductible

Medical

In-Network Benefits	PPO1	PPO2	HMO	HDHP	TRADITIONAL
DIAGNOSTIC SERVICES					
Laboratory & Pathology	100%	90% after deductible	100% *Some services require pre-authorization*	100% after deductible	90% (no deductible)
Diagnostic Tests (X-rays, blood work)	100%	90% after deductible	100% *Some services require pre-authorization*	100% after deductible	90% (no deductible)
Imaging (CT/PET scans, MRIs)	100%	90% after deductible	100% *Some services require pre-authorization*	100% after deductible	90% (no deductible)
Radiation Therapy & Chemotherapy	100%	90% after deductible	100% *Some services require pre-authorization*	100% after deductible	100%
INPATIENT HOSPITAL SERVICES					
General Conditions, Surgical Services, Semi-Private Room, Drugs, Intensive Care Unit, Hospital Equipment, Nursing Care, Meals	100% *Nonemergency services must be rendered in a participating hospital*	90% after deductible *Nonemergency services must be rendered in a participating hospital*	100% *Bariatric surgery & related services: $1,000 copay*	100% after deductible *Nonemergency services must be rendered in a participating hospital*	100% *Nonemergency services must be rendered in a participating hospital*
OUTPATIENT HOSPITAL SERVICES					
Outpatient Surgery	100%	90% after deductible	100%	100% after deductible	100%
Ambulatory Surgical Center	100%	90% after deductible	100%	100% after deductible	100%
Professional Surgical and Related Services	100%	90% after deductible	100%	100% after deductible	100%

Medical

In-Network Benefits	PPO1	PPO2	HMO	HDHP	TRADITIONAL
FAMILY PLANNING SERVICES					
Physician Services (delivery & inpatient)	100%	90% after deductible	100%	100% after deductible	100%
Hospital Care	100%	90% after deductible	100%	100% after deductible	100%
Routine Pre- & Post-Natal Care	100%	100%	100% pre-natal visits $20 copay post-natal visits	100%	100% for some pre-natal visits; otherwise, 90% after deductible
Assisted Reproductive Treatment	Not Covered	Not Covered	100% *One attempt at artificial insemination per lifetime*	Not Covered	Not Covered
Maven (maternity & post-partum support, adoption assistance, etc.)	Not Covered	Not Covered	100%	Not Covered	Not Covered
Voluntery Sterilization and FDA-Approved Contraceptive Methods	100%	100%	100%	100%	100%
BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH & SUBSTANCE ABUSE DISORDER)					
Inpatient Services	100%	90% after deductible *Covered according to plan guidelines*	100%	100% after deductible	100%
Outpatient Services	100%	90% after deductible	$20 copay	100% after deductible	100% in approved facilities only
AUTISM SPECTRUM DISORDERS; DIAGNOSES AND TREATMENT					
Applied Behavioral Analysis (ABA services must be obtained by an approved autism evaluation center [AAEC])	100%	90% after deductible	$20 coopay	100% after deductible	100%
Physical, Occupational, and Speech Therapy	100% unlimited	90% after deductible	$20 copay	100% after deductible	100%
Nutritional Counseling	100%	90% after deductible	$20 copay	100% after deductible	100%

Medical

In-Network Benefits	PPO1	PPO2	HMO	HDHP	TRADITIONAL
REHABILITATION SERVICES					
Outpatient Physical, Occupational and Speech Therapy	100%	90% after deductible *Limited to 180 combined visits per calendar year*	$20 copay *Up to 60 combined visits per benefit period*	100% after deductible *Limited to 180 visits per member per calendar year*	100% *Up to 60 combined or consecutive therapy visits per calendar year*
Chiropractic Spinal Manipulation	$20 copay *Limited to 38 visits per calendar year*	$20 copay *Limited to 24 visits per calendar year*	$20 copay *Limited 30 visits per calendar year (when referred)*	100% after deductible *Limited to 24 visits per calendar year*	90% after deductible *Limited to 38 visits per calendar year*
ALTERNATIVES TO HOSPITAL CARE					
Home Health Care Visits	100%	90% after deductible *Must be provided by a participating home health care agency*	100% unlimited *Does not include rehabilitation services.*	100% after deductible *Must be provided by a participating home health care agency*	100% *Must be provided by a participating home health care agency*
Hospice Care	100%	100% *Four 90-day periods. Must be provided through a participating hospice program.*	100%	100% after deductible *Four 90-day periods. Must be provided through a participating hospice program.*	100% *Four 90-day periods. Must be provided through a participating hospice program.*
Skilled Nursing Care	100%	90% after deductible *Limited to a maximum of 120 days*	100% *Covered for authorized services, up to 730 days.*	100% after deductible *Limited to a maximum of 90 days per member per calendar year*	100% *Must be in a participating skilled nursing facility*
Private Duty Nursing	90% after deductible	50% after deductible	Not Covered	50% after deductible	75% after deductible
Outpatient Infusion Therapy	100% *Must be given at a plan-approved site of service*	90% after deductible *Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center*	100% *Administration or infusion can take place in a physician's office, at home or in an outpatient setting*	100% after deductible *Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center*	100% *Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center*

Medical

In-Network Benefits	PPO1	PPO2	HMO	HDHP	TRADITIONAL
HUMAN ORGAN TRANSPLANTS					
Specified Human Organ Transplants	100%	100% *Covered according to plan guidelines*	100% *Covered according to plan guidelines*	100% *in an approved, designated facility and coordinated through the BCBSM Human Organ Transplant Program*	100% *In approved facilities*
OTHER COVERED SERVICES					
Allergy Testing	100%	100%	100%	100% after deductible	90% after deductible
Allergy Treatment & Injections	100%	100%	100%	100% after deductible	90% after deductible
Durable Medical Equipment, Prosthetic & Orthotics	90% after deductible	90% after deductible	100% covered *for approved equipment only*	100% after deductible	90% after deductible
Gender Affirming Care	Blue Cross/Blue Shield of MI (BCBSM) and Blue Care Network (BCN) health plans generally cover medically necessary gender-affirming services for members with gender disphoria. This includes hormone therapy and gender reassignment surgery. These services are subject to applicable member cost share: https://www.bcbsm.com/amslibs/content/dam/public/mpr/mprsearch/pdf/2065126.pdf				
Hearing Care	NOTE: Hearing aids and services are not covered under any Oakland County medical plans; however, there is a discount program available through Nations Hearing for a limited time. Visit nationsbenefits.com/nationshearing or call 1-877-439-2665.				

Medical

In-Network Benefits	PPO1	PPO2	HMO	HDHP	TRADITIONAL
PROGRAM PROVISIONS					
Out-of-Network Services	In general, Plan pays 85% of approved amount less applicable copays. For diabetic supplies, durable medical equipment, and private duty nursing, Plan pays 75% of approved amount after deductible (if applicable).	Plan pays 70% of approved amount, after out-of-network deductible less applicable copays. For private duty nursing, Plan pays 50% of approved amount after deductible.	Not covered except for emergencies	Plan pays 80% of approved amount, after out-of-network deductible. For private duty nursing, Plan pays 50% of approved amount after deductible.	This plan does not use a provider network. You can receive covered services from any provider.
Payment of Covered Services	**Preferred (Network) Hospitals:** 100% of covered benefits **Non-Network Hospitals:** 85% of approved payment amount after deductible **Preferred (Network) Physicians - Outpatient:** 100% after $20 copay **Non-Network Physicians - Outpatient:** 85% of approved payment amount after $20 copay	**Preferred (Network) Hospitals:** 90% of covered benefits, after deductible **Non-Network Hospitals:** 70% of approved payment amount after out-of-network deductible **Preferred (Network) Physicians:** 100% after $20 copay **Non-Network Physicians:** 70% of approved payment amount after out-of-network deductible and $20 copay	Copays as noted	**Preferred (Network) Hospitals:** 100% of covered benefits, after deductible **Non-Network Hospitals:** 80% of approved payment amount after out-of-network deductible. **Preferred (Network) Physicians:** 100% after in-network deductible **Non-Network Physicians:** 80% of approved payment amount after out-of-network deductible	**Participating Hospitals:** 100% of covered benefits **Non-participating Hospitals:** Inpatient care in acute-care hospital - $70 a day; Inpatient care in other hospitals -$15 a day **Medicare Surgical:** 100% of BCBSM's approved amount

**While every attempt has been made to ensure the accuracy of this Summary, in the event of any discrepancy the Summary Plan Description and Plan Document will prevail.*

Prescription

PRESCRIPTION DRUGS *All Oakland County medical plan enrollees and their eligible dependents will automatically receive prescription drug coverage.*					
Retail Prescription	Optumrx.com				
Mail Order Prescriptions Carrier	Optumrx.com				
In-Network Benefits	**PPO1**	**PPO2**	**HMO**	**HDHP**	**TRADITIONAL**
Participating / Network Pharmacies	**Covered / Copays:** ▪ **Tier 1:** $5 copay most generics / some brands ▪ **Tier 2:** $20 copay preferred brands / some generics ▪ **Tier 3:** $40 copay non-preferred products *(could include both brand and generic)* ▪ Select birth control pills covered $0 copay			**Covered / Copays (after deductible):** ▪ **Tier 1**: $5 most generics / some brands (after deductible) ▪ **Tier 2**: $20 preferred brands / some generics (after deductible) ▪ **Tier 3**: $40 non-preferred products *(could include brand and generic)* (after deductible) ▪ Select birth control pills covered $0 copay	**Covered / Copays:** ▪ **Tier 1**: $5 most generics / some brands ▪ **Tier 2:** $20 preferred brands / some generics ▪ **Tier 3:** $40 non-preferred products *(could include brand and generic)* ▪ Select birth control pills covered $0 copay
Non-Participating / Non-Network Pharmacies	Paid at the in-network cost, less $5, $20 or $40 copay		Not covered	Paid at the in-network cost, less $5, $20 or $40 copay after deductible	Paid at in-network cost, less $5, $20, $40 copay
Annual Out-of-Pocket Maximum	$3,775 per person / $5,550 per family per calendar year	$3,775 per person / $5,550 per family per calendar year	Included in Medical Out-of-Pocket Maximum	$3,775 per person / $5,550 per family per calendar year	$3,775 per person / $5,550 per family per calendar year
Generic Requirement	Generic medications meet the same standards of safety, purity, strength, and effectiveness as the brand-name drug. For this reason, if the patient requests a brand-name medication when a generic equivalent is available, you will be responsible for the Tier 3 copay plus the difference in price between the brand-name medication and its generic equivalent. If your doctor makes the request, you will be responsible for the Tier 3 copay.				
While in hospital	*NOTE: While in the hospital, drugs are covered under your medical plan.*				

Prescription

When you enroll for medical coverage, you and your covered family members also receive prescription drug benefits. The cost of your prescription depends on whether:

- Your drug is on the formulary (i.e., approved drug list)
- Your prescription is a generic drug or brand-name drug
- You met the annual out-of-pocket maximum

Understanding the types of medications

Formulary	Maintenance Medication	Generic Medications
▪ Preferred drug list established by a clinical committee of physicians and pharmacists. ▪ Formularies are evaluated based on effectiveness, side effects, drug interactions and cost. ▪ On-going evaluation of the formulary occurs to ensure inclusion of new drugs, new clinical restrictions, approval for generic options and more.	▪ Examples include medication for high blood pressure or high cholesterol ▪ Talk to your physician about issuing a three-month supply of medication through your local pharmacy with one copayment.	▪ Approved as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name drug. ▪ For this reason, if the patient requests a brand-name medication when a generic equivalent is available the patient is responsible for the Tier 3 copay plus the difference in cost between the brand-name medication and its generic equivalent. ▪ If your doctor makes the request, the patient will be responsible for the Tier 3 copay.

Three-tier prescription drug program

The county offers a three-tier prescription drug program. Under the three-tier program, the amount of the in-network copay varies as shown below:

Drug Tier	Description	Copay
Tier 1	Many generic medications and a few brand-name drugs	**$5**
Tier 2	Preferred brands and some generics	**$20**
Tier 3	Non-Preferred products (could include both brand and generic products)	**$40**

Prescription Administrators & Partners (BCBSM & BCN Plans)

Your prescriptions are administered through Optum; however, you will utilize your BCBSM medical ID card at the point of service for prescriptions. BCBSM is a parent company over Optum. Optum Rx is partnered with Pillar Rx for a High-Cost Drug Discount Program and partnered with Sempre Health on specified chronic condition medications. You will receive correspondence from these partners if you're utilizing these particular drugs.

Dental

DENTAL COVERAGE THROUGH DELTA DENTAL OF MICHIGAN - PPO

Plans listed below are designed to promote regular dental visits and good oral health, a key part of your overall wellness. Delta Dental coverage is available to you and your dependents up to the age 26. The plan pays benefits up to the annual maximum. The level of dental coverage you choose will determine how fast you reach your annual maximum benefit.

Your dental election is separate from your medical plan election, meaning you can elect dental coverage even if you waive medical coverage. Your covered dependents will be enrolled in the same coverage you enroll in.

Service	Standard Plan		High Plan		Modified Plan	
COVERAGE Bi-Weekly Contributions	Employee Emp +1 Family	**$0** **$0** **$0**	Employee Emp +1 Family	**$1.15** **$1.73** **$5.00**	Bi-Weekly Credit Employee Emp +1 Family	 **$1.15** **$1.73** **$3.27**
NO COVERAGE Opt-Out Bi-Weekly Credit	No coverage credit $1.93 / $3.85 / $5.77					
	No coverage credit (county spouse/parent coverage) $1.93 / $1.93 / $1.93					
Deductible						
Employee	$25					
Emp +1 and Family	$50					
Plan Coverage						
DIAGNOSTIC & PREVENTIVE Two routine exams, cleanings, and fluoride treatments (up to age 19) per year.	Covered at 100%; No copay or deductible					
BASIC Fillings, extractions, dental surgery, crowns, root canals, treatment for gum disease. Bitewing X-rays are payable twice per calendar year and Full mouth X-rays or Panorex are payable once in any three-year period.	Covered at 85%		Covered at 85%		Covered at 50%	

Dental

Service	Standard Plan	High Plan	Modified Plan
MAJOR Bridges, implants, and dentures are payable once per tooth in any five-year period.	Covered at 50%		
Orthodontia	Covered at 50%; up to age 19		
Maximum Benefit	$1,000 per individual per calendar year	$1,500 per individual per calendar year	$750 per individual per calendar year
Orthodontia Limit	$1,000 per individual per lifetime	$1,000 per individual per lifetime	$750 per individual per lifetime

DELTA DENTAL PPO Providers — a network of providers who agree to charge you fees for services that are lower than their usual rates. These fees are the lowest when you visit a PPO network.

DELTA PREMIER Providers — a network of providers who agree to charge you fees for services that are lower than their usual rates. These fees are not as low as the PPO network, but lower than a non-participating provider.

NON-PARTICIPATING Providers — these providers have no contracts with Delta Dental and can bill up to the full amount of their rates. Delta Dental will pay a pre-determined amount that may be lower than the providers full rates.

For additional information, refer to the Delta Dental Certificates and Benefit Summaries found **OakGov.com/benefits** under Health Benefit Plans.

FIND PPO DENTAL PROVIDERS

To find dental providers covered by your plan, visit deltadentalmi.com and click “Dentist Finder”

Vision

VISION COVERAGE THROUGH NATIONAL VISION ADMINISTRATORS (NVA)

To help you see your best, Oakland County offers vision coverage through National Vision Administrators. NVA vision coverage is available to you and your dependents up to the age 26. Services provided by a non-network provider will require you to pay for those services in full and submit a claim form to NVA for reimbursement. Treatment of a medical condition affecting your eyes, such as glaucoma or pink eye, is processed through your medical coverage.

	Standard Plan		High Plan		No Coverage	
Bi-Weekly Contributions	Employee Emp +1 Family	**$0** **$0** **$0**	Employee Emp +1 Family	**$1.35** **$2.88** **$3.85**	Employee Emp +1 Family	**$0** **$0** **$0**

Plan Coverage			
	In-Network		**Out-of-Network**
	Standard Plan	**High Plan**	**Standard or High Plan**
Examination	100% after $5 copay	100% after $5 copay	Reimbursed Amount: Up to $35
Lenses and Frames *(Standard Glass or Plastic Lenses)*			
Single, bifocal, trifocal, and lenticular	Covered 100% after $7.50 copay every 24 months	Covered 100% after $7.50 copay every 12 months	Up to $80
Polycarbonates	Covered 100%	N/A	N/A
Frame Retail Allowance	Up to $100 and 20% discount off frame balance every 24 months	Up to $100 and 20% discount off frame balance every 12 months	Up to $45
Contact Lenses *(In lieu of Lenses and Frames)*			
Elective Contact Lenses	Up to $50 retail every 24 months	Up to $50 retail every 12 months	Up to $35
Medically Necessary (Pre-approval from NVA required)	Covered 100% every 24 months	Covered 100% every 12 months	Up to $200

Additional information is located at OakGov.com/benefits under Health Benefit Plans > Vision.

FIND A NVA VISION CARE PROVIDER

Visit e-nva.com and click on “Find a Provider” tab and enter the Oakland County group #13061000 along with your zip code.

Flexible Spending Accounts

Flexible Spending Account (FSA) plans allow you to use pretax dollars to pay for qualified expenses in the 2024 plan year for you and your qualified dependents. Flexible Spending Accounts (FSAs) can only be used in partner with a PPO plan or an HMO plan. FSAs cannot be used with the HDHP.

Depending on your tax rate and filing status, you can save on average 30% a year on taxes contributing to a healthcare FSA account and/or dependent care FSA account. Visit Health Equity's tax calculator to calculate your potential savings.

1

STEP 1 • ESTIMATE YOUR NEEDS

- Estimate your out-of-pocket healthcare and daycare expenses for the year.
- Think beyond the doctor's office, review thousands of eligible medical expenses and discover all the ways to spend your FSA by visiting healthequity.com.
- Make a conservative estimate of your expenses for the year.

2

STEP 2 • ENROLL

- Enroll during your new hire or open enrollment benefit period. This amount is broken up into equal deductions from your paycheck using pre-tax earnings for the remaining pays of the plan year.
- **HEALTHCARE FSA** – Contribute between $100 and $3,050 for the 2024 plan year. Between $25 and $570 of unused funds will rollover to the next plan year.
- **DEPENDENT CARE FSA** – Contribute between $100 and $5,000 for the 2024 plan year. Dependent Care FSA funds not used by December 31st will be forfeited.

3

STEP 3 • USE/MANAGE YOUR FSA

- **HEALTHCARE FSA** – Your entire contribution amount is available on the 1st of the month when your benefits become effective. The full amount of your election is front-loaded for use on a Visa debit card.
- **DEPENDENT CARE FSA** – Funds are available as contributions are made through your payroll deductions.
  - › No card will be issued for the dependent care FSA. You pay for your childcare expenses up front, then submit for reimbursement from your dependent care FSA.

Flexible Spending Accounts

Important IRS Information

- In order to elect the Healthcare or Dependent Care FSA, you cannot be enrolled in the High Deductible Health Plan.
- You may not change your Healthcare or Dependent Care FSA during the plan year unless you experience a life event such as: marriage, birth, adoption, etc.
- IRS regulations do not allow exceptions if you miss the enrollment deadline, regardless of your reason.
- The IRS regulates qualified expenses and dependents, refer to IRS Publication 502 and IRS publication 503 at IRS.gov.
- Consult your tax preparer, tax attorney, or accountant if you have any questions regarding your specific tax situation.
- IRS guidelines require you to retain receipts for any eligible expense for which you receive reimbursement.

IMPORTANT FSA INFORMATION

You must re-elect your FSA accounts each year.

Rollover Feature
With this feature, you can rollover a minimum of $25 or up to $570 of your unused Healthcare FSA funds at the end of each plan year to use in the next plan year.

Filing FSA Reimbursement Claim

Claims can also be submitted through the mobile app, online, mail or fax. To file claims, include required documents such as invoices and receipts for payment to the provider for reimbursement.

Key FSA Deadlines

ENROLL

Enroll and elect contribution amount within 14 days of hire or during open enrollment.

EXPENSES DEADLINE

2024 eligible expenses must be incurred by Dec. 31, 2024.

All 2024 claims must be submitted by April 30, 2025.

CARRYOVER

Healthcare FSA carryover a minimum of $25 up to $570 for use in 2025.

Dependent Care FSA, remaining balance forfeited after December 31, 2024.

Flexible Spending Accounts

Flexible Spending Account Features at a Glance

	HEALTHCARE FSA	DEPENDENT CARE FSA
Purpose	Allows you to use pretax dollars to pay for qualified medical, prescription, dental and vision expenses.	Allows you to use pretax dollars to reimburse yourself for eligible childcare and adult care expenses.
Amount You Can Contribute	Contribute between $100 - $3,050 for the 2024 plan year. You can NOT change your election unless you have a qualifying life event	Contribute between $100 - $5,000 for the 2024 plan year. You can NOT change your election unless you have a qualifying life event
Examples of Eligible Expenses	▪ Deductibles/copays/prescriptions ▪ Contact lenses/eyeglasses/LASIK ▪ Dental treatments/orthodontia ▪ Menstrual care ▪ Certain over-the-counter items ▪ Visit **healthequity.com** for a complete list of qualified expenses	▪ Preschool ▪ Before/after school care ▪ Summer camp ▪ Care for a dependent in the employees' home or the home of the provider ▪ Visit **healthequity.com** for a complete list of qualified expenses
Eligible Dependents	▪ Child or adopted child that you claim as a tax dependent. ▪ Legal spouse ▪ Qualified relative you provided over half of their support. ▪ Certain rules apply, refer to IRS publication 502 for specific details.	▪ Dependent children under the age of 13 and whom you claim as a tax exemption on your federal tax return. ▪ Qualified relative unable to care for themselves. ▪ Certain rules apply, refer to IRS publication 503 for specific details.
Fund Availability	Your entire annual election amount is available for payment on January 1st even if you have not contributed the full amount.	Your funds are available as contributions are made through your payroll deductions.
Rollover	At the end of 2024, balances over $570 are forfeited at year-end.	Balances are forfeited at year-end.
Payment Method	▪ Health Equity Visa debit card ▪ Pay out-of-pocket for eligible medical expenses and submit for reimbursement through the mobile app, online or fax.	▪ Pay out-of-pocket for childcare expenses and submit for reimbursement through the mobile app, online or fax. ▪ Use the pay my provider option.

Health Savings Account

WHAT IS A HSA?

- A Health Savings Account (HSA) is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical, dental, vision, and prescription expenses.
- **ALL** of your HSA money can be rolled over from year to year (including into retirement).
- Depending on your tax rate and filling status, you can save an average of 30% a year on taxes when contributing to an HSA. You can visit Health Equity's tax calculator to calculate your potential savings.
- This type of savings account can **ONLY** be used with the High Deductible Health Plan (HDHP).

IMPORTANT INFORMATION

- You can not have **ANY** money left over/rolled over from your FSA if you participate in the HDHP with the HSA.
  > You will need to either use it or forfeit the remaining balance by the end of the calendar year.
- You **cannot** enroll in a HSA if any of the following apply:
  > You are enrolled in other healthcare coverage beyond the HDHP (including Medicare).
  > You are claimed as a dependent on someone's tax returns.
  > You have received Veterans Affairs benefits within the last three month.
- You are not able to elect or change elections outside of open enrollment, unless if you experience a life event such as: marriage, birth, adoption, etc.
  > No exceptions if the enrollment deadline is missed, regardless of the reason (per IRS rules).
- IRS regulates the qualifying expenses, limits, and dependents.
- You should consult a tax consultant, attorney, and/or accountant if you have any questions regarding your specific tax situation.
- Per IRS guidelines, you must keep the receipts for any eligible expense for which you receive reimbursement.

Health Savings Account

ADVANTAGES

TRIPLE TAX ADVANTAGES

- Make pre-tax payroll contributions
- Grow tax free earnings
- Enjoy **tax –free** distributions for qualified medical expenses

RETIREMENT

- Invest your money just like a 401(k)
- Access liquid funds anytime
- Enjoy lower fees and transparent pricing
- Advisory tools offered by HealthEquity Advisors

TOTAL OWNERSHIP

- Any unused money rolls over from year to year
- Even when you change jobs, change health plans, and/or retire

Health Savings Account

1

STEP 1 • ESTIMATE YOUR NEEDS

- Estimate your out-of-pocket healthcare expenses for the year and/or coming years.
- Think beyond the doctor's office, review thousands of eligible medical expenses and discover all the ways to spend your HSA by visiting healthequity.com.
- Funds can be applied to dental and vision appointments & equipment as well.

2

STEP 2 • ENROLL

- Enroll during your new hire or open enrollment benefit period. This amount is broken up into equal deductions from your paycheck using pre-tax earnings for the remaining pays of the plan year.
- **HEALTHCARE HSA**
  - > Single Coverage: Contribute between $100 and $4,150 for the 2024 plan year.
  - > Family Coverage: Contribute between $100 and $8,300 for the 2024 plan year.
- **All** unused funds will roll over year after year.
  - > Oakland County will also contribute up to $1,000 for single coverage and $2,000 for family coverage per year for the first two years.
    - This applies to the max contribution limits
    - Will be prorated per pay period

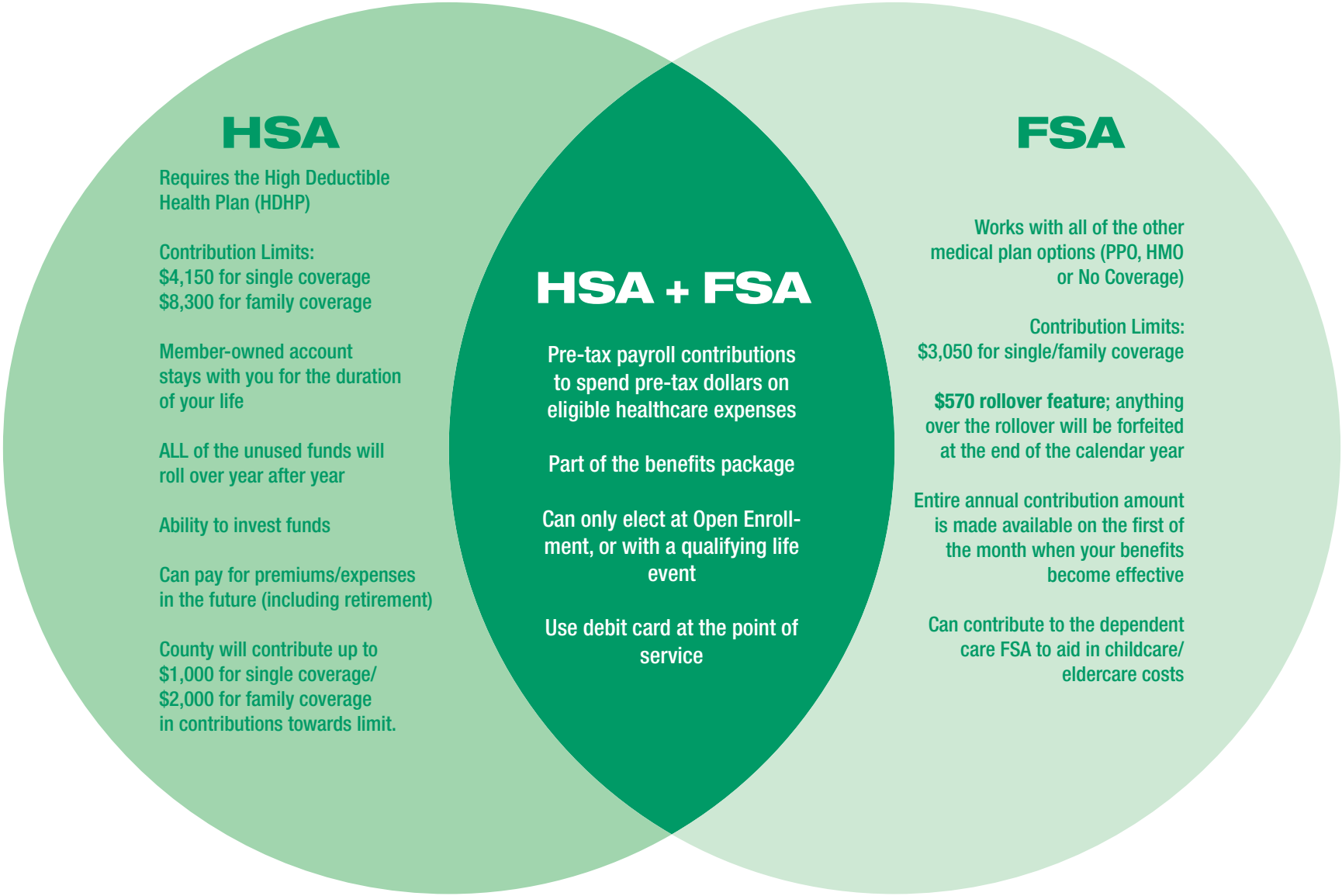
3

STEP 3 • USE/MANAGE YOUR HSA

- Funds are available as contributions are made through your payroll deductions.
- These funds can be used towards any qualifying medical expenses (i.e. office visits, prescriptions, deductible, equipment, etc.)
- 2024 eligible expenses must be incurred by Dec. 31, 2024. All 2024 claims must be submitted by April 30, 2025.
- Funds can be invested like a 401(k).
- 100% roll over of unused funds to the next year.

Health Savings Account

THE DIFFERENCE BETWEEN HSA & FSAs



Life Insurance | Accidental Death & Dismemberment Insurance

Basic Life Insurance and Accidental Death and Dismemberment (AD&D) plans are available to employees at no cost. Insurance plans protect your family from financial hardship in the event of your death or a loss of functionality. The amount of life and AD&D insurance is determined by your annual base salary and age. Life and AD&D insurance plans through Oakland County are term insurance plans administered by Unum with no cash value.

Group Term Life Insurance

During new hire benefit elections, you can select one of four levels of group term life insurance, to a maximum of $400,000.

- 1 times Annual Benefit Salary – buy down
- **1.5 times Annual Benefit Salary – Standard Plan is no cost to you**
- 2 times Annual Benefit Salary – buy up
- 3 times Annual Benefit Salary – buy up

Accidental Death & Dismemberment Insurance

During new hire benefit elections, you can select one of four levels of group term AD&D insurance, to a maximum of $400,000.

- **1 times Annual Benefit Salary – Standard Plan is no cost to you**
- 1.5 times Annual Benefit Salary – buy up
- 2 times Annual Benefit Salary – buy up
- 3 times Annual Benefit Salary – buy up

BE PROTECTED

Why Life & AD&D Insurance should be a part of your financial planning:

- 50% of American households would feel the financial impact from the loss of their primary wage earner in a year or less, more than 40% would feel the impact within six months.
- Unintentional injuries are the fifth leading cause of death in the U.S.

Helpful Information

- Your election will remain in force for the entire calendar year unless you have a qualifying life event.
- Coverage for your spouse or children is not available.
- The amount of insurance begins to decrease at age 70 by a percent of your pre-age 70 amount. Please refer to the carrier certificate/ benefit booklet for complete details and a schedule of benefits by visiting **OakGov.com/benefits** and clicking Life Insurance.

Life Insurance | Accidental Death & Dismemberment Insurance

Evidence of Insurability (EOI)

During New Hire Enrollment only, you have the opportunity to enroll in life insurance up to the guaranteed issue without the need for completing EOI. This means you will be automatically approved no matter any medical concerns. *(This information does not apply to annual Open Enrollment.)*

Accelerated Death Benefit

Unum provides an accelerated benefit option, which provides up to 80% of your benefit (up to $400,000) if you become terminally ill and have less than 12 months to live. Your beneficiary would then receive the remaining balance at your death.

Tax Consideration

According to federal law, only the first $50,000 of life insurance coverage is tax exempt. If your total coverage is more than $50,000, an amount called "imputed income," will be added to your W-2 earnings using IRS Tax Table 1.

Tax Consideration Example		
Annual earnings	$35,000	In this example, you would not be taxed on the $20,000 but would pay taxes on the cost of the premium for this amount. For example, let's assume you are 42 years old. In this case, your W-2 form would show imputed income of $0.92 per pay (or $24 per year) based on the IRS calculation. This deduction is taken each paycheck to ensure the appropriate amount of income tax and Social Security is deducted. The Group Term Life deduction is reflected under the earnings section of your paycheck. For additional details, refer to IRS Publication 15-B at IRS.gov.
Life insurance coverage (county and optional coverage)	$70,000	
Less Tax-free portion	$50,000	
Taxable portion	$20,000	

Continuing Coverage After Leaving Oakland County

When your employment with Oakland County ends, either at retirement or separation, your life and AD&D plans terminate. You may be able to convert or port your life insurance coverage. You must complete an application and apply for these options within 31 days of your coverage termination. To obtain an application, contact Unum using the contact information on the first page of this Benefits Guide.

Disability Coverage

SHORT AND LONG-TERM DISABILITY INSURANCE

UNUM

www.unum.com

Phone: 1-888-673-9940

Policy # 914587

Disability benefits help protect your income if you are unable to work due to a non-work-related disability. Short-term disability (STD) and long-term disability (LTD) benefits are available to eligible employees at no cost. Since this coverage is provided by the county, any benefits paid will be taxable income.

Short-Term Disability (STD)

Employees are eligible after completion of six consecutive months of service. The six-month eligibility period could be extended if the individual was not working due to a leave of absence.

Benefits are not payable if you become disabled from a pre-existing condition within the first 12 months of being insured.

This benefit replaces 60% of your base weekly salary, up to $8,000 per month. Employees have the option to supplement their pay with leave banks to pay for healthcare contributions and supplement additional income.

If your disability is expected to last more than seven consecutive calendar days (the waiting period), contact the county's disability provider, Unum, to provide the details of your disability and the contact information for your doctor.

Employees have 30 calendar days from their first day off work to contact Unum according to Merit Rule 22. A delay in contacting Unum will significantly delay disability payments. More information is available at **OakGov.com/benefits**.

Employees are required to keep their department informed of expected return-to-work dates and any delays in the claim process from the first day off work through the expected duration of absence.

Long-Term Disability (LTD)

If your short-term disability (STD) extends longer than six months (187 days), employees can apply for long-term disability. LTD is a continued benefit providing 60% of base salary, up to a maximum of $8,000 per month.

Elected officials are not eligible for short- or long-term disability.

NOTE: Term Life, AD&D and Disability coverages are issued by Unum insurance. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply.

Dependent Eligibility

Spouse

Eligible: Legal spouse of an employee.

Not Eligible: Legally separated, life partners or divorced spouses. Legal judgments that require you to maintain health coverage for your ex-spouse are not allowed to remain on your coverage after the date of divorce or legal separation. You must obtain separate coverage for them.

Dependent Children

Children by birth or legal adoption may be covered through the end of the year that they turn 26. This is regardless of the child living at home, listed as a dependent on your taxes, or married.

Disabled Children: Coverage is available to children, age 26 and older, if legally considered permanently and totally disabled and meet the following criteria

- The child became totally and permanently disabled prior to the age 19; AND
- They are incapable of self-sustaining employment; AND
- The employee provides more than half their support as defined by the IRS; AND
- Their disability has been certified by a physician and the health carrier is notified in writing by the end of the year in which the child turns age 26.

Legal Guardianship: Coverage is available to legal guardianship children, up to their 26th birthday, if they meet the following criteria

- They are unmarried; AND
- Their legal residence is with you; AND
- You supply more than half their support as defined by the IRS; AND
- You provide up-to-date legal guardianship documentation. Coverage ends when the legal guardianship ends.

Stepchildren: Coverage is available to stepchildren, up to their 26th birthday as long as the marriage has not ended due to divorce, legal separation or death. Stepchildren are not allowed to remain on coverage after the event date.

WHO QUALIFIES AS A DEPENDENT CHILD?

- ✓ Biological child
- ✓ Legally adopted child
- ✓ Stepchildren
- ✓ Court-appointed child with legal guardianship
- ✓ A child you are required to maintain health coverage under a National Medical Support Order

Dependent Eligibility

Dependent Eligibility Required Documentation

To add a dependent, you must provide a Social Security Number and acceptable documentation in the English language to verify their eligibility.

Add a Dependent	Required Documentation
Child/legally adopted child	Birth certificate
Legal guardianship	Birth certificate and current legal guardianship papers
Spouse	Marriage certificate
Stepchild	Birth certificate and marriage certificate

IF YOU AND YOUR SPOUSE BOTH WORK AT OAKLAND COUNTY

- **Medical Coverage - Only one county employee is allowed to elect coverage**
- **Dental and Vision Coverage - Both county employees may elect coverage**

Qualifying Life Events

SPECIAL ENROLLMENT PERIOD

Making a change to your benefit coverage is only available to employees during the annual Open Enrollment period in the fall. However, if you have a Qualifying Life Event, IRS Federal Regulations allow you to make a change to your benefits within 30 days of that event.

A change in your situation — getting married, having a baby, or losing health coverage — is considered a Qualifying Life Event (QLE) and makes you eligible for a mid-year enrollment change, allowing you to change your benefit elections outside of Open Enrollment.

Employees have 30 days following a QLE to initiate a benefit change in Workday and provide verification of the event. Once the 30-day window has passed to initiate a QLE in Workday, the next opportunity to make benefit changes is during Open Enrollment.

workday.

Need help with QLE in Workday?

Refer to the Enrollment Instructions by going to OakGov.com/benefits

QUALIFYING LIFE EVENTS as defined by IRS FEDERAL REGULATIONS

- ✓ Marriage
- ✓ Divorce or legal separation
- ✓ Birth or adoption
- ✓ Loss/gain of other coverage
- ✓ Death of a spouse or dependent child
- ✓ Turning 26 years old

Retirement

401(a) Defined Contribution Plan Information

Full-time employees of Oakland County are automatically enrolled in the plan. Oakland County will withhold a percentage of your pay on a pre-tax basis. This is a mandatory, non-elective contribution. In addition, Oakland County will contribute a mandatory non-elective contribution made to the plan on your behalf. The contribution amounts vary by job classification. For details, refer to the 401(a) Plan Highlights for Public Safety or 401(a) Plan Highlights for General and Union Employees by visiting **OakGov.com/retirement**.

457(b) Deferred Compensation Plan Information

A 457(b) Plan is a supplemental voluntary plan that allows you to save for retirement with pre-tax and/or after-tax deductions from your paycheck. All full- time employees can enroll after they have received their first paycheck. For additional details and enrollment instructions, refer to the 457(b) Plan Highlights for Public Safety or 457(b) Plan Highlights for General and Union employees by visiting **OakGov.com/retirement**.

Retiree Health Care Eligibility

Employees are eligible for health benefits once they have reached the required years of service and age. Oakland County currently has four retiree health care schedules (A,B,C,D).

Schedule	Eligibility Dates
Schedule A	Hired prior to 09/21/1985
Schedule B	Hired on or after 09/21/1985 and before 01/01/1995
Schedule C	Hired on or after 01/01/1995 and before 01/01/2006
Schedule D (All New Hires)	Retiree Health Savings (RHS) Account if hired on or after 01/01/2006. **Dates may vary depending on bargaining unit.*

For additional details on the health care schedule, refer to the full version of the Retiree Health Care Eligibility Schedule by visiting **OakGov.com/retirement**.

For questions, contact the retirement team at retirement@oakgov.com or (248) 892-2855.

Access your retirement account(s) by visiting **oaklandcounty.retirepru.com**. You can also schedule an appointment with our dedicated retirement counselor, Thomas May, at Thomas.may@empower.com or (248) 846-3289.

Employee Assistance Provider

Optum

Oakland County's Employee Assistance Program offers resources to help you deal with life's challenges. Everyone faces challenges from time to time, but with Optum you don't have to face these challenges alone. Explore the services and identify the right offerings to help you and your family live a balanced and healthy life. **Life advisors are available 24/7** for telephone support. Mobile app with chat functionality, video counseling, and a web portal are also available.

✓ Mental Health Support	Manage stress, anxiety, and depression, resolve conflict, improve relationships, overcome substance abuse, and address any personal issues.
✓ Life Coaching	Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.
✓ Financial Consultation	Build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identity theft, and saving for retirement or tuition.
✓ Legal Consultation	Get help with personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.
✓ Work-Life Resources & Referrals	Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.
✓ Personal Assistant	Save time with referrals for travel and entertainment, seeking professional services, cleaning services, home food delivery, and managing everyday tasks.
✓ Medical Advocacy	Get help navigating insurance, obtaining doctor referrals, securing medical equipment or transportation, and planning for transitional care and discharge.
✓ Member Portal and App	Provide easy access to thousands of articles, webinars, podcasts, and tools covering total well-being.

Visit Optum at liveandworkwell.com (*use company code "Oakgov"*) or call 1-866-248-4096

Tuition Reimbursement & Paid Time Off

TUITION REIMBURSEMENT

Tuition Reimbursement offers up to $4,200 per fiscal year to all full-time employees. Tuition reimbursement is provided to those in pursuit of a degree at an accredited institution. Contact HR training at training@oakgov.com or visit the internal county Telegraph website for more information.

PAID TIME OFF

Personal Leave

> Receive 5 days upon hire or 1st pay period of the year.

Floating Holiday

> Receive 1 day after 3 months of county service or 1st pay period of the year.

Annual Leave

> Accrued based on years of county service. Rates can be located in Merit Rule 23.

Paid Holidays

> New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Juneteenth, Independence Day (July 4th), Labor Day, Election Day, Veteran's Day, Thanksgiving Day, Friday after Thanksgiving, Christmas Eve, Christmas Day, and New Year's Eve.

> Refer to the holiday schedule located on the internal county Telegraph website.

Parental Leave

> Receive 6 weeks paid leave at 100% of current salary.

> Available for full-time employees after 6 months county service and can be used for the birth or adoption of a child.

Annual Leave Buyback

> Eligible employees with 60 (or more) annual leave hours.

> Cash out 20 hours minimum to 40 hours maximum.

> Email HRrecords@oakgov.com for information.

Elected and appointed officials are exempt from accrual of paid time off.

LENGTH OF ELIGIBLE COUNTY SERVICE *(see Rule 22)*		DAYS OF ANNUAL LEAVE EARNED*		MAXIMUM** ACCUMULATION HOURS/DAYS	
FROM	THROUGH	HOURS PER PAY	IN 12 MONTHS	ELIG. O/T	N/ELIG. O/T
0	1 year	3.07	10 days	N/A	N/A
2 years	4 years	3.69	12 days	144/18.0	288/36.0
5 years	9 years	4.61	15 days	180/22.5	360/45.0
10 years	14 years	5.53	18 days	216/27.0	432/54.0
15 years	19 years	6.15	20 days	240/30.0	480/60.0
20 years	24 years	6.76	22 days	264/33.0	528/66.0
25 years	Remainder of County Service	7.38	24 days	288/36.0	576/72.0

Childcare & OakFit Wellness

LITTLE OAKS CHILDCARE

Little Oaks, administered by Bright Horizons and accredited by the National Association for the Education for Young Children (NAEYC), offers high-quality childcare at discounted rates to Oakland County employees and the community. The center provides a safe, friendly, high-quality learning environment.

The center is located on Oakland County's main campus with hours of 6:45 am – 6:00 pm. Employees who wish to schedule a tour or seek additional information should contact the center at (248) 858-2080 or visit OakGov.com/hr.

OAKFIT WELLNESS PROGRAM

Oakland County's vision is to be a healthy, safe, and thriving place where everyone is valued, quality of life is high and economic opportunity abounds. Benefits offered through Oakland County play an important role in allowing our employees to make their physical and mental health a priority.

Employees can participate in several OakFit programs such as lunch-n-learns, exercise challenges, mindfulness and nutrition challenges, mental health campaigns, and many other healthy initiatives. More information can be found at OakGov.com/wellness.

Health Screening Incentive Program

The OakFit wellness program offers a $100 incentive (may differ based on union agreement) to full-time eligible employees that complete their annual health screening and health assessment.

Visit OakGov.com/wellness for program specifics.

Annual health screening physicals must be completed between January 1st – December 31st. Acute care clinics (minute clinics & urgent care clinics) do not qualify as a primary care visit.

A FEW OAKFIT PROGRAMS

- Couch to 5k/10k Running Program
- Employee Market Day
- Fitness Unleashed
- Health Screening Incentive

Benefits Glossary

Appeal
A request that your health insurer or plan, reviews a decision that denies a benefit or payment (either in whole or in part).

Beneficiary
Person designated as a recipient of funds under a will, trust, insurance policy, etc.

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services believed to be covered.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 10%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 10% would be $10.)

Copay
Fixed dollar amount, due at the time of service, for specific treatments or visits, such as a doctor visit.

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Deductible
Fixed dollar amount you are responsible for paying before the insurance carrier starts paying for non-preventive health expenses.

Diagnostic Test
Tests to determine health problems. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment
Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include oxygen equipment, wheelchairs, and crutches.

Flexible Spending Account (FSA)
FSA's allow employees to pay for certain qualified healthcare and childcare expenses with pretax dollars. The election amount is divided equally and deducted each paycheck before federal, state, FICA, and local taxes are calculated.

Formulary
A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Benefits Glossary

Grievance
A complaint that you communicate to your health insurer or plan.

In-network Provider
Providers that are contracted with the insurance carrier. In-network providers agree with insurance carrier pricing and apply discounts for their services. As a result, the in-network costs will be much lower than out-of-network fees.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Network
The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-network Provider
Providers that are not contracted with the insurance carrier. If you receive services from an out-of-network provider, you will not receive discounts on pricing and may be responsible for additional cost not covered by your insurance carrier.

Out-of-pocket Maximum
The most an employee could pay in a calendar year. Once this amount is reached, the plan pays the full cost of covered expenses.

Physician Services
A licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium
Amount that must be paid for your health insurance plan. This is paid primarily by Oakland County and employees pay a bi-weekly deduction from their paycheck.

Prescription Drug Coverage
Drugs and medication that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) who provides or coordinates a range of health care services for you.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Benefits Glossary

Provider
An individual or facility that provides healthcare services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

My Benefits Worksheet

Use this worksheet to create your own quick reference snapshot of the benefits you've chosen.

MEDICAL PLANS

	Available to all employees								Only available to employees who are currently enrolled.	
	☐ **PPO1** Blue Cross/Blue Shield of MI (BCBSM)		☐ **PPO2** Blue Cross/Blue Shield of MI (BCBSM)		☐ **HMO** Blue Care Network (BCN)		☐ **HDHP** Blue Cross/Blue Shield of MI (BCBSM)		☐ **TRADITIONAL** Blue Cross/Blue Shield Traditional Plan (BC/BS)	
Bi-Weekly Contributions	Employee Emp +1 Family	**$42** **$75** **$85**	Employee Emp +1 Family	**$52** **$80** **$95**	Employee Emp +1 Family	**$26** **$45** **$55**	Employee Emp +1 Family	**$10** **$15** **$20**	Employee Emp +1 Family	**$62** **$99** **$104**
No Coverage Option	☐ Refer to benefit elections in Workday									

DENTAL PLANS

	☐ **Standard Plan**		☐ **High Plan**		☐ **Modified Plan**	
Bi-Weekly Contributions	Employee Emp +1 Family	**$0** **$0** **$0**	Employee Emp +1 Family	**$1.15** **$1.73** **$5.00**	Bi-Weekly Credit	
					Employee Emp +1 Family	**$1.15** **$1.73** **$3.27**
No Coverage Option Opt-Out Bi-Weekly Credit	No coverage credit $1.93 / $3.85 / $5.77					
	No coverage credit (county spouse/parent coverage) $1.93 / $1.93 / $1.93					

VISION PLANS

☐ **Standard Plan**		☐ **High Plan**		☐ **No Coverage**	
Employee Emp +1 Family	**$0** **$0** **$0**	Employee Emp +1 Family	**$1.35** **$2.88** **$3.85**	Employee Emp +1 Family	**$0** **$0** **$0**

	Healthcare FSA	Dependent Care FSA	Health Savings Account HSA
Contribution Limits	Contribute between $100–$3,050 per calendar year for eligible healthcare expenses	Contribute between $100–$5,000 per calendar year for eligible dependent care expenses	Contribute between $100–$4,150 per employee only/$100–$8,300 per family per calendar year for eligible healthcare expenses
My planned contribution	☐ _____	☐ _____	☐ _____

Life Insurance	Accidental D&D
☐ 1 times Annual Benefit Salary	☐ 1 times Annual Benefit Salary *(Standard Plan = no cost)*
☐ 1.5 times Annual Benefit Salary *(Standard Plan = no cost)*	☐ 1.5 times Annual Benefit Salary
☐ 2 times Annual Benefit Salary	☐ 2 times Annual Benefit Salary
☐ 3 times Annual Benefit Salary	☐ 3 times Annual Benefit Salary
Reminder: designate your beneficiaries	

My Notes

My Notes

2100 Pontiac Lake Road, 41W
Waterford, MI 48328-2762
OakGov.com/Benefits

OAKLAND COUNTY
MICHIGAN
HUMAN RESOURCES