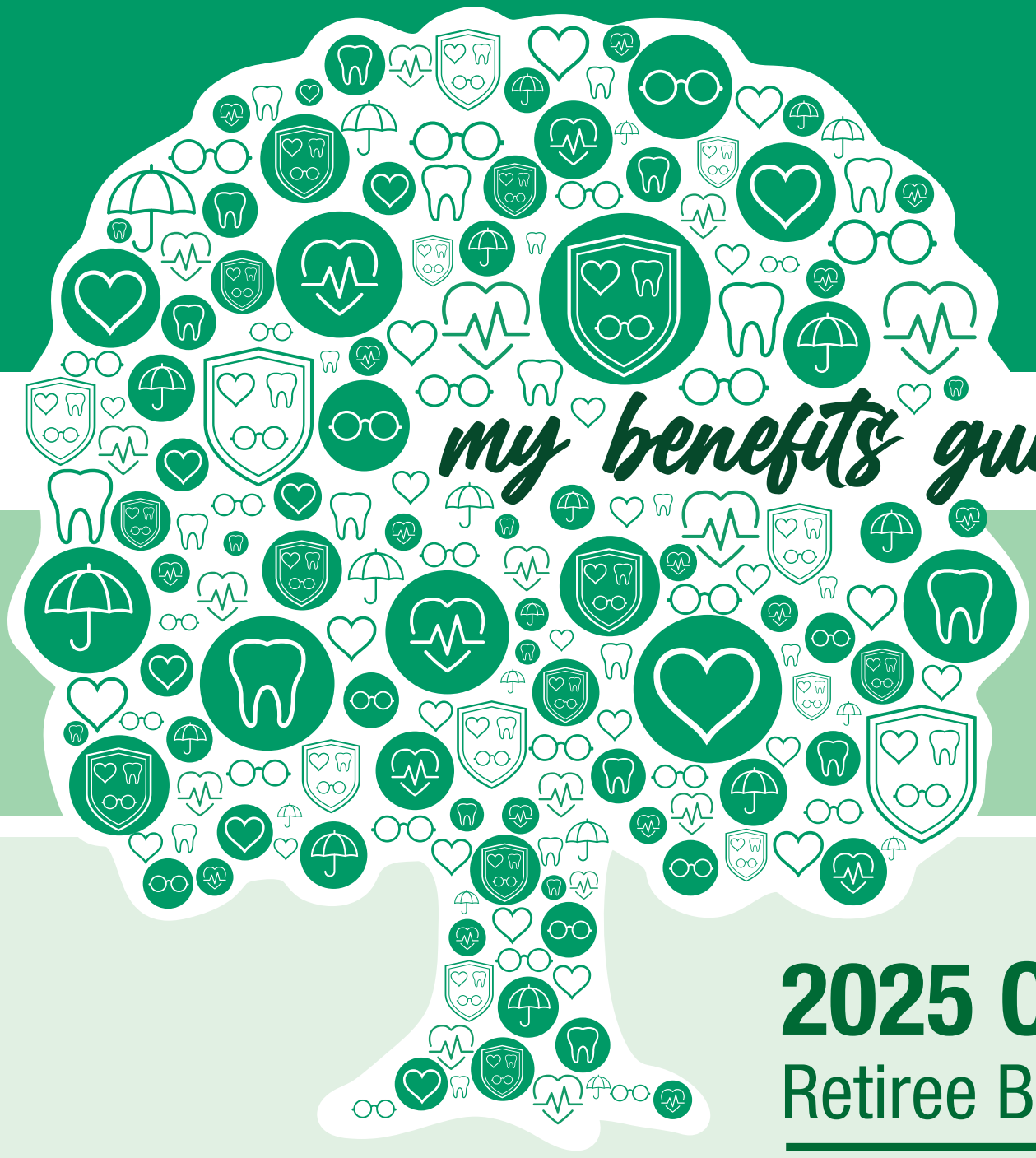

2025 Oakland County

Retiree Benefits & Wellness

OAKLAND COUNTY MICHIGAN

All ways, MOVING FORWARD

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MEDICAL	**Blue Cross/Blue Shield of MI** (877) 790-2583 bcbsm.com	**Blue Care Network** (877) 790-2583 bcbsm.com
PRESCRIPTION	**Optum** (800) 356-3477 optumrx.com	**Optum Mail Order** (800) 356-3477 optumrx.com
DENTAL • VISION	**Dental** Delta Dental (800) 524-0149 deltadentalmi.com	**Vision** Heritage Vision (800) 252-2053 heritagevisionplans.com
RETIREE PAYMENT INFORMATION	**Optum Financial** (855) 687-2921 cobra.optumfinancial.com	

Contact Information

OAKLAND COUNTY HUMAN RESOURCES • BENEFITS UNIT STAFF DIRECTORY

Katelyn Marvin
Supervisor, Employee Benefits
P: (248) 202-0476
marvink@oakgov.com

Uda Daniel
Retiree Medical
Dental • Vision
Prescriptions • COBRA
P: (248) 309-7910
danielu@oakgov.com

Raquel Little
New Hire Benefits
Family Status Changes
Disability • Life Insurance
P: (248) 452-9189
littler@oakgov.com

Riley Ogurek
Benefits Support
P: (248) 466-5822
ogurekr@oakgov.com

Katee Zora
Active Medical
Dental • Vision
Prescription • Flexible Spending Accounts
Unemployment
P: (248) 466-7232
zorak@oakgov.com

OAKLAND COUNTY HUMAN RESOURCES • RETIREMENT UNIT STAFF DIRECTORY

Carly Webster
Supervisor, Retirement & Deferred Compensation and VEBA Board
P: (248) 520-9727
websterc@oakgov.com

Kelly Pena
Retiree Medical
Defined Benefit Payroll
P: (248) 858-2043
penak@oakgov.com

Lisa Villella
Defined Contribution, Deferred Compensation
Payroll
P: (248) 892-2855
villellal@oakgov.com

LaKenya Keyes
Medicare, Retirements
P: (248) 858-0404
keyesl@oakgov.com

Karen Skupin
Retirement Specialist, Website
P: (248) 766-4155
skupink@oakgov.com

Medical

MEDICAL BENEFITS

Oakland County offers a variety of medical plans to pre-65 retirees, including two Preferred Provider Organization (PPO) plans, a Health Maintenance Organization (HMO) plan, and a Traditional Plan. You will determine the best plan based on your and/or your family's healthcare needs. Although the plans cover similar medical services, they are different in important ways:

1. Provider networks (in- and out-of-network coverage)
2. The amount of money spent for services (deductible, copays, coinsurance, etc.)

For post-65 retirees, we offer a Medicare Supplemental plan.

MEDICAL PLAN CHOICES FOR PRE-65 RETIREES

- PPO1 Blue Cross/Blue Shield of MI (BCBSM)
- PPO2 Blue Cross/Blue Shield of MI (BCBSM)
- HMO Blue Care Network (BCN)
- Traditional Plan Blue Cross/Blue Shield of MI (BCBSM) *(if eligible)*
- No Coverage

PPO PLANS

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

PPO plans allow 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 are 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 are 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.

TRADITIONAL PLAN

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

MEDICAL PLAN FOR POST-65 RETIREES

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

- Medicare Supplemental Plan

This plan will pay secondary to Medicare. Medicare Supplemental does not cover office visit copays.

NOTE: Reference the Medicare Supplemental Charts for plan details on deductibles, coinsurance, 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, including balance billing.

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: (877) 790-2583

BCN: (877) 790-2583

Medicare: (800) 633-4227

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 & TRADITIONAL 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 (877) 790-2583
MEDICARE SUPPLEMENTAL ADMINISTERED BY Blue Cross/Blue Shield of Michigan (BCBSM) with the Medicare Network
To find in-network providers, visit **medicare.gov/care-compare**

COMPARING MEDICAL PLAN OPTIONS

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

Medical

MEDICAL PLAN OPTIONS COMPARISON				
In-Network Benefits Shown	**AVAILABLE TO ALL PRE-65 RETIREES**			
	PPO1	**PPO2**	**HMO**	**TRADITIONAL (IF ELIGIBLE)**
	Blue Cross/Blue Shield of MI (BCBSM)	Blue Cross/Blue Shield of MI (BCBSM)	Blue Care Network (BCN)	Blue Cross/Blue Shield Traditional Plan (BCBSM)
Plan Website	BCBSM.com			
Network(s)	Blue Cross/Blue Shield	Blue Cross/Blue Shield	Blue Care Network	Blue Cross/Blue Shield
Deductible(s)	$0 per person / $0 per family *$200/$400 deductible only applies to durable medical equipment and private duty nursing care	$100 per person / $200 per family per calendar year	No deductible	$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	10% after deductible for most services; 25% after deductible for private duty nursing care
Coinsurance Maximum	$1,000 per person/per family per calendar year	$500 per person / $1,000 per family per calendar year	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

Medical

In-Network Benefits	PPO1	PPO2	HMO	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	90% after deductible
Specialty Provider Office Visit	$20 copay	$20 copay	$20 copay *PCP referal may be required*	90% after deductible
Telehealth Visit	100%	$20 copay	$20 copay *Must be provided through contracted telehealth services provider*	90% after deductible
Blue Cross/Blue Shield of MI (BCBSM) Online Visits	100%	$20 copay	$20 copay	90% after deductible
EMERGENCY / URGENT CARE SERVICES				
Urgent Care	$20 copay	$20 copay	$20 copay	100%
Emergency Room Visits	$100 copay *Copay will be waived if admitted*	$100 copay *Copay will be waived if admitted*	$100 copay *Copay will be waived if admitted*	$100 copay *Copay will be waived if admitted*
Ambulance Service for Medical Emergencies	90% after deductible	90% after deductible	100%	90% after deductible

Medical

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

Medical

In-Network Benefits	PPO1	PPO2	HMO	TRADITIONAL
FAMILY PLANNING SERVICES				
Physician Services (delivery & inpatient)	100%	90% after deductible	100%	100%
Hospital Care	100%	90% after deductible	100%	100%
Routine Pre- & Post-Natal Care	100%	100%	100% pre-natal visits $20 copay post-natal visits	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
Maven (maternity & post-partum support, adoption assistance, etc.)	100%	100%	100%	100%
Voluntary Female Sterilization and FDA-Approved Contraceptive Methods	100%	100%	100%	100%
Voluntary Male Sterilization and FDA Approved Contraceptive Methods	100%	90% after deductible	100%	Not Covered
BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH & SUBSTANCE ABUSE DISORDER)				
Inpatient Services	100%	90% after deductible *Covered according to plan guidelines*	100%	100%
Outpatient Services	100% after $20 Copay	90% after deductible Office and Online Visit: $20 copay	$20 copay	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 copay	100%
Physical, Occupational, and Speech Therapy	100%	90% after deductible	$20 copay	100%
Nutritional Counseling	100%	90% after deductible	$20 copay	100%

Medical

In-Network Benefits	PPO1	PPO2	HMO	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% *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)*	90% after deductible *Limited to 38 visits per calendar year*
HABILITATION SERVICES				
Outpatient Physical, Occupational and Speech Therapy	Not Covered	Not Covered	Not Covered	Not Covered
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% *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% *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% *Must be in a participating skilled nursing facility*
Private Duty Nursing	90% after deductible	50% after deductible	Not Covered	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% *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	TRADITIONAL
HUMAN ORGAN TRANSPLANTS				
Specified Human Organ Transplants	100%	100% *Covered according to plan guidelines*	100% *Covered according to plan guidelines*	100% *In approved facilities*
OTHER COVERED SERVICES				
Allergy Testing	100%	100%	100% after $20 copay	90% after deductible
Allergy Treatment & Injections	100%	100%	100% after $20 copay	90% after deductible
Durable Medical Equipment, Prosthetic & Orthotics	90% after deductible	90% after deductible	100% covered *for approved equipment only*	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 dysphoria. 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	Hearing aids and services covered once every 36 months. Allowance: 1 Hearing Aid $2,000/2 Hearing Aids $3,000.		Hearing aids and services covered once every 36 months. Allowance: 1 Hearing Aid $3,000/2 Hearing Aids $6,000.	Hearing aids and services covered once every 36 months. Allowance: 1 Hearing Aid $2,000/2 Hearing Aids $3,000.
Teladoc (Chronic Condition Management)	100%	100%	100%	100%

Medical

In-Network Benefits	PPO1	PPO2	HMO	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	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	**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 of Benefits Coverage (SBC) and Benefits at a Glance (BaaG) will prevail.*

Medical

Post-65 Medicare Supplemental Plan	
In-Network Benefits Shown	Medicare Network
Plan Website	BCBSM.com
Deductible(s)	No Deductible
Coinsurance	None
Coinsurance Maximum	N/A
Annual Out-of-Pocket Maximum	None

Preventive Care	
Annual Physical 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	Not Covered
Specialty Provider Office Visit	Not Covered
Telehealth Visit	Not Covered
Blue Cross/Blue Shield of MI (BCBSM) Online Visits	100%

Emergency/Urgent Care Services	
Urgent Care	Not Covered
Emergency Room Visits	$100 Copay
Ambulance Service for Medical Emergencies	100%

Inpatient Hospital Services	
General Conditions, Surgical Services, Semi-Private Room, Drugs, Intensive Care Unit, Hospital Equipment, Nursing Care, Meals	100%

Outpatient Hospital Services	
Outpatient Surgery	100%
Ambulatory Surgical Center	100%
Professional Surgical and Related Services	100%

Family Planning Services	
Physician Services (delivery & inpatient)	100%
Hospital Care	100%
Routine Pre & Postnatal Care	100%
Assisted Reproductive Treatment	Not Covered
Voluntary Sterilization and FDA-Approved Contraceptive Methods	100%

Behavioral Health Services (Mental Health & Substance Abuse Disorder)	
Inpatient Services	100%
Outpatient Services	100%

Medical

Human Organ Transplants	
Specified Human Organ Transplants	100% *In designated facilities only*

Other Covered Services	
Allergy Testing	100%
Allergy Treatment & Injections	100%
Durable Medical Equipment, Prosthetic & Orthotics	100%
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 dysphoria. 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/mpr-search/pdf/2065126.pdf
Hearing Care	Hearing aids and services covered once every 36 months. Allowance: 1 Hearing Aid $2,000/2 Hearing Aids $3,000.

Program Provisions	
Out-of Network Services	Not Covered
Payment of Covered Services	Medicare Supplemental plan pays secondary to Medicare

Rehabilitation Services	
Outpatient Physical, Occupational and Speech Therapy	100%
Chiropractic Spinal Manipulation	Not Covered

Alternatives to Hospital Care	
Home Health Care Visits	100% *Limited to a maximum of 100 visits per calendar year*
Hospice Care	100% *Inpatient - limited to a lifetime maximum of 30 days, Outpatient - limited to a lifetime maximum of $5,000*
Skilled Nursing Care	100% *Limited to 100 days per calendar year*
Private Duty Nursing	100%
Outpatient Infusion Therapy	100%

Autism Spectrum Disorders; Diagnoses and Treatment	
Applied Behavioral Analysis (ABA services must be optained by an approved autism evaluation center [AAEC])	100%
Physical, Occupational, and Speech Therapy	100%
Nutritional Counseling	100%

Diagnostic Services	
Laboratory & Pathology	100%
Diagnostic Tests (x-rays, blood work)	100%
Imaging (CT/PET scans, MRIs)	100%
Radiation Therapy & Chemotherapy	100%

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**	**TRADITIONAL**	**MEDICARE SUPPLEMENTAL**
Participating / Network Pharmacies	**Covered / Copays:** ▪ **Tier 1:** $10 copay most generics / some brands ▪ **Tier 2:** $30 copay preferred brands / some generics ▪ **Tier 3:** $50 copay non-preferred products *(could include both brand and generic)* ▪ Select birth control pills covered $0 copay				
Non-Participating / Non-Network Pharmacies	Paid at the in-network cost, less $10, $30 or $50 copay		Not covered	Paid at in-network cost, less $10, $30, $50 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	
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	Prior Authorization/Step Therapy
▪ Preferred drug list established by a clinical committee of BCBSM 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. ▪ The formulary can be found at **bcbsm.com/customdruglist**	▪ 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.	▪ Certain medications require prior authorization and/or step therapy. This process is initiated by the prescribing physician. ▪ BCBSM will review the prior authorization/step therapy request once all required information has been received. ▪ All medications that require prior authorization or step therapy will be marked with "PA" or "ST" on the formulary. ▪ Prior authorizations and step therapies must be renewed annually.

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	**$10**
Tier 2	Preferred brands and some generics	**$30**
Tier 3	Non-Preferred products (could include both brand and generic products)	**$50**

Prescription Administrators & Partners (BCBSM & BCN Plans)

Your prescriptions are administered through OptumRx; however, you will utilize your BCBSM medical ID card at the point of service for prescriptions. OptumRx 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 a particular drug within these programs.

Maven & Teladoc

MAVEN

Maven is a family building & women's health solution supporting all paths to parenthood and continued care with digital-first human care.

Family Building Support Solution
- Preconception care
- Egg freezing
- IUI & IVF
- Adoption & surrogacy

Maternity Support Solution
- Prenatal and postnatal care
- NICU support
- High-risk pregnancy care management
- Postpartum & return to work support
- Loss

Menopause & Ongoing Care
- Early intervention
- Symptom management
- Mental health

For a personalized experience, Maven will match a dedicated Care Advocate that will support members through their unique journey.

TELADOC

Teladoc is a virtual condition management tool to help control and minimize the risk of chronic conditions.

There are four condition management solutions:

Diabetes Management
- Members will receive cellularly-enabled glucometers that provide the member and the care team with readings real-time, along with lancets, personalized coaching, and educational content.

Hypertension Management
- Members will receive a cloud connected blood pressure monitor to share live results with the member and the care team, along with personalized educational content, and reinforcement of healthy behaviors.

Diabetes Prevention
- Members will receive a cellularly-connected scale, personalized type 2 diabetes prevention curriculum, and health challenges.

Weight Management
- Members will receive an advanced smart scale and app to track weight, activity, and food, along with personalized tools and tips based on goals.

Visit **hr.OakGov.com/Benefits** or use the camera on your phone to scan the QR code for additional information

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.

STANDARD PLAN	
Deductible	
Retiree	$25
Retiree +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%

Dental

Service	Standard 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 (does not include diagnostics and preventive services)	$1,000 per individual per calendar year
Orthodontia Limit	$1,000 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 “Find a Dentist”

Vision

VISION COVERAGE THROUGH HERITAGE VISION

To help you see your best, Oakland County offers vision coverage through Heritage. Heritage 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 Heritage for reimbursement. Treatment of a medical condition affecting your eyes, such as glaucoma or pink eye, is processed through your medical coverage.

STANDARD PLAN	
Plan Coverage - In-network	
Examination (Annually)	100% after $5 copay
Lenses and Frames *(Standard Glass or Plastic Lenses)*	
Single, bifocal, trifocal, and lenticular	Covered 100% after $7.50 copay every 24 months
Polycarbonates	Covered 100%
Frame Retail Allowance	Up to $100 and 20% discount off frame balance every 24 months
Contact Lenses *(In lieu of Lenses and Frames)*	
Elective Contact Lenses	Up to $50 retail every 24 months

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

FIND A HERITAGE VISION CARE PROVIDER

Visit heritagevisionplans.com and click on “Find a Provider” tab and select the national network along with your zip code.

Retiree Healthcare Eligibility

Once you have attained the required years of service and age, you are eligible for health coverage as a retiree from Oakland County. The schedule below applies to non-represented employees. If you are represented by a bargaining unit, the dates may vary and you are encouraged to contact the Retirement Unit to determine which schedule applies to you.
In all cases, except as specified differently by some Sheriff bargaining agreements, you must have met the requirements specified on the following pages and be at least age 60 with 8 years of service or age 55 with 25 years of service for coverage to commence.

At age 65 or sooner if you or your dependents become eligible for Medicare due to a disability, Medicare becomes the primary coverage and the coverage available through the County becomes secondary. Standard dental coverage and standard vision coverage is also available to retirees.

A - 8 YEAR SCHEDULE OF ELIGIBILITY

Employees hired prior to September 21, 1985 are eligible for full family health coverage at retirement. Age 60 with 8 years of service or Age 55 with 25 years of service.

B - REVISED SCHEDULE OF ELIGIBILITY

Employees hired on or after September 21, 1985 and before January 1, 1995. Dates may vary by bargaining unit.

Total Actual Service with Oakland County	Paid Health Coverage	
	Direct Retirement	Deferred Retirement
Less than 8 years	None	None
8 - 14 years	One Person*	None
15 - 19 years	Family	One Person*
20 years or more	Family	Family

*Retiree has the option to pay the difference for a family policy.

C - 15 YEAR SCHEDULE OF ELIGIBILITY

Employees hired on or after January 1, 1995 and before January 1, 2006. Dates may vary by bargaining unit.

At completion of:	Percentage of Retiree Paid
Up to 15 Years	0% (No Coverage)
15 Years	60%
16 Years	64%
17 Years	68%
18 Years	72%
19 Years	76%
20 Years	80%
21 Years	84%
22 Years	88%
23 Years	92%
24 Years	96%
25 Years	100%

**This is the percentage the County would pay toward a Single person or Family plan, depending on the plan the employee was enrolled in at the time of retirement. The employee would be responsible for the difference between this amount and the current full cost of their health plan, plus any deductibles or co-pays.

D - RETIREE HEALTH SAVINGS ACCOUNT (RHS)

Employees hired on or after January 1, 2006. Dates may vary by Bargaining Unit. Employees hired on or after January 1, 2006 will not be eligible for retiree health, dental or vision coverage through Oakland County. A Retirement Health Savings (RHS) account will be set up for full-time benefits eligible employees* at a contribution amount of $75 per pay**.

The RHS account may only be used to pay for medical, dental and vision expenses based on Internal Revenue Regulations. These expenses may include paying for health care premiums, co-pays, and deductibles.

A participant may access his or her RHS account after retirement or separation from county service based upon the following vesting schedule:

At completion of:	Vesting Schedule
Up to 6 Years	0% (Not Vested)
6 Years	60%
7 Years	70%
8 Years	80%
9 Years	90%
10 Years or More	100%

* A part-time eligible employee hired on or after January 1, 2006 will NOT be eligible for Oakland County contributions towards his or her RHS account.

** Some bargaining units may differ.

Dependent Eligibility

Spouse

Eligible: Legal spouse of a Retiree.

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 month 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 retiree 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, 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

Qualifying Life Events

SPECIAL ENROLLMENT PERIOD

Making a change to your benefit coverage is only available to retirees 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.

Retirees have 30 days following a QLE to initiate a benefit change with the benefits team and provide verification of the event, which includes; the Retiree Membership and Record Change Forms. Once the 30-day window has passed to initiate a QLE with the benefits team, the next opportunity to make benefit changes is during Open Enrollment.

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

OAKFIT WELL-BEING 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 retirees to make their physical and mental health a priority.

Retirees 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.

OAKFIT PROGRAMS

- Waterpark Days
- Movie Nights in the Park
- Lunch 'n' Learns
- Car Show and Shine

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.

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 a retiree 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.

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 Notes

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

OAKLAND COUNTY
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