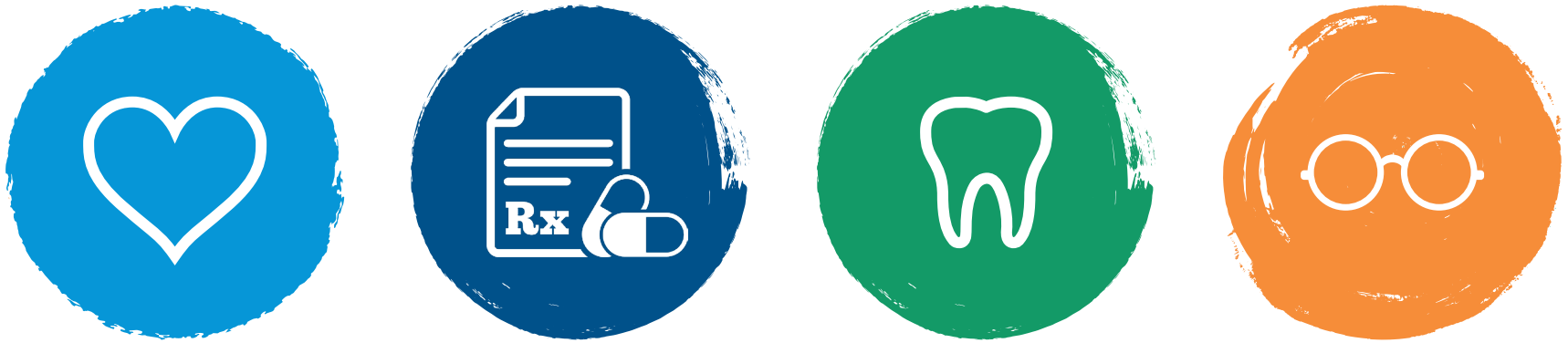


Your Benefits, Your Way.

2027 Oakland County

Retiree Benefits & Well-being Guide

Retirees Enrolled in the Medicare Supplemental Plan

OAKLAND COUNTY MICHIGAN
All ways, MOVING FORWARD

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Dear Colleagues,

Supporting your well-being remains one of our highest priorities, and this year's benefits offerings reflect that commitment.

We continue to expand resources that help you thrive. In addition to comprehensive health and wellness programs, we are excited to introduce the Marathon Health at Oakland County Clinic that will bring convenient, accessible care right into our community. It's another way we're working to make it easier for you and your family to stay healthy.

As open enrollment approaches, we encourage you to take time to explore the options available to you. This guide will help you understand what's new, what's changing and how to choose the coverage that best meets your needs.

We are grateful for your service to Oakland County and proud to support you.

All the best,

Katelyn Marvin
Supervisor, Benefits
Human Resources
Oakland County



Contact Information

MEDICAL	**Blue Cross/Blue Shield of MI** (877) 790-2583 bcbsm.com	**Blue Care Network** (877) 790-2583 bcbsm.com	**Marathon Health at Oakland County Clinic** (866) 434-3255 marathon.health
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		

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Benefit Eligibility

RETIREE ELIGIBILITY

Eligibility for retiree healthcare is based on date of hire, years of service and required age. Benefits typically begin on the first day of the month in which you become eligible for retiree healthcare.

REQUIRED DOCUMENTATION TO ADD ELIGIBLE DEPENDENTS

To add a dependent, you must provide a Social Security Number and acceptable documentation in the English language to verify their eligibility. Children and stepchildren are eligible for benefits through the end of the month that they turn 26.

Eligible Dependent	Required Documentation
Child/legally adopted child	Birth certificate and verification of birth
Legal guardianship	Birth certificate and current legal guardianship papers
Spouse	Marriage certificate
Stepchild	Birth certificate and marriage certificate

Benefit 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. Spouses married after the retirement date are not eligible after the death of the retiree. 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 through the end of the month that they turn 26 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

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 from the date of a QLE to request a benefit change. The request must be submitted to the Benefits Team along with the completed Record Change Form and required documentation verifying the event. 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. To initiate a benefit change due to a QLE, contact **benefits@oakgov.com**.

A special enrollment period is available for individuals that lose Medicaid or CHIP coverage. Retirees and/or qualified dependents have 60 days from the date of losing coverage to enroll in 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

Medical

MEDICAL PLAN FOR RETIREES OVER 65 YEARS OF AGE

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. Retirees will automatically switch over to the Medicare Supplemental plan on the first day of the month in which they turn 65 years of age.

NOTE: Reference the Medicare Supplemental Charts for plan details on deductibles, coinsurance, and services covered.

FIND A PROVIDER

This plan follows the Medicare network. Services received from out-of-network providers are not covered, and you will be responsible for the full cost.

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** To find BCBSM Hearing Aid Providers, visit **bcbsm.com/providers/#/**

Medical

PREVENTIVE CARE BENEFITS

The Medicare Supplemental plan 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
- Breast cancer screening (Female, ages 40-74)
- Cervical cancer screening (Female, ages 21-65)
- Colon cancer screening (ages 45-75)
- Prostate cancer screening (Male, ages 55-69)
- Well child care and immunizations
- Routine prenatal maternity services
- And more!

NOTE: Cancer screening recommendations may vary based on individual risk. Preventive care guidelines can change as new research and data becomes available.

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:

Medicare: (800) 633-4227

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.

Medical

MARATHON HEALTH AT OAKLAND COUNTY CLINIC

250 Elizabeth Lake Road, Pontiac, MI 48341 | **marathon.health/onsite**

Oakland County is proud to launch a near-site clinic offering a variety of services for full-time employees, retirees and their dependents enrolled in an Oakland County medical plan providing improved access to care and better health outcomes, personalized support from dedicated healthcare providers serving Oakland County families and lower out-of-pocket costs.

Services Offered

Preventive Care

» An annual visit with a primary care provider focused on preventive screenings, wellness assessments, health education and early detection of potential health concerns.

Primary Care or Urgent Care

» Convenient treatment for non-emergency illnesses and injuries that require prompt attention, such as minor infections, sprains, cuts or flu-like symptoms.

Physical Therapy

» One-on-one care designed to improve mobility, reduce pain, restore function and support recovery from injuries, surgeries or chronic conditions.

Mental Health

» Confidential support from a mental health professional to help manage stress, anxiety, depression, emotional challenges and overall mental well-being.

On-site Pharmacy

» Quick access to select generic medications for common health conditions, allowing prescriptions to be filled during your visit.

In-Network Benefits	MEDICARE SUPPLEMENTAL
MARATHON HEALTH AT OAKLAND COUNTY CLINIC	
Annual Physical Exam, Sports Physicals	100%
Immunization	100%
Primary Care Physician (PCP) Office Visit	100%
Urgent Care Visits	100%
Outpatient Mental Health	100%
Physical Therapy	100%

Medical

MEDICARE SUPPLEMENTAL PLAN	
Network	Medicare
Plan Website	BCBSM.com
Deductible	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%
Age Appropriate Annual Gynecological Exam, Pap Smear, Mammogram, Colonoscopy	100%
Immunization (adult & childcare)	100%
PHYSICIAN/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 through Teladoc Health	100%
EMERGENCY/URGENT CARE SERVICES	
Urgent Care	Not Covered
Emergency Room Visits	$100 Copay
Ambulance Service for Medical Emergencies	100%

Medical

DIAGNOSTIC SERVICES	
Laboratory & Pathology	100%
Diagnostic Tests (X-rays, blood work)	100%
Imaging (CT/PET scans, MRIs)	100%
Radiation Therapy & Chemotherapy	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%
Telemedicine Servies, including Teladoc	100%

Medical

AUTISM SPECTRUM DISORDERS; DIAGNOSES AND TREATMENT	
Applied Behavioral Analysis (ABA services must be obtained by an approved autism evaluation center [AAEC])	100%
Physical, Occupational, and Speech Therapy	100%
Nutritional Counseling	100%
REHABILITATION SERVICES	
Outpatient Physical, Occupational, and Speech Therapy	100% Physical Therapy and Speech Therapy are limited to a combined maximum of 14 visits per calendar year. Occupational Therapy is limited to a maximum of 14 visits per calendar year (not combined with Physical Therapy and Speech Therapy).
Chiropractic Spinal Manipulation	100% Covered with Medicare limitations
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%
HUMAN ORGAN TRANSPLANTS	
Specified Human Organ Transplants	100% In designated facilities only

Medical

OTHER COVERED SERVICES	
Allergy Testing, Treatment & Injections	100%
Durable Medical Equipment, Prosthetics & Orthotics	100%
Gender Affirming Care	Blue Cross/Blue Shield of MI (BCBSM) 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: hr.oakgov.com/bcbsmgenderaffirming
Hearing Care *Before you receive your hearing aid, you must have a medical examination of the ear performed by a participating board certified or board eligible otologist, otolaryngologist, or otorhinolaryngologist.*	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

Prescription

PRESCRIPTION DRUGS *All Oakland County medical plan enrollees and their eligible dependents will automatically receive prescription drug coverage.*	
Prescription Carrier Website	Optumrx.com
In-Network Benefits	Medicare Supplemental
Participating / Network Pharmacies	**Covered / Copays:** • **Tier 1:** Generic medications • **Tier 2:** Preferred brand medications • **Tier 3:** Non-preferred brand medications • **Tier 4:** Preferred specialty medications • **Tier 5:** Non-preferred specialty medications • Select birth control pills covered at $0 copay *Please note that your copay is associated with the tier listed on the formulary.*
90-Day Supply	90-day supplies of maintenance medications are available through your pharmacy with one copay (applies to mail order).
Non-Participating/Non-Network Pharmacies	Paid at in-network cost, less the applicable copay
Annual 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 applicable 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 associated tier 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/or 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

Five-tier prescription drug program

The County offers a five-tier prescription drug program in which the in-network copay amount varies by tier as shown below:

Drug Tier	Copay	Description
Tier 1	$10	**Generic:** includes generic non-specialty drugs and select specialty drugs. Members pay the lowest copay for generics, making them the most cost-effective option for treatment.
Tier 2	$30	**Preferred Brand:** includes preferred brand name drugs. These drugs are more expensive than generics, and members pay more for them.
Tier 3	$50	**Non-preferred Brand:** includes brand name drugs for which there are either generic alternatives or more cost-effective, preferred brand name drugs available. Members pay more for these non-preferred brand name drugs.
Tier 4	$100	**Preferred Specialty:** includes select specialty generic and brand-name drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective that non-preferred specialty drugs.
Tier 5	$150	**Non-preferred Specialty:** includes non-preferred brand name specialty drugs that are used to treat difficult health conditions. Members pay more for non-preferred specialty drugs because there are more cost-effective generic or preferred drugs available.

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 and Walgreen Specialty for High-Cost Drug Discount Programs 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.

Prescription

Understanding the Types of Medications

Formulary	Maintenance Medication	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.	• 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.

How to Check if a Prescription Medication is Covered

- Review the BCBSM Prescription Drug Formulary to determine whether your medication is covered and identify any coverage requirements. The formulary can be found at: **bcbsm.com/customdruglist**.
- Search for your medication by its generic or brand name in the formulary document.
- Check the drug's tier placement, as your out-of-pocket cost may vary based on the tier.
- Review any notes associated with the medication, such as prior authorization, quantity limits, or step therapy requirements.
- If you cannot find your medication or have questions about coverage, contact BCBSM Customer Service using the number on your member ID card.



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 at hr.oakgov.com/retireemedical under Dental Plan Information.

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%
Progressive Lenses	$50 copay (standard lenses) $100 copay (premium lenses)
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 **hr.oakgov.com/retireemedical** under Vision Plan Information.

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

Retiree Healthcare Eligibility

Oakland County offers retiree healthcare coverage to eligible employees hired before 01/01/06. There are four retiree healthcare schedules that are based on hire date.

Schedule	Eligibility
A	Hired prior to 09/21/85
B	Hired on or after 09/21/85 and before 01/01/95
C	Hired on or after 01/01/95 and before 01/01/06
D	Retirement Health Savings (RHS) Account if hired on or after 01/01/06. Dates vary by bargaining unit.

Details of each retiree healthcare schedule can be found on our website **oakgov.com/retirement.**

Employees must be eligible for retirement to receive healthcare coverage as a retiree from Oakland County.

Retiree Healthcare - Schedule C

Vesting refers to how much the county will pay toward the total healthcare premium amount for a single or family plan. County coverage is earned over time based on the following schedule:

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



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.

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.

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.

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 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.

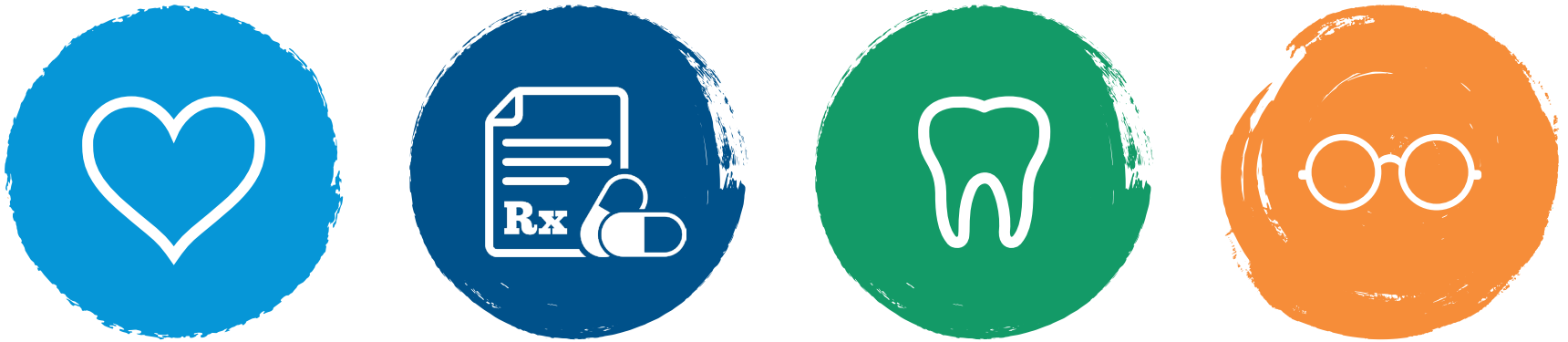
Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

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 health-care 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.



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

OAKLAND COUNTY
MICHIGAN
HUMAN RESOURCES