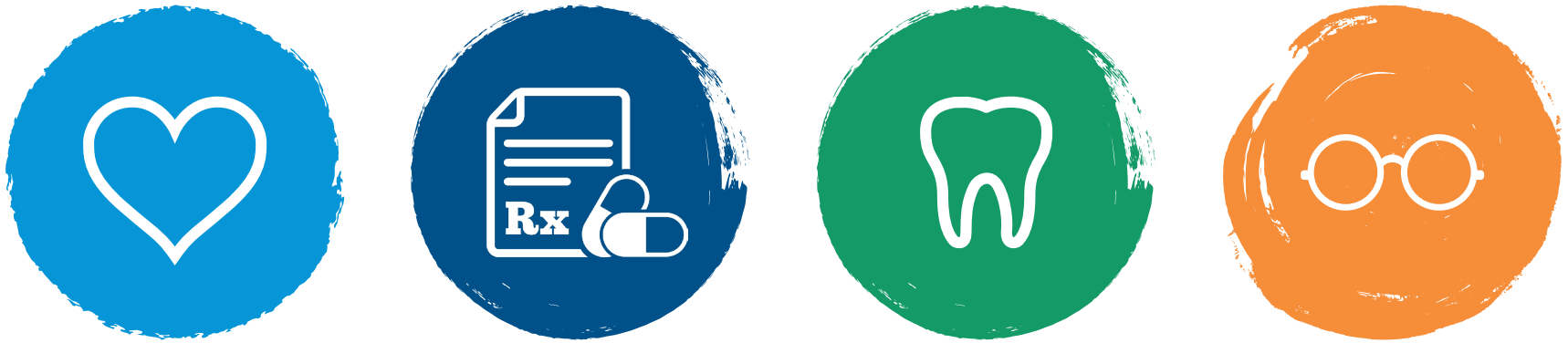


Your Benefits, Your Way.

2027 Oakland County

Retiree Benefits & Well-being Guide

Eligible Retirees Under Age 65

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 death of the retiree.

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 BENEFITS

Oakland County offers several medical plans including two Preferred Provider Organization (PPO) plans, a Health Maintenance Organization (HMO) plan and a Traditional Plan. These options allow you to choose the coverage that best fits your healthcare needs. While all plans cover similar medical services they differ in important ways:

1. Provider networks (in- and out-of-network coverage).
2. The amount of money spent for services (deductible, copays, coinsurance, etc.).
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)
- Traditional Plan Blue Cross/Blue Shield of MI (BCBSM) *(closed plan for current enrollees only)*
- No Coverage

Medical

PREFERRED PROVIDER ORGANIZATION (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 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.

HEALTH MAINTENANCE ORGANIZATION (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.

TRADITIONAL PLAN

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

Eligible retirees can elect the Traditional plan upon retirement. Once a retiree leaves the Traditional plan, it can't be elected again.

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

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
- 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.

PREVENTIVE 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

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.

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 Care”. For additional provider search instructions, contact BCBSM at (877) 790-2583.

COMPARING MEDICAL PLAN OPTIONS

All options provide coverage for preventive, routine and emergency medical services. The chart on the following pages helps you compare plan features and in-network benefits so you can choose the option that best fits your needs.

Medical

MARATHON HEALTH AT OAKLAND COUNTY CLINIC - COMING IN 2027

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	PPO1	PPO2	HMO	TRADITIONAL
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

MEDICAL PLAN OPTIONS COMPARISON				
	AVAILABLE TO ALL PRE-65 RETIREES			ONLY AVAILABLE TO RETIREES THAT ARE CURRENTLY ENROLLED
In-Network Benefits Shown	**PPO1**	**PPO2**	**HMO**	**TRADITIONAL**
	Blue Cross/Blue Shield of MI (BCBSM)	Blue Cross/Blue Shield of MI (BCBSM)	Blue Care Network (BCN)	Blue Cross/Blue Shield of MI (BCBSM)
Plan Website	bcbsm.com			
Deductible(s)	$0 per person / $0 per family *$200/$400 deductible only applies to durable medical equipment, ambulatory services 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, ambulatory services, 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%			
Age Appropriate 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 referral 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 pre-authorization.*	90% (no deductible)
Diagnostic Tests (X-rays, blood work)	100%	90% after deductible	100% *Some services require pre-authorization.*	90% (no deductible)
Imaging (CT/PET scans, MRIs)	100%	90% after deductible	100% *Some services require pre-authorization.*	90% (no deductible)
Radiation Therapy & Chemotherapy	100%	90% after deductible	100% *Some services require pre-authorization.*	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% prenatal visits $20 copay postnatal visits	100% for some prenatal visits; otherwise, 90% after deductible
Assisted Reproductive Treatment	Not Covered	Not Covered	100% *$25,000 maximum benefit per lifetime.*	Not Covered
Maven (maternity & post-partum support, adoption assistance, etc.)	100%	100%	100%	100%
Female Voluntary Sterilization and FDA-Approved Contraceptive Methods	100%	100%	100%	100%
Male Voluntary Sterilization	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 visit $20 copay	$20 copay	100% in approved facilities only
Telemedicine Services, including Teladoc Health	100%	$20 copay	$20 copay	100%
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	100%	100%
Nutritional Counseling	100%	90% after deductible	$20 copay	100%

Medical

In-Network Benefits	PPO1	PPO2	HMO	TRADITIONAL
HABILITATION SERVICES				
Outpatient Physical, Occupational and Speech Therapy	100% with approved ABA treatment	90% after deductible with approved ABA treatment	100% with approved ABA treatment	90% after deductible with approved ABA treatment
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 (when referred).*	100% *Up to 60 combined or consecutive therapy visits per calendar year; 61 or more visits covered 90% after deductible.*
Hinge Health Virtual Physical Therapy	100%	100%	Not covered	100%
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.*
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% *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.*	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 **members prescribed certain specialty infusion medications may be contacted by HelpScript to receive copay assistance.*	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, Treatment & Injections	100%	100%	$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: hr.oakgov.com/bcbsmgenderaffirming			
Hearing Care*	Hearing aids and services covered once every 36 months up to $3,000.		Hearing aids and services covered once every 36 months up to $6,000.	Hearing aids and services covered once every 36 months up to $3,000.

**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.*

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, prosthetic and orthotic devices, 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 the Benefits at a Glance (BAAG) will prevail.*

Prescription

PRESCRIPTION DRUGS *All Oakland County medical plan enrollees and their eligible dependents will automatically receive prescription drug coverage.*				
Prescription Carrier Website				
In-Network Benefits	**PPO1**	**PPO2**	**HMO**	**TRADITIONAL**
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 $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 the in-network cost, less applicable copay		Not covered	Paid at in-network cost, less applicable copay
Annual Out-of-Pocket Maximum	$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 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 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, brand-name drug, or specialty drug
- You met the annual out-of-pocket maximum

Five-tier prescription drug program

The county offers a five-tier prescription drug program. Under the five-tier program, the amount of the in-network copay varies 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 Optum Rx; however, you will utilize your BCBSM medical ID card at the point of service for prescriptions. 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 a particular drug within these programs.

Certain specialty medications must be filled through Walgreens Specialty Pharmacy. For assistance, contact Walgreens Specialty Pharmacy at (800) 516-9180 or visit their website at **walgreensspecialtyrx.com**.

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.

Maven, Teladoc & Hinge Health

Maven, Teladoc Health, and Hinge Health are support tools available to all individuals enrolled in an Oakland County medical plan.

Please note that Hinge Health is only available to retirees and dependents enrolled in PPO1, PPO2, and Traditional Health Plans.

MAVEN

Maven is a virtual family building & women's health solution supporting all paths to parenthood and continued care.

Maven is free for eligible retirees and dependents enrolled in an Oakland County medical plan.

For a personalized experience, you will be matched with a dedicated Care Advocate that supports members through their unique journey. Maven specializes in helping to achieve equitable care for all, including LGBTQIA+ and racially and ethnically diverse experiences.

Family Building Support Solution

- Support for preconception (including coaching support for IUI and IVF), adoption and surrogacy

Maternity Support Solution

- Prenatal and postnatal care, high-risk care management, and loss

Menopause & Midlife Care

- Symptom management, hormone replacement, and mental health support

Scan QR code to sign up for Maven Clinic

hr.oakgov.com/maven-login

TELADOC HEALTH

Teladoc Health provides virtual care offering 24/7 physical and mental health support and follows your medical plan's telemedicine coverage.

Virtual Care

- Virtual healthcare services offer 24/7 access to board-certified physicians and nurse practitioners, often with a wait time of less than 10 minutes
- Mental health providers are also available, many times with availability within the next business day

Scan QR code to sign up for Teladoc Health

teladochealth.com/smile/countyofoakland

HINGE HEALTH

Hinge Health is virtual physical therapy program available to retirees enrolled in the PPO1, PPO2, and Traditional medical plans, at $0 cost to you through Oakland County.

Physical therapy benefits offered:

- 1-on-1 support from a dedicated physical therapist or health coach
- A personalized care plan designed around your daily activities and busy schedule
- Gentle, guided exercises you can do anytime, anywhere
- Access to virtual physical therapy at no cost and all fees are fully covered

Scan QR code to sign up for Hinge Health

hinge.health/oakgov-join



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 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%
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.

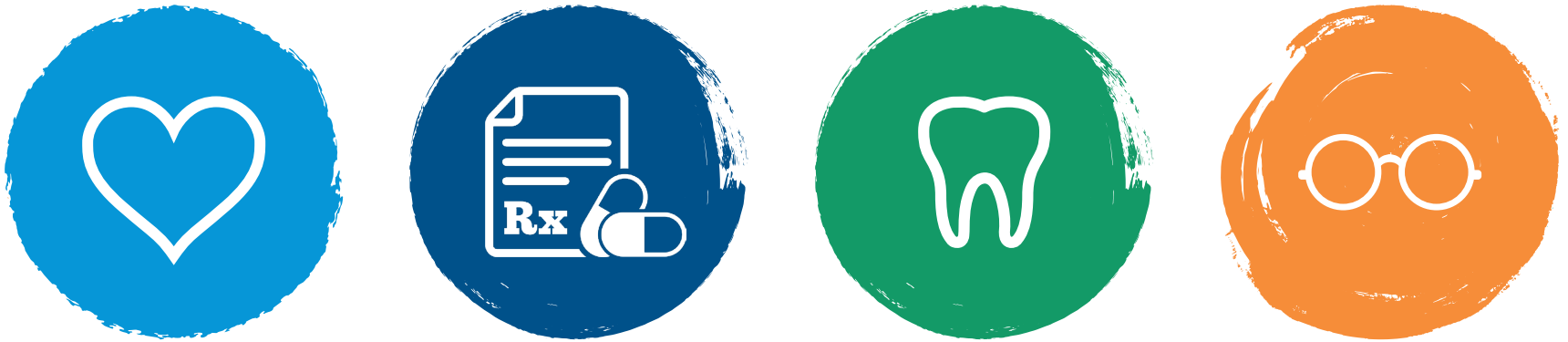
Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

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.



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OakGov.com/Benefits

OAKLAND COUNTY
MICHIGAN
HUMAN RESOURCES