

Natural Select

A natural growth of your benefit choices.

IF YOU HAVE MEDICARE OR WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS, FEDERAL LAW GIVES YOU MORE CHOICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE. PLEASE REFER TO PAGE 12 FOR MORE DETAILS.

***PLEASE NOTE:** At the time this booklet went to press, the impact of The Patient Protection and Affordable Care Act is still being evaluated and plan modifications may occur. Please refer to the www.ocbenefits.com website for the most up-to-date information or contact the Employee Benefits Unit.*



Our Mission Statement: Assist Oakland County employees with establishing and maintaining healthy behaviors in order to: improve overall quality of life, enhance productivity, and reduce long term employee/employer health care costs.

<http://My.OakGov.com/sites/hr/wellness/Pages/default.aspx>

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INTRODUCTION

This is your *Natural Select* workbook. This workbook describes the benefits available through *Natural Select*, raises some important points to think about, and walks you through the enrollment process.

YOUR NATURAL SELECT BENEFIT OPTIONS

Choosing the best benefit program for you and your family's financial security is easy with *Natural Select*. Just take it one step at a time. It's as easy as one, two, three.

Step #1. Become Knowledgeable

The first step is to become knowledgeable. This workbook contains comparison charts, overviews all of the benefits, and lists things you may wish to consider. As you read this information, you should begin to identify the benefit options that best meet your personal needs.

Step #2. Identify Your Personal Needs

The next step is to think about your needs. Remember that there is no one plan that is best for everyone. You should focus on the plan that is best for you. Consider the following points as you design your personal program:

- Your personal and family needs
- Your benefit needs today
- Your short-term future needs -- for example, are you expecting a baby in the next few months?
- Your budget
- Other insurance coverage that you have -- for example, the coverage provided through a working spouse or life insurance you have purchased on your own
- Tax advantages available through *Natural Select*

Step #3. Record Your Choices

The last step in the planning process is to record your benefit choices. To assist you in considering the right options, there is a Personal Reference Worksheet (Form E in the Appendix). Changing your mind is a part of the benefit selection process. That is the purpose of the worksheet.

When you have decided on each of your *Natural Select* choices for the Plan Year, any changes can be recorded using the Internet at www.ocbenefits.com. Detailed instructions are found in the section titled IMPORTANT INFORMATION, on page 44 of this workbook.

After your enrollment information has been processed, you will receive a *Natural Select* Confirmation Statement listing the benefits you have selected for the upcoming Plan Year. **Review the Confirmation Statement carefully.** You will not have a second enrollment period to make any corrections or changes to your selections; for corrections you will need to contact the Employee Benefits Unit of the Human Resources Department.

DEFINITIONS

Here are some definitions that you need to know:

- **Annual Benefit Salary:** The amount used to calculate pay related benefits.
- **Benefit Statement:** An individualized statement displaying the estimated annual costs paid by Oakland County and you toward the purchase of each option. This form also helps you choose your benefits. It shows the options from which you can choose and the employee contribution or earnings for each option. Your current elections are bolded. You will make your actual selections using the Internet (see page 44).
- **Confirmation Statement:** A statement you will receive to verify the selections you made and to ensure that they have been recorded properly. **Please read your confirmation statement carefully.**
- **Default Benefit Package:** If you do not use our Website enrollment system to record your *Natural Select* benefit changes, you will be provided with the same benefit selections (along with the applicable employee contributions) that you have for the current Plan Year, including Health Care and Dependent Care Reimbursement amounts.
- **Dependent:** Your legal spouse and children under age 26. Please refer to the Eligibility section of this workbook.
- **Effective Date:** Your elections will be effective January 1.
- **Employee Contributions:** What you will have to contribute on a bi-weekly pay basis for your selected benefit options.
- **Employee Earnings:** What you will have added to your paycheck as a result of selecting a reduced benefit or no coverage.
- **Formulary:** A list of preferred brand name prescription drugs as determined by a medical plan.
- **Non-Formulary:** Brand name prescription drugs not on the preferred list as determined by a medical plan.
- **Generics:** These are drugs whose patent has ended and can be manufactured by anyone. The Plan will consider as a Generic Drug, any Federal Food and Drug Administration approved generic pharmaceutical which is dispensed according to the professional standards of a licensed pharmacist, is clearly designated by the pharmacist as being generic and has a physician's prescription.
- **Options:** These are the choices you have in each benefit area.
- **Plan Year:** The Plan Year for the Oakland County *Natural Select* benefit program begins January 1 and ends December 31 each year. During the annual enrollment period, you will have an opportunity to change the benefits you need and want. Your benefit election will remain in effect for one Plan Year unless there is a qualifying status change*.
- **Status Code:** This is your "family status code." It indicates who you are electing to provide coverage for: yourself only (one party); yourself and one dependent, spouse or child (two-party); or yourself and at least two dependents, spouse and child(ren) (three or more persons). All dependents on your coverage must have the same health, dental, and vision coverage you do if they have any coverage at all. To change your Status Code, you will need to complete an Open Enrollment Membership and Record Change Form (Form A in the Appendix) and submit it to the Employee Benefits Unit of the Human Resources Department.

* See page 3 for more information regarding status changes.

PURCHASING YOUR BENEFITS

Oakland County *Natural Select* gives **you** more control over the dollars spent on your benefits.

The employee contributions that result from your benefit elections will be deducted on a pre-tax basis.

Your reduced reported earnings due to the *Natural Select* program will not affect benefits based on salary, such as Life and AD&D insurance amounts.

STATUS CHANGES

In accordance with federal regulations, the benefits you choose under your *Natural Select* program will remain in effect until the next Plan Year. You will only be able to change your benefit elections during the Plan Year if you have a qualifying change in status, the election change is consistent with your status change and you contact the Employee Benefits Unit of the Human Resources Department within 30 days of the status change.

Examples of qualifying status changes include the following events:

- Change in legal marital status, including marriage, divorce, legal separation, or annulment
- Change in number of dependents
- Termination or commencement of employment by the employee, spouse, or dependent
- A reduction or increase in hours worked by the employee, spouse, or dependent (including a switch between part time and full time) in accordance with IRS guidelines

Required Supporting Documents with an eligible Status Change:

(Photocopies are acceptable)

Event Category	Required Document
Birth of Child	Birth Certificate
Add Children	Birth Certificate
Marriage <ul style="list-style-type: none">• Add Step-Children	Marriage License <ul style="list-style-type: none">• Birth Certificate and Marriage License
Adoption	Legal Documentation
Legal Guardianship	Legal Documentation

The Internal Revenue Service requires that the change in benefits must be consistent with the change in status. The examples above are only illustrative. The IRS has issued detailed guidelines that must be applied to individual cases. All requests for changes in benefits as a result of a status change event must be reviewed and approved by the Employee Benefits Unit of the Human Resources Department. If you have a change in status (such as the birth of a child) and wish to add or change a benefit, you must complete a “Membership and Record Change” and a “Family Status Change” form and required documents. These forms are available on our Website at www.ocbenefits.com or in the Employee Benefits Unit of the Human Resources Department. Assistance is available should you have any questions. According to the Plan, the form must be completed within **30 days*** of the change in status to be eligible. Requests for **changes made after 30 days will not be accepted.**

*** Forms must be completed within 60 days for changes in eligibility for Medicaid or CHIP (Child Health Insurance Program). Please contact the Employee Benefits Unit of the Human Resources Department for additional details.**

TAX INFORMATION

Natural Select is designed to provide tax advantages to you, allowing you to take home more of your paycheck. The employee contribution for many of your chosen benefits is not taxed for federal, state, local, or Social Security purposes. This means that the total amount you contribute to these benefits is not included on your annual W-2 form. Remember that when you choose non-taxable benefits, any employee benefit deductions are subtracted from your pay **before** taxes are calculated, saving you tax dollars. All of the *Natural Select* benefit options are non-taxable.

The following example shows how significant these savings can be for \$500 of benefits purchased in both the 27% and 40% tax brackets:

	<i>Inside Natural Select</i>	<i>Outside Tax Rate 27%</i>	<i>Outside Tax Rate 40%</i>
Benefits Purchased	\$1,000	\$1,000	\$1,000
Earnings Required	\$1,000	\$1,370	\$1,666
Taxes Payable	\$0	\$370	\$666

Note: You should be aware that when you elect to spend some of your pay that is now taxable to obtain additional non-taxable benefits, your Social Security (FICA) taxable income is reduced. This could have an effect on the benefits you and your family may receive from Social Security. Social Security benefits are calculated based on taxable earnings, your Social Security benefits may be reduced if you reduce your taxable income.

ELIGIBILITY

CRITERIA FOR CHILDREN

Children of the Employee by birth or legal adoption may be covered through the end of the year in which they have their 26th birthday if:

- The child does not have other health coverage available (whether or not they are actually enrolled) through their own employer or if married, through their spouse.

You must provide a copy of the child's birth certificate to add them to your coverage.

If a child does not meet the above criteria, they may only be covered if the employee is directed to do so by a Qualified Medical Child Support Order and the Employee Benefits Unit of the Human Resources Department has been provided with the appropriate updated and current documentation.

Children by birth or legal adoption of the employee's spouse (stepchildren of the employee) may be covered through the end of the year in which they have their 26th birthday if:

- The child does not have other health coverage available (whether or not they are actually enrolled) through their own employer or if married, through their spouse's employer

You must provide a copy of the child's birth certificate AND a copy of your marriage license to add them to your coverage

Disabled children of the employee may be covered to any age if:

- The child became totally and permanently disabled prior to age 19; **AND**
- They are incapable of self-sustaining employment; **AND**
- The employee provides over half their total support as defined by the Internal Revenue Code; **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 19 (or age 26 in the case of dependent continuation).

Legal Guardianship children of the employee may be covered through the end of the year in which they have their 26th birthday if:

- They are unmarried
- Their legal residence is with you
- You supply over half their total support as defined by the Internal Revenue Code
- You provide up to date legal guardianship papers

Coverage for children of whom you are the Legal Guardian may only continue as long as the legal guardianship is in effect. For example, if a Legal Guardianship order ends when a child attains the age of 18, the child is no longer eligible to be covered and must be removed.

CRITERIA FOR SPOUSES

Oakland County allows for the legal spouse of an employee to be covered under your *Natural Select* benefits.

CANCELING COVERAGE

At such time that your spouse or child no longer meets the eligibility criteria, you must complete a Membership and Record Change form to remove him/her from coverage. The Membership and Record Change Form, Form A, which can be found at the back of this workbook, must be submitted, within 30 days from the date of the event, to the Employee Benefits Unit of the Human Resources Department.

DEPENDENT VERIFICATION

If your child's 18th through 25th birthday is in 2011, you must verify their continuing eligibility for coverage by using www.ocbenefits.com during open enrollment. Failure to do so will result in termination of their coverage effective January 1.

Below is an example of how your Dependent information will be displayed during open enrollment.

Below is a list of your dependents according to the Oakland County Human Resource system. Please verify if ALL dependents are still eligible for coverage during the 2012 calendar year. Refer to your *Natural Select* workbook for eligibility criteria. If you are verifying a child age 18-25, you certify that the child does not have other health coverage available (whether or not they are actually enrolled) through their own employer or if married, through their spouse.

To validate your dependent's continuing eligibility, check the appropriate "yes" or "no" radio button beside EACH DEPENDENT listed below.

Those dependents you have verified as "no" will NOT have coverage on January 1, 2012.

In order to confirm your dependents, you must go through the entire selection process below, click the "submit" button on the next page and receive a confirmation number. Otherwise your selections will not be recorded.

Dependents

Name	Relationship	Gender	Birth Date	Eligibility Verification
Smith, Spouse	Spouse	Male	01-01-1956	Yes <input type="radio"/> No <input type="radio"/>
Smith, Child	Child	Female	02-01-1988	Yes <input type="radio"/> No <input type="radio"/>

All Dependents marked "No" will be removed effective January 1, 2012

By checking this box you agree that the verification information you provided above is accurate and you are able to provide supporting documentation if requested, (such as birth certificates for children and marriage license for your spouse) in the event that the County conducts an eligibility audit of the health plan enrollees. Improperly enrolling or continuing coverage for an ineligible dependent may result in both recovery of improperly paid claims and potential disciplinary action up to and including termination of employment. Next

Note in the above example, we are requesting employees who visit the enrollment site to verify **ALL** dependents on their coverage by requiring a "yes"(they are eligible and qualified) or "no" (they are not) answer. Dependents between ages 18-25 must be verified to continue eligibility January 1.

IMPORTANT NOTICES

A GRANDFATHERED HEALTH PLAN WITHIN THE MEANING OF SECTION 1251 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator contact Dean Shackelford at 248-858-5212.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

Federal law mandates coverage for Post-Mastectomy services. Under the Women’s Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- ◆ Reconstruction of the breast on which the mastectomy was performed;
- ◆ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- ◆ Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed. Post-Mastectomy services are subject to any deductible, co-pays, or dollar maximums required by your plan.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

On April 7, 1986, a federal law was enacted (Public Law 99272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage" commonly referred to as COBRA) at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully. If you are an employee of Oakland County covered by our health care plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by our health care plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under our health care plan for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with Oakland County;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by our health care plan, he or she has the right to continuation coverage if group health coverage under our health care plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with Oakland County;
3. The employee's divorce or legal separation;
4. The employee becomes entitled to Medicare; or
5. The dependent child ceases to be a "dependent child" under our health care plan.

Under the law, the employee or a family member has the responsibility to inform Oakland County of a divorce, legal separation, or a child losing dependent status under our health care plan. When Oakland County is notified that one of these events has happened, Oakland County will, in turn, notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the events described above to inform Oakland County that you want continuation coverage. Oakland County has the responsibility in the event of the employee's death, termination of employment or reduction in hours or Medicare eligibility to notify the parties involved.

Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

If you do not choose continuation coverage, your group health insurance coverage will end. Not choosing continuation coverage may cause a break in your continued coverage, and any such break of more than sixty-three days may cause loss of coverage portability.

If you choose continuation coverage, Oakland County is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated

employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18 month period. Also, if you or your spouse gives birth to or adopts a child while on continuation coverage, you will be allowed to change your coverage status to include the child.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes) as of the termination or reduction in hours of employment or within sixty days thereafter. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18 month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. Oakland County no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. You become covered under another group health plan;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay all of the premiums for you continuation coverage.

This law was applied to our health care plan beginning January 1, 1987. If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please notify Oakland County at Oakland County Benefits Unit, 2100 Pontiac Lake Rd, Waterford MI 48328.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

MICHELLE'S LAW

Michelle's Law allows seriously ill or injured college students who are covered dependents under group health plans to continue coverage for up to one year while on medically necessary leaves of absence. More specifically, Oakland County cannot terminate coverage of a dependent child, as defined by Oakland County's Plan Document, due to a "medically necessary leave of absence" before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

A "dependent child" for these purposes is a beneficiary under the group health plan who:

- is a dependent child, under the terms of the plan or coverage, of a participant under the plan or coverage; and
- was enrolled in the plan or coverage, as a student at a post-secondary educational institution (including colleges and universities), immediately before the first day of the medically necessary leave of absence involved.

A "medically necessary leave of absence" means, with respect to a dependent child in connection with a group health plan or health insurance coverage offered in connection with such plan, a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that:

- commences while the child is suffering from a serious illness or injury;
- is medically necessary; and
- causes the child to lose student status for purposes of coverage under the terms of the plan or coverage.

Written certification must be provided by a treating physician of the dependent child to the Employee Benefits Unit of the Human Resources Department in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary (as defined above).

PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Oakland County has determined that the prescription drug coverage offered by Navitus and Health Alliance Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage with Oakland County will not be affected, as it remains your primary coverage. If you do decide to join a Medicare drug plan and drop your current [Insert Name of Entity] coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period. In addition, dropping your prescription coverage would also drop your medical coverage for you and your dependents.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Oakland County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty)

as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this Notice or your current prescription drug coverage contact Dean Shackelford at (248) 858-5212.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [Insert Name of Entity] changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/01/2011
Name of Entity/Sender: Oakland County Human Resources
Contact--Position/Office: Dean Shackelford
Address: Human Resources Bldg 41 W Employee Benefits
2100 Pontiac Lake Road, Waterford, MI 48328
Phone Number: (248) 858-5212

MEDICAL PLANS

Medical benefits are an important part of the *Natural Select* program. Oakland County is very aware of the different needs that each of us has for comprehensive medical coverage. It is understood that the medical plan you prefer may be different from the plan that your co-worker feels would be best for his/her needs. Some employees have no need for medical benefits, as they may have coverage elsewhere. This is why *Natural Select* offers you several comprehensive medical plan options from which to choose.

This workbook covers several different groups of employees. Please carefully review the information below to determine which plans are available to you.

Employees hired prior to May 31, 2003 may choose from the following medical plans:

- Blue Cross/Blue Shield Traditional Plan (for current enrollees only)
- Blue Preferred Provider Organization Plan (PPO)
- Blue Comprehensive Major Medical Plan (CMM)
- Health Alliance Plan (HAP) HMO
- No Coverage

Employees hired on or after May 31, 2003 may choose from the following medical plans:

- Blue Preferred Provider Organization Plan (PPO)
- Blue Comprehensive Major Medical Plan (CMM)
- No Coverage

All employees represented by the *Oakland County Deputy Sheriff's Association* may choose from the following medical plans regardless of hire date:

- Blue Cross/Blue Shield Traditional Plan (for current enrollees only)
- Blue Preferred Provider Organization Plan (PPO)
- Blue Comprehensive Major Medical Plan (CMM)
- Health Alliance Plan (HAP) HMO*
- No Coverage

***Corrections Deputies hired on or after 12/2/09 are not eligible for Health Alliance Plan**

Note: If you are not changing health plans but wish to add or delete a member from your contract, complete Open Enrollment - Membership and Record Change Form, found in the Appendix Form A.

Note: All dependents on your coverage must have the same health, dental, and vision coverage you do if they have any coverage at all.

BLUE CROSS/BLUE SHIELD TRADITIONAL PLAN

More information can be found at www.bcbsm.com

No new enrollments are allowed in the Traditional Plan. Once you leave the Traditional Plan, you cannot elect it again in the future.

The Blue Cross/Blue Shield Traditional Plan being offered under *Natural Select* is made up of two parts: basic and master medical.

The basic coverage provides benefits for inpatient hospital, physician, and laboratory services, as well as various outpatient surgical, medical, and laboratory services. Outpatient x-ray and laboratory services are covered with a \$5.00 or 10% co-payment, whichever is greater.

The master medical plan covers such items as office visits, durable medical equipment, and ambulance services, as well as extending coverage in certain circumstances when benefits under the basic portion are exhausted. Before the master medical plan provides reimbursement for eligible services, you must first satisfy a calendar year deductible of \$200 for a single person or \$400 for a family. The plan will pay 75% to 90% of the covered and approved expense.

Preventive services include routine pap, mammogram and PSA testing. Refer to the Medical Options comparison chart for details. Fertility treatments are not covered.

BLUE PREFERRED PLAN (PPO)

More information can be found at www.bcbsm.com

If you are changing to this plan, complete the Membership and Record Change Form, Form A, and the BCBSM COB form, Form D, which can be found at the back of this workbook and return it to the Employee Benefits Unit of the Human Resources Department.

The Blue Preferred Plan being offered under *Natural Select* consists of two parts: basic and master medical.

The basic coverage provides benefits for in-patient hospital, physician, and laboratory services, as well as for various outpatient surgical, medical, and laboratory services. In contrast to the Traditional Plan, outpatient x-ray and laboratory services are covered with no co-payments, as long as a participating Blue Preferred Plan provider is utilized.

The master medical plan covers such items as durable medical equipment and ambulance services, as well as extending coverage in certain circumstances when benefits under the basic portion are exhausted. Before the master medical plan provides reimbursement for eligible services, you must first satisfy a calendar year deductible of \$200 for a single person or \$400 for a family, and then the plan will pay 75% to 90% of the covered and approved expense.

In addition, certain services not covered by the Traditional Plan are covered under the Blue Preferred Plan. Well-baby care (to age one) and immunizations (to age six) are both covered with a \$20 co-payment. Further, office visits for illness and routine exams are also covered with a \$20 co-payment. Laboratory tests for routine exams are not covered.

Keep in mind that the Blue Preferred Plan is a Preferred Provider Plan (PPO) and, as such, differs from the Traditional Plan in that to receive the benefits you must use participating providers. Failure to do so can result in a 15% reduction in the amount the Blue Preferred Plan will pay. Unlike an HMO, however, you are free to see any of the participating doctors you wish without a referral, just like the Traditional Plan.

In most instances, the Blue Preferred Plan will result in less out-of-pocket expense for you when compared with the Traditional Plan while still allowing the freedom to choose from a large group of doctors.

Preventive services include routine physicals, well baby care, pap, mammogram and PSA testing. Refer to the Medical Options comparison chart for details. Fertility treatments are not covered.

COMPREHENSIVE MAJOR MEDICAL (CMM)

More information can be found at www.bcbsm.com

If you are changing to this plan, complete the Membership and Record Change Form, Form A, and the BCBSM COB form, Form D, which can be found at the back of this workbook and return it to the Employee Benefits Unit of the Human Resources Department.

The Blue Cross/Blue Shield Comprehensive Major Medical (CMM) Plan offered by Natural Select is similar to the Traditional Plan, but all services are paid through a major medical arrangement.

The CMM Plan covers inpatient and outpatient hospital care, surgical and diagnostic services, maternity care, x-rays, laboratory tests, and emergency care. There is an annual deductible of \$350 per individual/\$700 per family, applied to all covered services. After your annual deductible is met, the plan will pay 80% of the covered and approved expense(s). Your out-of-pocket expense maximum is \$1,000 per individual/\$ 2,000 per family. After that amount has been reached, most eligible services and charges that are usual, reasonable, and customary under the CMM Plan will be paid 100%.

Preventive services include routine pap, mammogram and PSA testing. Refer to the Medical Options comparison chart for details. Fertility treatments are not covered.

HEALTH ALLIANCE PLAN (HMO)

More information can be found at www.hap.org

If you are changing to this plan, complete the Membership and Record Change Form, Form A, which can be found at the back of this workbook and return it to the Employee Benefits Unit of the Human Resources Department.

As a reminder, the HAP option is not available to those employees hired on or after May 31, 2003 or Corrections Deputies hired after 12/02/09.

Health Alliance Plan (HAP) is a Health Maintenance Organization (HMO) and, as such, there are little or no out-of-pocket costs for hospital and physician care or diagnostic testing. In addition, well check-ups, immunizations, office visits (whether for illness or routine), and many other services are covered at a benefit level of 100% of usual, reasonable and customary charges, with a \$20.00 co-payment for every office visit and a \$25.00 co-payment for each emergency room visit.

Preventive services include routine physicals, well baby care, pap, mammogram and PSA testing. Refer to the Medical Options comparison chart for details.

It is important to recognize an HMO operates quite differently from the Traditional or PPO plan, in that a **primary care physician directs all of your care in an HMO**. You **must** have a referral from your primary care physician to see a specialist or receive other medical care. There are no out-of-network benefits.

Additional information and a list of participating providers are available at the Website noted above. Fertility treatments have limited coverage.

NO COVERAGE OPTION

If you are covered under another medical benefit plan, you may choose not to participate in any of the medical benefit plans available.

You must provide evidence you are enrolled in another medical plan by completing the medical portion of the Other Coverage Verification form, Form B, which can be found at the back of this workbook and returning it to the Employee Benefits Unit of the Human Resources Department no later than October 28, 2011. The “No Coverage” option will not be processed without a form on file. If we do not receive your form, your current coverage will continue. **You will not receive another reminder.**

Please note: If your spouse is providing your medical coverage **and** your spouse is also an employee of Oakland County, **your earnings** for the “No Coverage” medical option will be less. Refer to your Benefit Statement.

Thoughts To Consider

Think about the following questions when deciding which medical option is best for you:

- Are you or could you enroll in your spouse’s group medical plan? If so, perhaps you might consider electing the No Coverage Opt-Out option.
- Are you the provider of medical coverage for your dependents?
- Do you require medical attention frequently, or are you considered a healthy individual?
- Did you compare how the various plans differ in the areas where you generally require medical attention?

Health Care Reimbursement Account (HCRA)

Remember your medical plan is just one part of your *Natural Select* health care package. Your Health Care Reimbursement Account can play a significant role in limiting the cost for your health care needs. You can use your deposits to the HCRA to pay for prescription drug co-payments, deductibles, co-payments, and some other items not covered or not paid in full by your selected medical coverage. You can learn more about how to use the HCRA to your advantage by referring to the section on Health Care Reimbursement Accounts in this workbook.

PRESCRIPTION DRUG PLANS

BLUE CROSS BLUE SHIELD MEDICAL PLANS

This section applies to employees with the following medical plans:

- Blue Cross/Blue Shield Traditional Plan
- Blue Preferred Provider Organization Plan (PPO)
- Blue Comprehensive Major Medical Plan (CMM)

More information can be found at www.navitus.com.

The Navitus formulary, or preferred drug list, includes prescription drugs established to be clinically sound and cost effective by a committee of physicians and pharmacists. The Pharmacy and Therapeutics (P&T) Committee at Navitus evaluates which drugs to include and exclude from the formulary list. Experts evaluate prescription drugs based on the following criteria:

- Effectiveness
- Side-effects
- Drug interactions
- Cost

Formulary (preferred drug list) additions, exclusions and coverage changes are made at the discretion of physicians and pharmacists on the Navitus P&T Committee. On-going evaluation of new and existing prescription drugs ensures the formulary is up-to-date, and meets patient health needs.

Therapeutic class reviews, a review of a group of drugs that are chemically similar, and have the same effect in the body, may also be carried out at each P&T Committee meeting. At least once a year the Navitus P&T Committee reviews the entire formulary (preferred drug list).

A three-tier prescription drug program is in effect for Oakland County employees. Under the three-tier program, the amount of the co-payment varies as shown below:

- Tier 1 – This is your lowest cost option, including many generic medications and a few brand name drugs. Your co-payment for Tier 1 prescriptions is \$5.00.
- Tier 2 – This offers more brand name options, including preferred brands and some generics. Your co-payment for Tier 2 prescriptions is \$10.00.
- Tier 3 – This is your most costly option with non-preferred brand medications. If your drug falls in Tier 3, discuss other options with your pharmacist or physician to determine if an alternative, less expensive medication in Tier 1 or 2 is appropriate for you. Your co-payment for Tier 3 prescriptions is \$25.00.

If you request a prescription be filled with a brand name drug and there is a generic available, you will be responsible for the full cost differential between the cost of the brand and the co-pay of the generic drug. If your doctor makes the request, you will be responsible for the tier 3 co-payment.

More information about Navitus, including participating pharmacies and formulary information, can be found at www.navitus.com or by calling (866) 333-2757.

You can obtain a three (3) month supply of medication by mail order or through your local pharmacy with one (1) copayment. This works especially well with maintenance drugs that are prescribed to you. To enroll or obtain the necessary forms regarding the mail order prescription service, contact NoviXus at www.novixus.com and www.ocbenefits.com or by calling (888) 240-2211.

Certain drugs are handled by Navitus Specialty Rx. In the event your physician prescribes a specialty drug, you may contact Navitus Specialty Pharmacy directly at (800) 218-1488.

HAP MEDICAL PLAN

This section applies to employees with Health Alliance Plan (HAP) HMO.

More information can be found at www.hap.org

HAPs Ambulatory Pharmacy & Therapeutics Committee reviews and approves the drugs listed based on how well they work and how safe they are. If more than one drug is safe and works well in treating a disease in question, the committee will look at the cost of the drugs. The less expensive drug may be placed in a lower tier. Drugs may switch tiers without notice.

A three-tier prescription drug program is in effect for Oakland County employees. Under the three-tier program, the amount of the co-payment varies as shown below:

- Tier 1 – Most generic prescription covered drugs. Your co-payment for Tier 1 prescriptions is \$5.00.
- Tier 2 – Select brand prescription drugs. Your co-payment for Tier 2 prescriptions is \$10.00.
- Tier 3 – Brand prescription covered drugs with lower cost alternatives. This would include lifestyle prescription covered drugs (eg. Drugs for infertility, weight loss, erectile dysfunction) and injectable drugs. Your co-payment for Tier 3 prescriptions is \$25.00.

Members will pay the Brand Drug Copayment when a physician requests a Brand Drug as Dispensed as Written and a generic equivalent is available. Members, who request a Brand Drug when a Generic Drug is available, will be responsible to pay the Generic Copayment plus the difference between the cost of the Generic equivalent and the Brand Drug.

More information about HAP, including participating pharmacies and formulary information, can be found at www.hap.org or by calling (800) 422-4641.

With mail order you can obtain a three (3) month supply of medication with one (1) copayment. Mail order works especially well with maintenance drugs that are prescribed to you. At the local retail pharmacy, you may obtain 100 pills or a 35 day supply (whichever is greater) with one co-payment. Information regarding the mail order prescription service through Medco Health is available at www.medcohealth.com and www.ocbenefits.com.

MEDICAL OPTIONS COMPARISON

Important Note: The information contained on this comparison is intended to be an easy to read summary to help you and your family make choices among the different options available to you. Be sure to carefully study each option before making your choice. This comparison summarizes some of the provisions and certain features of each plan. It cannot modify or affect the coverage or benefits provided in any way. No right will accrue to you and/or your eligible dependents because of any statement, error or omission from this comparison. Its provisions do not constitute amendments, modifications or changes in any existing contract.

BENEFITS	<u>ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED</u> Blue Cross/Blue Shield Traditional Plan (BC/BS) Hospital and Medical/Surgical with Master Medical (MM)	<u>AVAILABLE TO ALL EMPLOYEES</u> Blue Cross/Blue Shield Comprehensive Major Medical (CMM) Comprehensive Major Medical Plan	<u>AVAILABLE TO ALL EMPLOYEES</u> Blue Preferred Plan (PPO) Hospital & Medical/Surgical with Master Medical (MM)	<u>NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER 5/31/03 or CORRECTIONS DEPUTIES HIRED AFTER 12/02/09</u> Health Alliance Plan (HAP) HMO
INPATIENT HOSPITAL CARE				
General Conditions ◆ Semi-Private Room ◆ Drugs ◆ Intensive Care Unit ◆ Meals ◆ Hospital Equipment ◆ Special Diets ◆ Nursing Care	120 days, 60-day renewal ; additional days under MM with no deductible, co-pays	80% after deductible	120 days, 60-day renewal; additional days under MM with no deductible, co-pay	Covered
OUTPATIENT HOSPITAL CARE				
Emergency Room ◆ Accidental Injuries ◆ Medical Emergencies	Covered Covered for approved diagnosis	80% after deductible 80% after deductible	Covered Covered	Covered; \$25 Co-pay Covered; \$25 Co-pay
Physical Therapy	60 consecutive days per condition; additional days under MM; 90% after deductible	80% after deductible	60 consecutive days per condition; additional days under MM, 90% after the deductible	Covered 60 combined annual visits per PT/OT/ST.
MENTAL HEALTH CARE				
Inpatient Mental Health Care	120 days (combined with inpatient care days), 60 day renewal; additional days under MM; no deductible, co-pays	80% after deductible	120 days (combined with inpatient care days), 60 day renewal; additional days under MM; no deductible, co-pays	Covered
Inpatient Substance Abuse Care Chemical Dependency	120 days (combined with inpatient care days), 60 day renewal; (no MM benefits)	80% after deductible	120 days, (combined with inpatient care days), 60 day renewal (no MM benefits)	Covered
Outpatient Mental Health Care	90% under MM after deductible	80% after deductible	90% under MM after deductible	\$20 Co-pay
Outpatient Substance Abuse Care Chemical Dependency	Covered 100% of approved amount, no Master Medical	80% after deductible	Covered 100% of approved amount, no Master Medical	\$20 Co-pay
SPECIAL HOSPITAL PROGRAMS				
Hospice Care	Covered up to a lifetime maximum that is adjusted annually	80% up to a maximum that is adjusted annually	Covered up to a lifetime maximum that is adjusted annually	Covered up to 210 days per lifetime.
Specified Human Organ Transplants	Covered up to program maximums in approved facilities	80% after deductible, in approved facilities	Covered up to program maximums in approved facilities	Covered if authorized

BENEFITS	<u>ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED</u>	<u>AVAILABLE TO ALL EMPLOYEES</u>	<u>AVAILABLE TO ALL EMPLOYEES</u>	<u>NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER 5/31/03 or CORRECTIONS DEPUTIES HIRED AFTER 12/02/09</u>
	Blue Cross/Blue Shield Traditional Plan (BC/BS) Hospital and Medical/Surgical with Master Medical (MM)	Blue Cross/Blue Shield Comprehensive Major Medical (CMM) Comprehensive Major Medical Plan	Blue Preferred Plan (PPO) Hospital & Medical/Surgical with Master Medical (MM)	Health Alliance Plan (HAP) HMO
MEDICAL AND SURGICAL CARE				
Surgery	Voluntary second surgical opinion on certain surgeries	80% after deductible; voluntary second surgical opinion on certain surgeries.	Voluntary second surgical opinion; \$20 Co-pay	Voluntary second surgical opinion; \$20 Co-pay
◆ Technical Surgical Assist. ◆ Anesthesia	Covered Covered	80% after deductible 80% after deductible	Covered Covered	Covered Covered
Maternity Care				
◆ Delivery ◆ Pre- and Post-Natal Care	Covered 90% under MM after deductible	80% after deductible 80% after deductible	Covered 100% under basic; no co-pay	Covered \$20 Co-pay per visit
Inpatient Medical Care	General-unlimited	80% after deductible	General — unlimited	Covered
Inpatient Consultations	Covered	80% after deductible	Covered	Covered
Emergency Care* (Physician)				
◆ Accidental Injuries ◆ Medical Emergencies * Life threatening emergencies	Covered	80% after deductible 80% after deductible	Covered	Covered - \$25 copay Covered - \$25 copay
Laboratory & Pathology	Covered-\$5 or 10 %co-pay	80% after deductible	Covered	Covered
Diagnostic Services	Covered-\$5 or 10 %co-pay	80% after deductible	Covered	Covered
Diagnostic and Therapeutic Radiology	Covered-\$5 or 10% co-pay	80% after deductible	Covered	Covered
ADDITIONAL BENEFITS				
Office Visits	90% under MM after deductible	80% after deductible	\$20 Co-pay	\$20 Co-pay***
Well-Baby Care	Not covered	Not Covered	\$20 Co-pay (up through 1 year)	\$20 Co-pay***
Chiropractic Services	20 Visits first 90 consecutive days, after 90 days limited to 2 visits per month.	Covered 38 visits per calendar yr	20 Visits first 90 consecutive days, after 90 days limited to 2 visits per month. \$20 Co-pay.	Not Covered
Immunizations	Not covered	Not Covered	\$20 Co-pay (up through age 6)	Covered
Allergy Testing	90% under MM after deductible	80% after deductible	Covered	\$20 Co-pay***
Allergy Therapy	90% under MM after deductible	80% after deductible	Covered	Covered
Ambulance Services	90% under MM after deductible	80% after deductible	90% under MM after deductible	Covered
Prosthetic Appliances	90% under MM after deductible	80% after deductible	90% under MM after deductible	Covered
Durable Medical Equipment	90% under MM after deductible	80% after deductible	90% under MM after deductible	Covered
Private Duty Nursing	75% under MM after deductible	80% after deductible	75% under MM after deductible	Not Covered
Skilled Nursing Facility	Covered	80% after deductible	Covered	Covered up to 730 days renewable after 60 days.
Assisted Reproductive Technologies	Not Covered	Not Covered	Not Covered	1 attempt of artificial insemination per lifetime.
Voluntary Sterilization	Not covered	80% after deductible	Covered	Covered
Routine Pap Smear	Covered	80% after deductible	Covered*	Covered
Routine Mammogram	Covered	80% after deductible	Covered	Covered

BENEFITS	<u>ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED</u> Blue Cross/Blue Shield Traditional Plan (BC/BS) Hospital and Medical/Surgical with Master Medical (MM)	<u>AVAILABLE TO ALL EMPLOYEES</u> Blue Cross/Blue Shield Comprehensive Major Medical (CMM) Comprehensive Major Medical Plan	<u>AVAILABLE TO ALL EMPLOYEES</u> Blue Preferred Plan (PPO) Hospital & Medical/Surgical with Master Medical (MM)	<u>NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER 5/31/03 or CORRECTIONS DEPUTIES HIRED AFTER 12/02/09</u> Health Alliance Plan (HAP) HMO
Routine Physical	Not covered	Not Covered	\$20 co-pay; labs not covered*	\$20 Co-pay
			*If a routine PAP smear and physical are performed separately, only one is covered in a 12 month period-not both.	***All services performed during one visit will be a one time \$20 Co-pay.
PROGRAM PROVISIONS¹				
Deductibles, Co-payments and Dollar Limitations	<u>Basic:</u> No deductible, co-pays as noted: <u>Master Medical:</u> Deductible; \$200 per person, \$400 per family per calendar year. <u>MM Co-payments:</u> 10% for general services (\$1,000 out-of-pocket maximum); 10% for mental health care (separate \$1,000 out of pocket maximum) and 25% for private duty nursing (separate from out of pocket maximums above). <u>Maximum:</u> None on Basic. \$1 million master medical additional benefits. \$1 million per member per covered type of organ transplant.	<u>Deductible:</u> \$350 per person, \$700 per family, per calendar year. Co-pays as noted. <u>Co-payments:</u> 20% general services (\$1,000 per person out of pocket max. \$2,000 per family max.); 20% mental health care and substance abuse treatment (separate \$1,000 per person out of pocket max, \$2,000 per family max); 20% private duty nursing (separate from out of pocket maximums above). <u>Maximum:</u> \$1 million per member per covered type of organ transplant. \$5 million per member lifetime other services.	<u>Basic:</u> No deductible, co-pays as noted: \$1 million maximum per covered type of organ transplant. <u>Master Medical:</u> Deductible; \$200 per person, \$400 per family per calendar year. <u>MM Co-payments:</u> 10% for general services (\$1,000 out-of-pocket maximum); 10% for mental health care (separate \$1,000 out of pocket maximum) and 25% for private duty nursing (separate from out of pocket maximums above). <u>Maximum:</u> \$5 million per member lifetime maximum.	Co-pays as noted
Payment of Covered Services	<u>Participating Hospitals:</u> 100% of covered benefits, less applicable co-pays.		<u>Preferred (Network) Hospitals:</u> 100% of covered benefits, less applicable co-pays.	Co-pays as noted.

<p>BENEFITS</p>	<p><u>ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED</u></p> <p>Blue Cross/Blue Shield Traditional Plan (BC/BS)</p> <p>Hospital and Medical/Surgical with Master Medical (MM)</p>	<p><u>AVAILABLE TO ALL EMPLOYEES</u></p> <p>Blue Cross/Blue Shield Comprehensive Major Medical (CMM)</p> <p>Comprehensive Major Medical Plan</p>	<p><u>AVAILABLE TO ALL EMPLOYEES</u></p> <p>Blue Preferred Plan (PPO)</p> <p>Hospital & Medical/Surgical with Master Medical (MM)</p>	<p><u>NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER 5/31/03 or CORRECTIONS DEPUTIES HIRED AFTER 12/02/09</u></p> <p>Health Alliance Plan (HAP)</p> <p>HMO</p>
	<p><u>Non-participating Hospitals:</u> Inpatient care in acute-care hospital-\$70 a day, less applicable co-pays. Inpatient care in other hospitals-\$15 a day, less applicable co-pays.</p> <p><u>Medicare Surgical:</u> 100% of BCBSM's approved amount, less applicable co-pays.</p>		<p><u>Non-Network Hospitals:</u> 85% of BCBSM's approved payment amount, less applicable co-pays (refer to non-participating under Traditional option).</p> <p><u>Preferred (Network) Physicians:</u> 100% of BCBSM's scheduled payment amount, less applicable co-pays.</p> <p><u>Non-network Physicians:</u> 85% of BCBSM's scheduled payment amount, less applicable co-pays.</p>	
<p>PRESCRIPTION DRUG PROGRAM</p>				
<p>NAVITUS</p> <p>(except HAP, which have their own prescription coverage).</p> <p>www.navitus.com</p> <p>NoviXus Pharmacy Services - Mail Order</p> <p>www.novixus.com</p> <p><i>Note: While in the hospital, all drugs are covered under your health plan.</i></p>	<p><u>NAVITUS</u> <u>Participating /Network Pharmacies:</u> Covered, co-pays, \$5 Most Generics/Some Brands; \$10 Preferred Brands/Some Generics; \$25 Non-Preferred Brands. Birth Control pills not covered.</p> <p><u>Non-participating/Non-network Pharmacies:</u> Paid at 75% of allowed cost, less \$5, \$10 or \$25 Co-pay.</p> <p><u>NoviXus</u> Also, available is the mail order program for drugs taken on a long-term basis. A three month supply can be ordered for a one month co-pay.</p>	<p><u>NAVITUS</u> <u>Participating /Network Pharmacies:</u> Covered, co-pays, \$5 Most Generics/Some Brands; \$10 Preferred Brands/Some Generics; \$25 Non-Preferred Brands. Birth Control pills covered.</p> <p><u>Non-participating/Non-network Pharmacies:</u> Paid at 75% of allowed cost, less \$5, \$10 or \$25 Co-pay.</p> <p><u>NoviXus</u> Also, available is the mail order program for drugs taken on a long-term basis. A three month supply can be ordered for a one month co-pay.</p>	<p><u>NAVITUS</u> <u>Participating /Network Pharmacies:</u> Covered, co-pays, \$5 Most Generics/Some Brands; \$10 Preferred Brands/Some Generics; \$25 Non-Preferred Brands. Birth Control pills covered.</p> <p><u>Non-participating/Non-network Pharmacies:</u> Paid at 75% of allowed cost, less \$5, \$10 or \$25 Co-pay.</p> <p><u>NoviXus</u> Also, available is the mail order program for drugs taken on a long-term basis. A three month supply can be ordered for a one month co-pay.</p>	<p><u>HAP</u> <u>Participating /Network Pharmacies:</u> *Covered, co-pays \$5 Most Generic; \$10 Select Brand name; \$25 Non-Preferred. Birth Control Pills covered.</p> <p><u>Non-Network Pharmacies:</u> Not Covered.</p> <p>If you request a prescription be filled with a brand name drug and there is a generic available, you will be responsible for the full cost differential between the cost of the brand and the co-pay of the generic drug. If your doctor makes the request, you will be responsible for the tier 3 co-payment.</p> <p>Also, available for maintenance drugs taken on a long-term</p>

BENEFITS	<u>ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED</u> Blue Cross/Blue Shield Traditional Plan (BC/BS) Hospital and Medical/Surgical with Master Medical (MM)	<u>AVAILABLE TO ALL EMPLOYEES</u> Blue Cross/Blue Shield Comprehensive Major Medical (CMM) Comprehensive Major Medical Plan	<u>AVAILABLE TO ALL EMPLOYEES</u> Blue Preferred Plan (PPO) Hospital & Medical/Surgical with Master Medical (MM)	<u>NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER 5/31/03 or CORRECTIONS DEPUTIES HIRED AFTER 12/02/09</u> Health Alliance Plan (HAP) HMO
	<p>Also, available for maintenance drugs taken on a long-term basis, a three-month supply can be obtained for a one-month co-pay at your local pharmacy.</p> <p><i>Please Note: All BCBS payments are based on approved amounts.</i></p>	<p>Also, available for maintenance drugs taken on a long-term basis, a three-month supply can be obtained for a one-month co-pay at your local pharmacy.</p> <p><i>Please Note: All BCBS payments are based on approved amounts.</i></p>	<p>Also, available for maintenance drugs taken on a long-term basis, a three-month supply can be obtained for a one-month co-pay at your local pharmacy.</p> <p><i>Please Note: All BCBS payments are based on approved amounts.</i></p>	<p>basis. A 35 day supply or 100 doses, whichever is greater, can also be obtained for one co-pay at your local pharmacy.</p> <p>A 90 day supply of maintenance drugs may be obtained through Pharmacy Advantage.</p>

Note: Hearing aids and services are not covered under any Oakland County medical plans.

¹At the time this booklet went to press, the impact of The Patient Protection and Affordable Care Act is still being evaluated and plan modifications may occur. Please refer to the www.ocbenefits.com website for the most up-to-date information.

DENTAL PLANS

Good dental care is important for the maintenance of your overall good health. Regular check-ups and cleanings help you stop small problems before they become big problems. *Natural Select* offers you a choice of dental coverage through **Delta Dental of Michigan** to meet the dental care needs for you and your family. The choice is yours.

Delta Dental PPO (Point-of-Service) is a national point-of-service program that, in most cases, offers you reduced costs for dental services if you receive care from any dentist who participates with Delta Dental PPO. However, if your dentist does not participate with Delta Dental PPO, you can also save by visiting a dentist who participates in another Delta Dental Program, Delta Dental Premier.

You may want to ask your dentist at your next visit whether they participate with Delta Dental PPO. You can find a list of participating dentists by going to www.ocbenefits.com and following the link to Delta Dental and selecting "Enrollees" and then "Find a Dentist".

Since Delta Dental PPO is part of the existing Delta Dental plan, it is essentially invisible to you in its operation and there are no choices to make during open enrollment time for *Natural Select*.

More information can be found at www.deltadentalmi.com.

YOUR DENTAL OPTIONS

You have four dental options to choose from to allow you to tailor your benefit plan to best suit your needs:

- High Option Plan
- Standard Plan – No cost to you.
- Modified Plan
- No Coverage

DENTAL BENEFITS

Your *Natural Select* dental plan provides the following choices:

<i>Service</i>	<i>High Plan</i>	<i>Standard Plan</i>	<i>Modified Plan</i>
Deductible			
Single	\$25	\$25	\$25
Family	\$50	\$50	\$50
Plan Pays			
Preventive	100%	100%	100%
Basic ⁴	85%	85%	50%
Major	50%	50%	50%
Orthodontia	50%	50%	50%
Maximum Benefit [†]	\$1,250 [‡]	\$1,000 [‡]	\$750 [‡]
Orthodontia Limit [§]	\$1,000	\$1,000	\$750

[†] Per individual per calendar year

[‡] All benefits based on maximum approved fees

[§] Per eligible member per lifetime

Endosteal implants are covered at the same level as other prosthodontic services and apply to the annual plan maximum. Oakland County provides for two routine cleanings or two periodontal cleanings covered at 100% per calendar year. There is also enhanced coverage for enrollees with certain high-risk medical conditions. For those with a condition, you may be eligible to receive up to four teeth cleanings in a calendar year instead of the typical two. In addition, for people undergoing head and neck radiation, fluoride applications by your dentist are covered twice per benefit year.

DENTAL PLAN DEFINITIONS

- **Preventive Services:** This category includes routine oral exams, cleanings and emergency treatment.
- **Basic Services:** This category includes fillings, x-rays, extractions, treatment of gum diseases, root canal therapy, oral surgery, periodontal maintenance crowns and relines and repairs to bridges and dentures.
- **Major Services:** This category includes endosteal implants and installation of full or partial dentures and bridgework.
- **Orthodontic Services:** Minor treatment for tooth guidance, full banding treatment, and monthly active treatment visits.

DENTAL PLANS

If you currently have “No Coverage” and you are electing a dental plan for the upcoming Plan Year, you must complete the Membership and Record Change Form, Appendix A, which can be found at the back of this workbook and return it to the Employee Benefits Unit of the Human Resources Department.

For all dental plans listed below, a \$25 single or a \$50 family deductible applies to Basic and Major services. The deductible does not apply to Preventive or Orthodontic services. There is no copayment on Preventive services and a 50% copayment applies to Major and Orthodontic services. Orthodontic services are for eligible members to age 19. Non-Orthodontic maximums are per person per calendar year; orthodontic maximums are per eligible member per lifetime.

The major differences between the dental plans are outlined below.

	<u>Non-orthodontic Benefit maximum</u>	<u>Orthodontic Benefit maximum</u>	<u>Copayment for Basic services⁴</u>
• The High Option Plan	\$1,250	\$1,000	15%
• The Standard Plan	\$1,000	\$1,000	15%
• The Modified Plan	\$750	\$750	50%
• No Coverage Option -- If you are covered under another dental plan, you may choose not to participate in an Oakland County <i>Natural Select</i> dental plan.			

You must provide evidence that you are enrolled in another dental plan by completing the dental portion of the Other Coverage Verification form, Form B, which can be found at the back of this workbook and returning it to the Employee Benefits Unit of the Human Resources Department no later than October 28, 2011. The “No Coverage” Option will not be processed without a form on file. **You will not receive another reminder.**

⁴There is no copayment for periodontal maintenance (cleaning)

Please note: If your spouse is providing your dental coverage **and** your spouse is also an employee of the County, **your** earnings for the “No Coverage” Dental option will be less. Please refer to your Benefit Statement.

YOUR CONTRIBUTIONS

The High Option Plan requires a contribution and the Standard Plan does not. If you choose the Modified Plan or the No Coverage Option, these amounts will show as earnings on your paycheck.

All dependents on your coverage, including eligible dependent children between their 18th and 26th birthdays, must have the same health, dental, and vision coverage as you do if they have any coverage at all. Contact the Employee Benefits Unit of the Human Resources Department for details.

Thoughts To Consider

Think about the following questions when deciding which dental option is best for you.

- If you are married, does your spouse have a dental plan that covers you and your family?
- Historically, what have your dental needs been?
- What do you project your future dental needs to be?
- What expenses can be paid for under the Health Care Reimbursement Account?

Health Care Reimbursement Account

Your Health Care Reimbursement Account (HCRA) is an important portion of your total health care program. As you review the dental plan options, remember that you can set aside money in the HCRA to pay for some of your dental care expenses not covered or not paid in full by your selected dental option such as employee copayments, deductibles and the cost for orthodontic services. With your HCRA, these expenses can be paid for on a pre-tax basis.

Because of the variety of provider payment plans available for orthodontic expenses, you are encouraged to contact our Health Care Reimbursement account administrator, WageWorks, at (800) 342-8017 prior to committing money to your Health Care Reimbursement Account (HCRA) to be sure that you will be reimbursed in the manner you request.

VISION PLANS

More information can be found at www.bcbsm.com

Oakland County has recognized the importance of good vision care by providing a comprehensive vision care program. *Natural Select* allows you the opportunity to select the option that best meets your family's personal vision care needs.

YOUR VISION OPTIONS

You can choose one of two vision options under the *Natural Select* program. Both plans are offered through Blue Cross and Blue Shield of Michigan and services must be through a participating provider to receive the benefits shown.

- The **Standard Plan which is no cost to you** offers you a vision examination for a \$5 co-payment and lenses and frames for a \$7.50 co-payment. These benefits are payable 24 months from the date you last incurred an expense for an examination, lenses or frames.
- The **High Plan** also offers you a vision examination for a \$5 co-payment and lenses and frames for a \$7.50 co-payment. However, these benefits are payable 12 months from the date you last incurred an expense for an examination, lenses or frames.

To maximize your benefits under the plans and limit your out-of-pocket expenses, lenses and frames must be from the approved BCBS selection. If you anticipate expenditures exceeding BCBS approved amounts, you might want to consider funding these by contributing to a Health Care Reimbursement Account.

All dependents on your coverage, including eligible dependent children between their 19th and 26th birthdays, must have the same health, dental and vision coverage you do if they have any coverage at all.. Contact the Employee Benefits Unit of the Human Resources Department for details.

You must select one of the vision options, as there is no opt-out (No Coverage) option for vision.

Additional information and a list of participating providers are available at the Blue Cross Blue Shield of Michigan Website noted above.

Note that going to an eye care provider that is not a Blue Cross Blue Shield of Michigan participating provider will result in reduced payment of benefits and higher out of pocket expenses.

YOUR CONTRIBUTIONS

The High Option Plan requires a contribution and the Standard Plan does not.

Health Care Reimbursement Account

Your Health Care Reimbursement Account (HCRA) is an important portion of your total health care program. As you review the vision plan options, remember that you can set aside money in the HCRA to pay for your vision care expenses not covered or not paid in full by your selected vision option such as employee co-payments, expenses for uncovered services, and the cost for an extra pair of glasses. With your HCRA, these expenses can be paid for on a pre-tax basis.

EMPLOYEE LIFE INSURANCE

Oakland County recognizes that life insurance is an important benefit for your family's financial security.

Life insurance through Oakland County is a Term Insurance plan administered by Aetna Life and Casualty. Loans are not available from the plan. Coverage for your spouse or dependent children is not available. There is no cash value.

YOUR EMPLOYEE LIFE INSURANCE OPTIONS

With *Natural Select*, you can select one of the four following levels of group term life insurance, to a maximum of \$400,000. **Each year you may increase your current life insurance coverage by one level without providing evidence of insurability.** Any increase of **more** than one level will require you to complete the Aetna Life Insurance (Statement of Health) form, Form C, which can be found at the back of this workbook showing evidence of good health and returning it to the Employee Benefits Unit of the Human Resources Department by October 28, 2011. Increases of more than one level will be subject to approval by the insurance company. The Employee Benefits Unit of the Human Resources Department must receive the questionnaire or your current coverage will continue. **You will not receive another reminder.**

- One times Annual Benefit Salary
- One and one-half times Annual Benefit Salary – Standard Plan is no cost to you.
- Two times Annual Benefit Salary
- Three times Annual Benefit Salary

At age 70, your coverage amount is reduced to 60% of your pre-age 70 amount; at age 75, it is reduced to 40% and at age 80 to 30% of your pre-age 70 amount.

The amount of insurance is determined by your Annual Benefit Salary as of August 26, 2011.

Aetna life insurance rates that are used to calculate your benefit costs for open enrollment are subject to change each Plan Year.

You must select one of the life insurance options, as there is not a No Coverage option for life insurance.

CONVERSION OF YOUR LIFE INSURANCE

If your life insurance ceases because your employment ceases or you are no longer in a class eligible for such insurance, the amount of insurance which ceases (or a lesser amount if desired) may be converted to an individual life insurance policy. Written application must be made for an individual policy and the first premium must be paid on it within 31 days after your life insurance ceases.

In order to convert to an individual life insurance policy, please contact Aetna at 866-282-8495.

TAX CONSIDERATIONS

Federal tax laws state that the first \$50,000 of group life insurance protection is not subject to taxes. Amounts in excess of \$50,000 are taxable. The government assigns a value to these amounts and this value is added to your W-2 earnings based on your age as of the end of a calendar year. These amounts are called Imputed Income and are calculated based on the following rate table:

Imputed Income Table	
Age Category	Monthly rate per \$1,000 of Employee Life Insurance
<25	\$0.05
25-29	\$0.06
30-34	\$0.08
35-39	\$0.09
40-44	\$0.10
45-49	\$0.15
50-54	\$0.23
55-59	\$0.43
60-64	\$0.66
65-69	\$ 1.27
70+	\$ 2.06

Example:

If your Annual Benefit Salary is \$30,000, you are or will be 43 years old at the end of the current calendar year, and you elect three times (3x) your salary of Employee Life Insurance coverage, your coverage amount would be \$90,000.

Imputed income applies to any amount over \$50,000 of life insurance. To calculate your imputed income for the year, follow these steps:

SAMPLE IMPUTED INCOME CALCULATION

1. Find the amount of Employee Life Insurance over \$50,000
example: $\$90,000 - \$50,000 = \$40,000$
2. Divide the difference in Step 1 by 1,000 (because the rate table is per \$1,000 of life insurance coverage basis).
example: $\$40,000 / 1,000 = 40$
3. Take the product of Step 2 and multiply it by the Imputed Income Rate. This rate is found by taking your age, at the end of the calendar year for the Plan Year you are doing the calculation for, finding which category it falls into within the Imputed Income Rate Table, and using that category's Imputed Income Rate found in the column next to the age category.
example: $\$0.10 \times 40 = \4
4. Finally, multiply the amount calculated in Step 3 by 12 (twelve months in a year), and this will be your Imputed Income (the amount that will be taxed) for the upcoming Plan Year.
example: $\$4.00 \times 12 = \48

Federal tax law currently states that benefits received in the event of your death are not taxable to your beneficiaries.

YOUR CONTRIBUTIONS

The County provides you with a life insurance benefit of one and one-half times your Annual Benefit Salary which requires no employee contributions. Selecting levels of coverage above that will require an employee contribution.

Selecting One (1) times your Annual Benefit Salary coverage will result in earnings on your paycheck.

SELECTING THE RIGHT AMOUNT

Only you can decide how much life insurance is right for your circumstances. The box below gives you some questions to think about which may help you decide how much life insurance you need.

Thoughts To Consider

- What would happen to your family without your pay? Would they have to alter their lifestyle?
- Is your income primary or secondary?
- Are there major payments to continue, such as a mortgage or car payment?
- Are you planning to pay for college for your child(ren)?
- Are your parent(s) depending on your support in their retirement years?

You should consider other resources that might be available when thinking about the above scenarios, including the following:

- Oakland County 401 (a) Plan.
- Oakland County 457 Deferred Compensation Plan.
- Oakland County Defined Benefits Retirement Plan.
- Social Security benefits.
- Life insurance policies you or your family may have purchased individually.
- Mortgage insurance.
- Personal savings you may have accumulated.
- Group term life insurance on your life provided through your spouse's employer.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

With *Natural Select*, you can choose a different level of Accidental Death and Dismemberment (AD&D) Insurance coverage than you selected for your life insurance protection. You may wish to obtain extra inexpensive coverage in case you die, or are dismembered, as a result of an accident.

AD&D insurance through Oakland County is a Term Insurance plan administered by Aetna Life and Casualty. Loans are not available from the plan. Coverage for your spouse or dependent children is not available.

YOUR AD&D OPTIONS

You can choose one of the four coverage options listed below to a maximum of \$400,000.

- One times Annual Benefit Salary – Standard Plan is no cost to you
- One and one-half times Annual Benefit Salary
- Two times Annual Benefit Salary
- Three times Annual Benefit Salary

The amount of insurance is determined based on your Annual Benefit Salary as of August 26, 2011. At age 70, 75, and 80, benefits reduce in accordance with the same schedule as your Life insurance.

You must elect one of the AD&D options as there is not a No Coverage option for Accidental Death & Dismemberment Insurance.

AD&D BENEFITS

If you suffer bodily injury caused by an accident; and if, within 90 days after the accident as a direct result of the injury, you lose:

- Your life.
- A hand, by actual severance at or above the wrist joint.
- A foot, by actual severance at or above the ankle joint.
- An eye, involving irrecoverable and complete loss of sight in the eye.
- Your speech or hearing; the loss must be total and deemed permanent.
- Your thumb and index finger of the same hand, by actual severance of entire digit. Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If your accident causes you to lose your life, your beneficiary will receive the AD&D amount you selected. This AD&D amount will be in addition to your Employee Life Insurance amount. Payment for all other losses are payable to the participant. The amount payable is determined by the loss incurred. The amount payable as well as exclusions that apply can be found in the Summary Plan Description.

YOUR CONTRIBUTIONS

The County provides you with AD&D insurance in the amount of one times your Annual Benefit Salary which requires no employee contribution. Selecting levels above that will require an employee contribution.

The employee contributions listed on your Benefit Statement represent the total cost for providing each option for a Plan Year.

Aetna AD&D insurance rates that are used to calculate your benefit costs for open enrollment are subject to change each Plan Year.

Thoughts To Consider

- Are you in the family formation years and desire additional, inexpensive protection in case of your accidental death?
- Do you travel frequently?
- Do you engage in activities that could result in an accidental death?

REIMBURSEMENT ACCOUNTS

TAX ADVANTAGES

Oakland County *Natural Select* offers a Health Care Reimbursement Account and a Dependent Care Reimbursement Account administered, for claims incurred beginning January 1, by WageWorks. Any remaining claims you have incurred against your 2011 account should continue to be sent to Professional Benefits Services as before. A Reimbursement Account enables you to pay for certain out-of-pocket health care or dependent care expenses before Social Security, federal, state, and local income taxes are calculated and withheld from your pay. Contributing to a Reimbursement Account reduces your taxable income, lowering your taxes, and may also lower future Social Security benefits you may become eligible for.

HOW A REIMBURSEMENT ACCOUNT WORKS

First you determine how much money you would like to place in the account(s). You can use the calculator at <https://www.wageworks.com/employee/calculators.htm> to help you determine the amount to place in the account(s). You elect the amount you want deducted from your pay each pay period. This election will remain in effect for the entire Plan Year.

Throughout the year when you incur an eligible health care or dependent care expense, pay for it as you normally would. Then simply complete a Pay Me Back Claim online at <http://www.wageworks.com> or fax your Pay Me Back Claim Form and any necessary documentation to 1-855-291-0625. You may use Pay My Provider online to pay for eligible expenses directly such as orthodontia, doctor's visits or hospital bills.

You can make claims against the total amount you elected to contribute to your Health Care Reimbursement Account. However, you will only be reimbursed up to the amount already deducted from your pay for dependent care claims. You will receive a check or direct deposit once the claim has been processed.

As long as you are an active employee you can request reimbursement for health care expenses incurred until March 15 of the year following your original election. Dependent claims must be incurred in the original Plan Year. You have until April 30 of the following year to submit a claim for either account. Reimbursement Accounts by law are "use it or lose it"; any monies not used are forfeited. You may keep track of your account(s), submit claims and/or download claim forms online at <http://www.wageworks.com>.

Reimbursement Account elections are for the entire Plan Year. However, you may be able to change your payroll deduction amount during the Plan Year if you have a qualified Change in Status (CIS). IRS-approved changes include: a change in marital status, a change in number of dependents, the termination or commencement of employment by the employee, spouse, or dependent, a reduction or increase in hours worked by the employee, spouse, or dependent, a dependent satisfying or ceasing to satisfy the plan eligibility requirements, and a change in place of residence or work of the employee, spouse, or dependent. In addition, IRS defines a CIS for the Dependent Care Reimbursement Account as the death of a dependent parent or a change in your spouse's student status. The IRS requires that the change in benefits must be consistent with the CIS. All requests for changes in benefits as a result of a CIS must be reviewed and approved by the Employee Benefits Unit of the Human Resources Department. You only have 30 days from the date of the CIS to notify the Employee Benefits Unit of the Human Resources Department of your status change event. If you do not notify them within this time frame, you cannot change your Plan Year elections. Current elections will remain in effect until the end of the Plan Year or until another CIS occurs (whichever comes first).

HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)

Unsure whether or not to participate in the Health Care Reimbursement Account? Consider the following:

- Do you typically incur and pay your medical plan deductible each year for yourself or an enrolled dependent?
- Do you have extensive dental expenses not covered under a dental plan?
- Are you or one of your dependents planning to get new glasses or contact lenses?
- Do you have any other medical, dental, vision or hearing expenses not covered under any insurance plan such as co-payments and co-insurance?

If you have any of these expenses, or other recurring eligible medical expenses an HCRA may be right for you.

Each calendar year you can contribute between \$4 and \$192 per pay period to the HCRA for eligible expenses. Eligible health care expenses are out-of-pocket health care expenses incurred by you, your spouse and any eligible dependents within the IRS guidelines and not reimbursed by your medical, prescription drug, dental or vision coverage. IRS Publication 502 provides the most current requirements regarding who is an eligible dependent.

If you separate from County employment, you have until April 30th following the end of the Plan Year to submit your requests for Health Care and Dependent Care reimbursements. Only covered health care expenses incurred prior to your date of separation of your County employment are eligible for reimbursement consideration

Eligible Expenses

Below are some expenses generally eligible for reimbursement under an HCRA. Please refer to Section 213(d) of the Internal Revenue code for the IRS definition of deductible medical expenses that are eligible for reimbursement or contact Customer Service at 1-877-WageWorks (877-924-3967) for more details.

Eligible Health Care Expenses

Acupuncture	Osteopathic services
Ambulance	Oxygen equipment
Artificial limbs	Physical examination
Bandages	Physician
Braille books & magazines	Physiotherapist
Breast pumps	Podiatrist
Birth control pills	Prescription drug(s)
Chiropractor	Psychiatric care
Crutches	Psychologist
Drugs and medicines (with a doctor's prescription)	Psychoanalysis
Fertility treatment	Surgery
Guide dog or other animal	Telephone/television for hearing impaired
Hearing devices	Therapy/counseling
Hospital services	Transplants
Laboratory fees	Vasectomy
Medical services	Weight-loss programs (prescribed by a physician to treat a specific illness)
Medical supplies	Wig to replace hair lost to disease
Nursing services	X-ray
Operations	

Eligible Dental Expenses

Artificial teeth: caps	Orthodontia *
Dentures	Root canals

* **Orthodontia note:** Due to the variety of provider payment plans available for orthodontic expenses, you are encouraged to contact Customer Service at 1-877-WageWorks (877-924-3967) for specific reimbursement requirements.

Eligible Vision Expenses

Contact lenses	Eye surgery: Lasik
Eyeglasses/reading glasses	Optometrist
Eye examinations	Prescription sunglasses

Ineligible Expenses

Automobile insurance premiums	Health club membership or exercise class (unless prescribed by a doctor to treat a specific medical condition)
Contact lens service contracts	Insurance premiums for other medical, dental or supplemental coverage
Cosmetic surgery or similar procedures	Long-term care services or premiums
Cosmetics, toiletries, toothpaste, mouthwash feminine products	Over the counter drugs and medicine without a prescription
Electrolysis or hair removal	Teeth whitening/bleaching
Hair transplants, hair re-growth treatments	Sunglasses
Herbal supplements	Weight loss programs or medication to promote general health

OVER-THE-COUNTER MEDICATION CHANGE

The Health Care Reform law passed on March 23, 2010 requires any Over-the-Counter drug and/or medicine be prescribed by your physician to be eligible for reimbursement. Over-the-Counter items that are not drugs or medicines, such as bandages, breast pumps, blood pressure cuffs and contact solution can be purchased without a prescription. Examples of items typically covered through your flexible spending accounts can be found at www.wageworks.com/employee/health-care/expenses/fsa.htm or you can contact Customer Service directly at 1-877-WageWorks (877-924-3967) for more information.

PLANNING YOUR ACCOUNT

To plan the right amount in your Health Care Reimbursement Account for you during the Plan Year, consider the following possible expenses and complete the guide below.

Medical plan deductible(s) and co-pays	\$ _____
Dental expenses	\$ _____
Vision care expenses	\$ _____
Prescription drug co-payments	\$ _____
Other expenses	\$ _____
TOTAL (See note below)	\$ _____

Make sure that your TOTAL amount is not more money than you expect to use in a Plan Year or you will lose whatever is left over*.

Divide by number of pay periods	÷ 26
Round to nearest whole dollar (to a maximum of \$192) for your per pay period deduction.	\$ _____

In accordance with IRS regulations, any expenses incurred from January 1, 2012 through March 15, 2013 can be reimbursed with any unused prior Plan Year money; in this case, unused money from the 2012 Plan Year. Please refer to page 42 for information on submitting claims for reimbursement.

* Except for distributions after June 18, 2008 as provided under IRS Notice 2008-82 (Distribution to Reservists).

Thoughts to Consider

To assist you in deciding whether or not to participate in the Health Care Reimbursement Account, consider the following:

- Do you typically incur and pay your medical plan deductible each year for yourself or an enrolled dependent?
- Do you have dental expenses not covered under a dental plan?
- Are you or one of your dependents planning to get new glasses or contact lenses?
- Do you have any other medical, dental, vision or hearing expenses not covered under any insurance plan such as co-payments and co-insurance?

Your Choices

- You may select any qualifying dollar amount from a minimum of \$4 per pay to a maximum of \$192 per pay per period Plan Year.
- You may choose not to participate in the benefit.

DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

Unsure whether or not to participate in the Dependent Care Reimbursement Account? Consider the following:

- Do you have children under the age of 13 who require day care so you and your spouse can work?
- Are you a single parent with a child that requires day care so you can work?
- Do you pay for day care, before or after-school care so you can work full-time? (if you have a spouse, he/she either works full-time or is considered to be a full-time student)

If you have any of these expenses, or other recurring eligible dependent care expenses a DCRA may be right for you and your dependents.

Each calendar year you can contribute between \$4 and \$192 per pay period to a DCRA for your eligible expenses to care for your qualified dependents, which allow you (and your spouse, if you are married) to work. The caregiver can even be a relative of yours, as long as he or she is not also one of your dependents for tax purposes. Also, you are required by law to provide your caregiver's Federal Tax ID number or Social Security number. Your caregiver does not need to be licensed, but must claim your payments as income.

IRS regulations identify eligible dependents as:

- A child (including adopted children, stepchildren, and foster children) under age 13, who qualifies as your tax dependent
- A person who is physically or mentally incapable of self-care (for example, a child or elderly parent living with you), who qualifies as your tax dependent
- A spouse who is physically or mentally incapable of self-care.

If you separate from County employment, you have until April 30th following the end of the Plan Year to submit your requests for Dependent Care reimbursements. Dependent care expenses may be incurred after contributions cease and after separation for the remainder of the Plan Year. Please refer to page 42 for information on submitting claims for reimbursement.

Eligible Dependent Care Expenses

IRS regulations define eligible expenses as those dependent care expenses "incurred to enable the taxpayer to be gainfully employed". You may contact Customer Service at 1-877-WageWorks (877-924-3967) for more details. These expenses may include:

Adult day care center	Day care center (e.g. Little Oaks)
Babysitter in your home	Senior center
Before and/or after-school care	Summer camp

Ineligible Expenses – Even if Incurred on Behalf of a Dependent

Clothing	Insurance premiums
Food	Medical equipment
Health care expenses	Sleep-away summer camps

PLANNING YOUR ACCOUNT

To calculate the right amount for your Dependent Care Reimbursement Account for you during the Plan Year, complete the guide below. Dependent care expenses can only be reimbursed to the extent of your payroll deductions to date at the time you submit the expense for payment.

Cost of care per week	\$ _____
Times number of weeks needed	x _____
TOTAL (See note below)	\$ _____

Make sure that your TOTAL amount is not more money than you expect to use in a Plan Year or you will lose whatever is left over.

Divide by number of pay periods ÷ 26

Round to nearest whole dollar (to a maximum of \$192) for per pay period deduction. \$ _____

Thoughts to Consider

To assist you in deciding whether or not to participate in the Dependent Care Reimbursement Account, consider the following:

- Do you have a child(ren) under the age of 13, who requires caregiving services, to enable you (and your spouse, if married) to work outside the home?
- Do you have a disabled spouse for whom you must provide care to enable you to work?
- Do you have a parent who is incapable of self-care who qualifies as your tax dependent?
- Did you compare the Federal Tax Credit vs. the Reimbursement Account to see which is best for you? (See the worksheet at the end of this workbook.)

Your Choices

- You may select any qualifying dollar amount from a minimum of \$4 per pay to a maximum of \$192 per pay period for a Plan Year.
- You may choose not to participate in this benefit.

FEDERAL TAX CREDIT VS. DEPENDENT CARE REIMBURSEMENT ACCOUNT

The maximum amount you are eligible to deduct in any taxable year may not exceed the lesser of your earned income, or up to \$5,000 combined income if you are married; amounts are per family, not per plan. If you and your spouse file separate tax returns, you are each limited to an annual reimbursement account limit of \$2,500. If your spouse is a student continuing his/her education, the IRS limits the amount of earned income that will affect the amount of your contribution. Some higher paid employees may be restricted to lower limits for this reimbursement account.

You may be claiming a Federal Tax Credit for childcare expenses now. Use the following worksheets to see if the Federal Tax Credit or the Dependent Care Reimbursement Account is best for you. You may also use the calculator at www.ocbenefits.com/fsa.html.

<https://www.wageworks.com/employee/calculators.htm> or contact your tax preparer.

Federal Tax Credit for Dependent Care Expenses: Calculating the Federal Tax Credit

1. The estimated annual dependent care expenses (cannot exceed the lesser of your income or that of your spouse). \$ _____
2. Maximum expenses eligible for tax credit (\$3,000 for one dependent, \$6,000 for more than one dependent) \$ _____
3. Estimated adjusted gross income for you and your spouse \$ _____
4. Tax credit percentage from Table 1 below, based on adjusted gross income _____%
5. Estimated tax credit (multiply line 4 by the smaller of line 1 or line 2) \$ _____

Table 1	
Adjusted Gross Income	Tax Credit Percentage
Up to \$15,000	35%
15,001-17,000	34%
17,001-19,000	33%
19,001-21,000	32%
21,001-23,000	31%
23,001-25,000	30%
25,001-27,000	29%
27,001-29,000	28%
29,001-31,000	27%
31,001-33,000	26%
33,001-35,000	25%
35,001-37,000	24%
37,001-39,000	23%
39,001-41,000	22%
41,001-43,000	21%
43,001 and over	20%

TAX SAVINGS CALCULATOR

Calculating Withholding Tax Savings Using the Reimbursement Account

1. The amount of deposit to your Dependent Care Reimbursement Account must not exceed the lesser of your income, or that of your spouse's or \$4,992 (\$2,500 if married but filling separate returns) \$ _____
2. Marginal Federal tax rates (using your combined annual income for you and your spouse) from Table 2 below _____%
3. Social Security tax rate: Enter 5.65% if your annual salary is equal to or less than the Social Security annual wage base maximum (\$106,800). Otherwise, enter 1.45% _____%
4. State tax rate _____%
5. City tax, if applicable _____%
6. Total tax rate (add lines 2,3,4, and 5) _____%
7. Estimated tax savings (multiply line 1 by line 6) \$ _____

Table 2			
Single		Married	
Income	Tax Rate**	Income	Tax Rate
Up to \$8,500	10%	Up to \$17,000	10%
\$8,500-\$34,500	15%	\$17,000-\$69,000	15%
\$34,500-\$83,600	25%	\$69,000-\$139,350	25%
\$83,600-\$174,400	28%	\$139,350-\$212,300	28%
\$174,400-\$379,150	33%	\$212,300-\$379,150	33%
\$379,150 and over	35%	\$379,150 and over	35%

Comparing the Calculations

After you have estimated your dependent care expenses, calculate the Federal Tax Credit and the withholding tax savings, and compare the two calculations. You can then make an informed choice as to which alternative is best for you.

The Federal Tax Credit is for federal income tax purposes and does not include Social Security or state taxes.

** Federal Tax Rates (in effect as of 04/2011)

REIMBURSEMENT ACCOUNT CLAIM PROCEDURES

If you elect to participate in a Health Care Reimbursement Account and/or Dependent Care Reimbursement Account, you will receive claim filing instructions and claim forms before the Plan Year begins, directly from WageWorks. This is a new company for 2012. Your elected amount will also be included and should be checked for accuracy.

Your request for reimbursement will be processed within five business days, provided no additional information is required, from the time your properly completed and signed claim form is received. Reimbursement checks are mailed, or direct deposited into your bank account, within 48 hours of claim approval.

Receipts for Health Care Reimbursements need to include:

- Name of patient
- A list of services
- The date of each service listed
- Name of provider
- What insurance will pay (an Explanation of Benefits – EOB) or proof of payment

Receipts for Dependent Care Reimbursements need to include:

- Name of employee
- Name and address of provider
- The date of each service listed
- Federal Tax ID number or social security number of provider
- Proof of payment (receipt) from provider

If your reimbursement claim is denied, a letter will be mailed to your home explaining the reason(s) for the denial.

If you have any questions concerning the reimbursement of a Health Care and/or Dependent Care expense, you can call Customer Service toll-free at 1-877-WageWorks (877-924-3967).

Claims for reimbursement can be faxed to 1-855-291-0625 or submitted online at <http://www.wageworks.com>. Online you may also use the Pay My Provider option to pay you, and your dependents, eligible expenses directly from your Health Care or Dependent Care Reimbursement Account. You may also mail your Claim Form to:

Claims Administration-FBWW
PO Box 14326
Lexington, KY 40512

If you need a Pay Me Back Claim Form for Health Care and/or Dependent Care expenses, or a Direct Deposit Authorization Form, you can download one from www.ocbenefits.com or www.wageworks.com.

All requests for changes to your Health Care Reimbursement and/or Dependent Care Reimbursement Account amounts during a Plan Year must be reviewed in accordance with IRS guidelines and approved by the Employee Benefits Unit of the Human Resources Department within 30 days from the date of the event.

Consider both accounts carefully. Utilizing the accounts requires a little planning, but the tax savings could make the planning effort worthwhile.

DISABILITY BENEFITS

Although not currently a part of the *Natural Select* program, the County provides both non-occupational short- and long-term disability income protection in the event you are totally disabled and unable to work due to a non-occupational injury or illness. The chances of being disabled are small, but the financial consequences can be serious. Hospital and medical expenses are generally covered by your medical plan, but what about your paycheck? If you are unable to work, where will you get the money on which to live? The non-occupational disability payments continue until you die, recover, or reach age 65, whichever occurs first. Disabilities which begin after age 60 are paid for varying lengths of time, depending on the age you became disabled.

Your non-occupational disability plans provide for replacement of 60% of your salary. Because this coverage is provided totally by the County, any benefits paid will be taxable income.

Initially, you will be deemed to be disabled if you are not able, solely because of disease or injury, to perform the material duties of your own occupation. This definition applies to the first two years of benefit payments. Thereafter, payments will continue only if you found unable to work at any reasonable occupation.

Social Security and other income benefits paid to you and your family are included in the benefit percentage amount. Your non-occupational disability plan makes up the difference between the Social Security and other income benefits and the benefit percent of pay.

The monthly benefit maximum payment from all sources is \$8,000 per month.

As long as the short term disability claim is approved, health benefits are continued and the biweekly health contributions will go into arrears until you return to work. At such time, the past due deductions are taken out of your payroll check at a maximum \$300.00 increments.

Keep in mind, you can supplement disability payments with your leave banks to decrease the amount owed when returning to work.

You become eligible after you have completed six (6) consecutive months of service since the date of your most recent hire. A pre-existing condition investigation will apply to employees who file a claim within the first 18 months of County employment. Pre-existing conditions are not covered during the first 18 months of employment.

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

Plan B employees are covered by a different non-occupational short-term disability program, and are not eligible for non-occupational long-term disability.

Important Note: If your disability is expected to last more than 7 consecutive calendar days (the waiting period), you must obtain the necessary forms from your department, www.ocbenefits.com, or the Employee Benefits Unit of the Human Resources Department. You have 30 calendar days from your first day off work to return the forms completed by you and your doctor to the Employee Benefits Unit of the Human Resources Department. Failure to return the forms within the 30 days shall result in ineligibility to receive this benefit. Due to the uncertainties connected with doctors' offices, you are strongly encouraged to contact the Employee Benefits Unit prior to the deadline to ensure they have been received.

Employees receiving Short Term Disability benefits must keep their own department/division, as well as the Human Resources department, informed at all times as to the status and expected duration of their condition.

IMPORTANT INFORMATION

BENEFIT STATEMENT

You have received a personalized Benefit Statement with this workbook. The Benefit Statement shows your current coverage elections and contributions, what options are available to you for the coming year with their associated prices, and all of your current covered dependents. Use your Oakland County ID# and open enrollment password found at the top of your Benefit Statement to enroll in *Natural Select* 2012, found at www.ocbenefits.com. Please note that for security purposes your password changes every year.

PERSONAL REFERENCE WORKSHEET

In the Appendix is a Personal Reference Worksheet, Form E. This form is designed to aid you in enrolling on the website and determining the cost. Once you have recorded the option and corresponding employee contributions or earnings for each benefit you should total your employee contributions and/or earnings, including those to your reimbursement accounts.

Take a moment now to review the selections you have made.

- Did you accurately record your selections on your Personal Reference Worksheet?
- Do the employee contributions or earnings that you have recorded match your chosen options?
- Are your Reimbursement Account deductions recorded properly?
- Did you correctly add up your employee contributions and or earnings?

Retain your Benefit Statement and *Natural Select* Personal Reference Worksheet for your records.

HOW TO ENROLL

The enrollment website, www.ocbenefits.com, is available 24 hours a day beginning **Wednesday September 28, 2011, through Wednesday October 12, 2011.**

Proceed as follows:

- Access the Website
 - From your home computer at www.ocbenefits.com
- **Or**
 - From My.OakGov, left click on “Human Resources” at the top of the page and then left click on “Benefits & Retirement” on the left side of the page.
- Left click on “Active” Employee.
- Left click on “*Natural Select*” option in the middle of the page that you wish to view.
- Finally, left click on “Enrollment 2012”
- Follow the instructions, which will begin with the entry of your Employee Identification Number and 2012 Open Enrollment Password (found on your Benefit Statement).
- Verify your dependents.
- Check the “agree” box on the left bottom side; and
- Print the screen for your records
- Click on the “next” button.
- Make your elections using the information you have recorded on your Personal Reference Worksheet.
- Click on the “submit” button and print a copy of the screen for your records.

Retain your screen print, Benefit Statement and Personal Reference Worksheet for your records.

Important Reminders

- The *Natural Select* Website is available 24 hours a day.
- Verify your dependents.
- Remember to click on the “Submit” button and print a copy for your records.
- Your benefits are recorded at the Website, so your worksheets are for your files.
- If you do not enroll through the Website you will keep all of your current benefit selections.

CONFIRMATION STATEMENT

If you make changes to your current benefit elections, you will receive a Confirmation Statement with which to verify your selections.

Please review the Confirmation Statement carefully to ensure that your selections were recorded properly. If a change is necessary, you must call the Employee Benefits Unit of the Human Resources Department no later than October 28, 2011. A member of the Employee Benefits Unit of the Human Resources Department will assist you.

Keep the confirmation statement for your records. This is verification that you made changes to your 2012 coverages.

No changes will be accepted beyond October 28, 2011.

If you are making any changes to your medical coverage or are enrolling in dental coverage, you must complete and return the Membership and Record Change Form, Form A, which can be found at the back of this workbook, to the Employee Benefits Unit of the Human Resources Department no later than October 28, 2011. Your selections cannot be processed until this form is received.

In addition, if you are selecting the “No Coverage” option for medical and/or dental, you must complete the Medical and/or Dental Plan sections found on the Other Coverage Verification, Form B and return it to the Employee Benefits Unit of the Human Resources Department no later than October 28, 2011. The “No Coverage” option will not be processed without a form on file.

You will not receive another reminder.

APPENDIX

MEMBERSHIP AND RECORD CHANGE FORM A

WHEN ADDING DEPENDENTS TO MEDICAL DENTAL OR VISION COVERAGE OR ENROLLING IN
COVERAGE FROM A NO COVERAGE OPTION.
IF COMPLETING THIS FORM FOR ENROLLING IN A BCBS PLAN, COMPLETE FORM D ALSO.

OTHER COVERAGE VERIFICATION.....B

WHEN ELECTING THE “NO COVERAGE” MEDICAL AND/OR DENTAL OPTION

AETNA LIFE INSURANCE - STATEMENT OF HEALTH..... C

WHEN ELECTING TO INCREASE YOUR LIFE INSURANCE BY MORE THAN ONE LEVEL

BCBS COORDINATION OF BENEFITS INFORMATION..... D

TO RECORD YOUR COORDINATION OF BENEFITS INFORMATION WITH BCBS

PERSONAL REFERENCE WORKSHEETE

RETURN ALL FORMS NO LATER THAN OCTOBER 28, 2011 TO:

Executive Office Building
Human Resources Department
Employee Benefits Unit
Oakland County Bldg. 41W
2100 Pontiac Lake Road
Waterford, MI 48328

Oakland County

Act/Rsn ____ Mbr Chg ____
DPDT ____ DE ____

Open Enrollment - Membership and Record Change Form

CHOOSE ONE:

- I am enrolling in HAP coverage (please complete the ADD section below to list all dependents to be covered and their HAP Code.
Employee HAP#/Physician Code: _____
- I am enrolling in Medical coverage from a no coverage status. (Please complete the ADD section below to list all dependents to be covered.)
- I am enrolling in Dental Coverage from a no coverage status. (Please complete the ADD section below to list all dependents to be covered.)
- I wish to make the following changes to my current coverage. (Please complete the appropriate sections below.)

PERSONAL INFORMATION:

Subscriber's Last Name _____ Subscriber's First Name _____ M.I. _____ Date of Birth ____/____/____

SSN _____ EMPLOYEE ID# _____ Telephone: Home / Work _____

Home Address _____ Street _____ City _____ State _____ Zip _____

ADD* Members to contract (additions)					If enrolling in HAP -
Name (last, first)	Relationship*	Date of Birth	SSN (Required)	Gender	Include Physician Code
	Spouse*				
	Child**				
<input type="checkbox"/> Child by legal guardianship or adoption (attach legal papers)**					

***You must attach marriage license of spouse and/or birth certificate(s) of all children being added.**

****You must attach a copy of a birth certificate to add a child or the legal supporting documentation with this form which includes legal guardianship papers from Court Order. If you are adding a new spouse and their child(ren), you must include both marriage and birth certificates.**

For any child named above, is there a court order saying which parent is responsible for providing health insurance? **If yes, attach a copy of the court order.**

Yes If "YES", Father
 No which parent? Mother

REMOVE members from contract (deletions). Please fill out "Supplemental Form" for COBRA.

Event	Name (last, first)	Relationship	Date of Birth	SSN (Required)	Gender
<input type="checkbox"/> Divorce from		Spouse			
<input type="checkbox"/> Death of Dependent					
<input type="checkbox"/> Dependent/ Misc					
<input type="checkbox"/> Other					

I certify the above information is true and correct to my knowledge and belief. I have provided the required legal documents to add dependents to my coverage and certify that they do not have other coverage available through their own or their spouse's employer. Improperly enrolling or continuing coverage for an ineligible spouse or child may result in both recovery of improperly paid claims and potential disciplinary action, up to and including termination, if determined to be inaccurate.

Subscriber's Signature _____ Date _____

HR DEPARTMENT USE ONLY

Group Authorization Signature _____ Effective Date _____ Group/Suffix: _____



OTHER COVERAGE VERIFICATION

Complete only if Medical and/or Dental "No Coverage" Option(s) is selected.

Your Employee ID #

Your Social Security Number

Your Name Printed

Medical:

I wish to select "NO COVERAGE" as my **Medical** Plan option through Oakland County.

I am currently enrolled in _____
(Name of Medical Plan)

through my _____ 's coverage with _____
(Relationship) (Name of Company or Organization)

Dental:

I wish to select "NO COVERAGE" as my **Dental** Plan option through Oakland County.

I am currently enrolled in _____
(Name of Dental Plan)

through my _____ 's coverage with _____
(Relationship) (Name of Company or Organization)

Please Read and Sign:

I understand that I can rejoin Oakland County's medical and/or dental plan during the Plan Year only if I experience a qualifying status change as defined by the IRS and reviewed and approved by the Employee Benefits Unit of the Human Resources Department. I also understand that I can participate in Oakland County's medical and/or dental insurance plan in the next or any subsequent Plan Year.

I certify the above information is true and correct.

--	--

Subscriber's Signature

Date

This form is to be submitted after your online Open Enrollment has been completed and before Friday, October 28, 2011.

NATURAL SELECT AETNA LIFE INSURANCE

Your Employee ID #

- -
Your Social Security Number

Your Name Printed

Dear Employee:

If you indicated during the Website enrollment that you wished to increase your Life Insurance by **more than one level**, Aetna requires you to complete the two following medical questions:

Has there been any disease/impairment of or treatment for any of the following during the past five years?

Cancer, including leukemia and Hodgkin's disease; AIDS or any other immune system disorder; diabetes mellitus, kidney or liver disorder; mental illness or brain or nervous system disorder. Yes No

Heart, lung or circulatory disease; stroke or high blood pressure Yes No

Your request for additional Life Insurance Coverage cannot become effective unless this form has been returned and approved, so please send it in now.

**Failure to submit the required form by October 28, 2011,
will result in denial of your request to increase your coverage.**

--	--

Subscriber's Signature

Date

This form is to be submitted after your online Open Enrollment has been completed and before Friday, October 28, 2011.

C

PERSONAL REFERENCE WORKSHEET

(for use when enrolling)

Employee ID #:

PASSWORD:

	A Employee Contribution	B Employee Earnings
Medical	\$ <input type="text"/>	\$ <input type="text"/>
Dental	\$ <input type="text"/>	\$ <input type="text"/>
Vision	\$ <input type="text"/>	\$ <input type="text"/>
Employee Life Insurance	\$ <input type="text"/>	\$ <input type="text"/>
Accidental Death & Dismemberment	\$ <input type="text"/>	

Health Care Reimbursement	Per-Pay Amount	Annual Amount
	\$ <input type="text"/>	\$ <input type="text"/>

Dependent Care Reimbursement	Per-Pay Amount	Annual Amount
	\$ <input type="text"/>	\$ <input type="text"/>

Employee contribution and earnings information is for you to determine your annual cost.	Total:	A \$ <input type="text"/>	B \$ <input type="text"/>
	Your Annual Cost (total of A less the total of B):	\$ <input type="text"/>	
	Confirmation Number:	<input type="text"/>	

Refer to your Benefit Statement for option and Employee Contribution and earnings information.
 The *Natural Select* enrollment period is **Wednesday, September 28, 2011**, through **Wednesday, October 12, 2011**.
 The Internet Website will be accessible 24-hours a day during this time period. If you have any problems or questions, call the Employee Benefits Unit of the Human Resources Department. Your Password, along with your Employee Identification Number, will allow you access to the Oakland County *Natural Select* enrollment systems. To ensure the confidentiality of your benefit information, do not share your Password or Employee Identification Number with others.

THIS WORKBOOK IS INTENDED TO BE AN OVERVIEW OF OUR FLEXIBLE BENEFITS CAFETERIA PLAN PROGRAM - *NATURAL SELECT*. IT IS NOT INTENDED TO BE A COMPLETE AND THOROUGH RESTATEMENT OF THE INDIVIDUAL PLAN OPTIONS AND THE PROVISIONS, CONDITIONS, LIMITATIONS AND EXCEPTIONS THAT MAY APPLY SPECIFICALLY TO A PARTICULAR BENEFIT. IF THERE IS ANY CONFLICT BETWEEN THIS WORKBOOK AND THE ACTUAL TERMS OF OUR PLAN(S), THE PROVISIONS OF THE PLAN(S) WILL CONTROL.

Important Contact Information

Medical

Blue Cross/Blue Shield of Michigan
(800) 245-8401
www.bcbsm.com

Health Alliance Plan
(313) 872-8100
www.hap.org

Prescription

Navitus Health Solutions
(866) 333-2757
www.navitus.com

NoviXus Mail Order
(888) 240-2211
www.novixus.com

Dental

Delta Dental of Michigan
(800) 524-0149
www.deltadentalmi.com

Flexible Spending Accounts

WageWorks
(877) 924-3967
www.wageworks.com

Retirement

Fidelity Investments
(800) 430-2363
www.fidelity.com/atwork

ICMA Retirement Corporation
(800) 326-7060
www.icmarc.org

Employee Benefits

Oakland County Employee Benefits
2100 Pontiac Lake Road 41W
Waterford, MI 48328-0440
www.ocbenefits.com

Dean Shackelford (Supervisor)
(248) 858-5212
shackelfordd@oakgov.com

Angie Broegman-Stinde
(Dental, PeopleSoft Support)
(248) 858-0465
broegmana@oakgov.com

Chaunda Nash-Tipton
(STD, Sheriff's Office, FSA, PeopleSoft Support)
(248) 452-9189
nashc@oakgov.com

Debra Myers (Medical, Vision, Life)
(248) 858-0545
myersd@oakgov.com

Carol Sawinski (STD, LTD, COBRA)
(248) 858-5205
sawinski@oakgov.com