OAKLAND COMMUNITY COLLEGE

Flexible Compensation Plan (Flex Comp)

Faculty

Plan Year January 1, 2019-December 31, 2019

The benefits described in this booklet do not constitute a guarantee of such benefits and are subject to change by the Board of Trustees, provided, however, that all such benefits and other conditions of employment may be subject to a collective bargaining agreement. Any conflict between the terms and conditions of benefits provided in this booklet and those provided in an applicable collective bargaining agreement will be resolved with reference to the collective bargaining agreement.

Please note when selecting your benefits during open enrollment in November, you are electing benefits for the calendar year January-December.

Table of Contents

Introduction

It is inconceivable to think a single person, a family with children or a couple approaching retirement would all want the same benefits. That is why OCC created the **Oakland Community College Flexible Compensation Plan (FlexComp).**

FlexComp is based on the concept that you are the best judge of your benefit needs. Therefore, the program provides you with a core of essential coverage then gives you the option of either electing additional coverage, less coverage or declining coverage altogether. Should you decide to take less comprehensive coverage or no coverage at all, you will receive a cash payment. ***That cash payment will be added to your earnings and received over your normal pay schedule.***

FlexComp also gives you the opportunity to pay health and dependent care expenses with pre-tax dollars. Through the College's Flexible Spending/Reimbursement Account, you can use pre-tax rather than after-tax dollars to pay your out-of-pocket expenses. This approach may reduce your current tax liability and could result in greater take home pay.

FlexComp also gives you the opportunity to participate in a health savings plan (HSA). To open an HSA you must be in an HSA qualified health plan, which is currently WMHIP/BCBS HSA PPO.

That's what FlexComp is all about — receiving the most value from your pay and benefits by choosing what best fits your personal needs. And, because you will have the opportunity to make your selections once each year, you can impact your total compensation as your needs change.

The opportunity to choose is accompanied by the responsibility of understanding your choices. This booklet provides extensive information about FlexComp and the options that are available to you.

Prior to January 1 of each year, you will be offered the opportunity to add or drop coverages for the following 12 months. If you do not enroll in the benefit online program established by the College, you will continue the coverages in effect (except for the flexible spending accounts), for the next 12 months. Each year you must re-elect your contribution to the flexible spending account, otherwise you will be treated as having elected not to participate.

Plan Overview

Core Program

Oakland Community College's Flexible Compensation Program is made up of two components. The Core Program and Employee Options include all the current levels of coverage provided by the College.

- Medical Coverage for you and your eligible dependents, cost-sharing required
- Dental Coverage for you and your eligible dependents
- Vision Coverage for you and your eligible dependents
- Group Term Life/Accidental Death and Dismemberment Insurance
- Short-Term Disability
- Long-Term Disability

OCC allow you to modify the Core Program, as you wish. Cost for enhanced benefits is conveniently made through payroll deduction. Included among your Employee Options are a number of different alternatives:

- Enhanced Dental Coverage (nominal cost to employee)
- Decline Dental Coverage in exchange for cash
- Less Comprehensive Vision Coverage in exchange for cash
- Decline Vision Coverage in exchange for cash
- Less Comprehensive Group Life and AD and D in exchange for cash
- Enhanced Short Term Disability (nominal cost to employee)
- Additional Group Term Life and Accidental Death and Dismemberment Insurance
- An Employee Flexible Spending/Reimbursement Account for Health Care, Adoption and/or Dependent Care Expenses (using pre-tax dollars)
- An employee health savings account (HSA), using pre-tax dollars.
- In addition to the Flexible Compensation menu, you will also have the opportunity to participate in other benefit programs through payroll deduction. Those programs include:
- Portable Whole Life Insurance
- Tax-Deferred Annuities
- Personal Accident Insurance

It is up to you to decide which of these options you would like for the plan year.

FlexComp increases the value of your compensation by allowing you to choose the benefits that are best for your personal situation from a range of options. The enrollment process is designed to make sure you have all the information you need to make good FlexComp decisions.

Full-time employees can enroll in the FlexComp program immediately following hire. Refer to the appropriate Master Agreement/Board Policy for effective dates of coverage.

After your initial enrollment, FlexComp elections can be made once each year, giving you the opportunity to change your benefits as your personal needs change.

Making Your FlexComp Decisions

Your personal situation, your financial position, and FlexComp's flexibility are among the factors to consider in deciding on your FlexComp program.

The following list of factors may help you in considering the choices available to you. These observations should not be viewed in any way as recommendations or advice. Especially for your first enrollment, the College strongly recommends that you discuss your program options with your family and a tax advisor, if you use one.

Your need for benefit coverage and the kind of coverage you want are likely to vary, depending on your family situation and lifestyle:

- Age—Your health and financial responsibilities, which affect the coverage you need, tend to vary with age.
- Children—Your medical bills may be higher; thus the need to replace your income in the event of death or disability may be greater if you have children.
- Spouse's job—Coordination with your spouse's benefit plans may be a consideration.
- Retirement plans—Your savings decisions very early in your career can significantly affect the funds available for your retirement.
- Flexible Spending/Reimbursement Account—You can use Flexible Spending/ Reimbursement Account funds to pay dependent care expenses, as well as medical, adoption, vision and dental expenses not covered by the carrier.
- Health Savings Account- an employee can use to pay medical, dental and vision expenses.

Dollars/Cost
If you were to choose the highest level of coverage in each benefit area, you may have a deduction from your pay. If you choose lower levels of coverage, you may have cash payments included in your pay. **Cash payments are subject to ordinary taxes.**

Making Flexible Compensation Decisions

- Do I have duplicate coverage?
- How can I coordinate coverage?
- If I leave my employer for whatever reason, does the employer-provided life insurance coverage stop? If so, have I provided for coverage elsewhere?
- If I become disabled, would my disability benefit check be enough to maintain my current lifestyle?

Enrollment Period

To take advantage of FlexComp choices, you need to understand the differences among the options. This summary booklet which describes each plan, and suggests factors you may wish to consider in making FlexComp decisions.

Each year you will have an opportunity to change your selections during the annual open enrollment process. Should any costs or levels of coverage be changed, the re-enrollment period allows you to assess those changes as they pertain to your own personal situation. **Therefore, it is required that each employee participate in the annual open enrollments to make certain that your benefit choices remain up-to-date and consistent with your objectives.**

If you have questions relative to your own particular situation, please contact a Human Resources Specialist.

Payment of any benefit is subject to the terms and conditions of the Summary Plan Document rather than any information given here. This description does not change in any way the provisions set forth in the Plan Document.

Benefits Summary

Medical Coverage
Employees, their spouses, and dependent children, are eligible for medical coverage. These benefits are effective the first day of the second full month following official hire date.

Dental and Vision Coverage
Employees, their spouses, and dependent children, are eligible for dental and vision coverage. Employees have the option to increase their benefit levels through payroll deduction, or they may reduce their benefit levels and receive a cash payment.

Group Life Insurance and Accidental Death and Dismemberment
The College provides life insurance coverage for all full-time employees. Employees may have option(s) to reduce their life insurance coverage in exchange for a cash payment. Optional life insurance coverage is paid fully by the employee and requires proof of good health.

Short-Term Disability
Employees are entitled to a weekly benefit based on a percentage of their gross wages. Benefits commence after satisfying the applicable elimination period. Employees may have the option to increase their weekly benefit. Cost for the increased coverage is made through payroll deduction.

Long-Term Disability
Employees are entitled to a monthly benefit based on a percentage of their gross wages. Benefits commence after the qualifying period which is the greater of 90 days or the applicable period of paid leave.

Faculty
"Flexible Benefits at a Glance"

The menu should be read across not vertically. You may select only one option for each benefit category.

Benefits	Core	Option I	Option II	Option III	Option IV
Medical Coverage In Network Deductible In Network Office Prescription Co-pay Out-of-Network Deductible Out-of-Network Cost Sharing	**WMHIP/BCBS PPO** $250/$500 $20 $10/$40 $500/$1,000 See plan for details Cost Sharing Required	**WMHIP/BCBS PPO** $500/$1,000 $20 $10/$40 $1,000/$2,000 See plan for details Cost sharing required	**WMHIP/ BCBS Plan 1** $1,3500/$2,700 Deductible $10/$40 after deductible $2,700/$5,400 See plan for details Cost-sharing required	**WMHIP/ BCBS Plan 2** $2,000/$4,000 Deductible $20/$40/$80 after deductible 20% Coinsurance See plan for details	**OPT OUT** **REFUND** **$1,000**
Dental Coverage Year Benefit Cost Sharing Ortho Life Benefit Cost Sharing Cash Cost / Refund	$1000 80/20% $2,000 60/40% No Refund	Not Available	$1,200 90/10% $2,000 60/40% $96 Cost	OPT OUT $150 Refund	ADN
Vision Coverage Exam Frames Lenses Contacts Cash Cost / Refund	100% $65 100% $125 No Refund	Not Available	Not Available	Not Available	NVA
Group Term Life and ADandD Coverage Cash Refund	$120,000	$50,000 $48 refund	$25,000 $96 refund	Not Available	The Hartford
Optional Term Life/AD and D Maximum Coverage Cash Cost	$120,000 * Cost Varies	$50,000 * Cost Varies	$25,000 * Cost Varies	Not Available	Optional coverage, paid for by the employee, requires proof of good health. Cost based on age. The Hartford
Short Term Disability Base	60% No Refund	65% $24 Cost	70% $48 Cost	Not Available	The Hartford

Benefits	Core	Option I	Option II	Option III	Option IV
Salary Maximum Benefit Cash Cost / Refund					
Long Term Disability Base Salary Maximum Benefit Cash Cost / Refund	70% $5,000 No Refund	Not Available	Not Available	Not Available	The Hartford

Flexible Spending/Reimbursement Account

Health Care - Minimum-$120, Maximum 2,650

Dependent Care – Minimum $520, Maximum $5,000

Pre-Tax Payroll Deduction available for Health and Dependent Care Expenses

Adoption Expense –Minimum $0, Maximum $13,840

Adoption Claims are administered by E.B.C., Inc.

Cash cost represents annual cost to employee of enhanced benefits. Cash payment represents annual refund paid to employee. Annual open enrollment period will be during Oct/Nov with an effective date of January 1. Selection of carrier is subject to change.

Medical Coverage

Plan Year is 12 months - January 1 through December 31
Fortunately, most of us are in good health most of the time. But illness and accidents are unpredictable. So, it is essential to plan for large and unexpected medical expenses. FlexComp provides a range of plans, so you can choose the protection that's right for you.

Several different plans are available. Choices include WMHIP/BCBS PPO and WMHIP/BCBS high deductible plans. This section gives you a summary of all your health plan options and describes how the health plans work.

When an employee receives an Explanation of Benefit Statement from the insurance carrier, it is the responsibility of the employee to follow-up with the insurance carrier and/or doctor if appropriate payment is not made. Failure to do so may result in the employee being responsible for the balance of payment.

Dependents
If you choose dependent coverage, your eligible dependents will be covered under the plan you select. Eligible dependents include your spouse and your children to the end of the calendar year in which they reach 26 years of age. Dependents that are "totally and permanently" disabled by either a physical or mental condition prior to age 19 may be covered beyond the end of the calendar year in which they turn age 26.

Eligible children include:

Stepchildren, legally adopted children and children over whom the employee has legal guardianship. The eligible children may be included the same as your own children provided they depend upon you for support and maintenance.

An OCC employee cannot be enrolled in any OCC benefit both as the subscriber and as a spouse. In the case of both parents being eligible for OCC benefits, dependents are only eligible for coverage under one parent.

The cost-sharing payment shall be made through pre-tax payroll deductions.

If a change in family status occurs during the year (birth, death, marriage, divorce, adoption or loss of coverage due to loss of a spouse's employment) coverage may be added or deleted, to the extent such addition or deletion is consistent with and on account of the family status change. The employee must notify Human Resources within 31 days of the event. Coverage becomes effective on the date of the event.

IMPORTANT
An employee participating in WMHIP/BCBS will receive a WMHIP/BCBS identification card to be used for health services.

Important Notice

On October 21,1998, President Clinton signed the massive Omnibus Appropriations Bill (HR 4328). Included in it is a mandate that health plans cover reconstructive surgery after mastectomy, known as the Women's Health and Cancer Rights Act of 1998.
Please review the following act, if you have any questions; please contact your insurance carrier or Human Resources Specialist.

Notice - Women's Health and Cancer Rights Act of 1998

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

1. all stages of reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

The law became effective for the plan year beginning on or after October 21, 1998.

Please visit the Oakland Community College's Infomart website for more information on the plans offered.

Or visit Blue Cross Blue Shield of Michigan's website to log onto your account.

https://bcbsm.com/index.html

PLEASE CONTACT HUMAN RESOURCES FOR MEDICAL PLAN SUMMARIES.

Dental Coverage

Dental care is an important, continuing expense for nearly everyone. To help with dental expenses, you have three dental plans from which to choose, or you may decide to decline coverage for a cash payment.

Benefits are based on **reasonable and customary charges.** This is the normal charge in your geographical area for a comparable service.

Plan year 12 months – January 1 through December 31

Preventive services are paid at 100% of reasonable and customary, subject to the maximum benefit.

Dental Coverage	Description	CORE	OPTION I	OPTION II	OPTION III
Preventive Services	**Preventive services** are treatments given to maintain your teeth in a healthy state. Preventive services include oral exams, cleaning, and x-rays (twice during a Plan Year). Full mouth x-rays limited to once every 36 months. Fluoride treatments limited to one application every 12 months, for dependents under the age of 14.	**80%**		**90%**	**0**
Additional Services	**Additional services** are treatments to restore your teeth to a healthy state. Basic services include extractions, fillings and treatment of dental disease. Major services include inlays,	**80%**		**90%**	**0**

Dental Coverage	Description	CORE	OPTION I	OPTION II	OPTION III
	crowns, bridges, dentures, and related services.				
Orthodontic Treatment	**Orthodontic treatment** is treatment to correct your "bite", which is how the teeth in your upper jaws fit together when you close your mouth. Braces are included under orthodontic treatment. Limited to a dependent child to age 19 regardless of whether services commenced prior to age 19.	**60%**		**60%**	**0**
Annual Maximum	Each member is entitled to maximum benefits of this amount every plan year. Does not apply to orthodontic treatment.	**$1,000**		**$1,200**	**0**

Orthodontic Lifetime Coverage

Description	CORE	OPTION I	OPTION II	OPTION III
Each member (up to age 19 has a lifetime maximum amount available for orthodontic services. No benefits paid are paid after dependent's 19th birthday, regardless of whether services commenced prior to age 19.	$2000		$2000	0
Cash Refund/Cost	No Refund		$96 Cost	$150 Refund

Employee is responsible for all co-payments.

Eligible dependents include your spouse, and dependent children to the end of the calendar year in which they turn age 25.

Although it is not mandatory, it is recommended that a pre-determination of benefit is requested for claims in excess of $250.00

Vision Coverage

This vision program will provide payment for covered services applicable to the following schedule:
12 months- January 1 through December 31

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Optometrist	**100%**	**$35**
Ophthalmologist	**100%**	**$45**
Single Lenses	**100%**	**$38**
Bifocal	**100%**	**$60**
Trifocal	**100%**	**$72**
Lenticular	**100%**	**$108**
Contacts Necessary	**100%**	**$200**
Contacts Cosmetic	**$125**	**$125**
Tinted Single vision	**100%**	**$42**
Tinted Bifocal	**100%**	**$70**
Tinted Trifocal	**100%**	**$84**
Tinted Lenticular	**100%**	**$118**
Polarized Single vision	**100%**	**$56**
Polarized Bifocal	**100%**	**$90**
Polarized Trifocal	**100%**	**$110**
Polarized Lenticular	**100%**	**$138**
Oversize	**100%**	
Rimless	**100%**	
Blended bifocal	**100%**	

Covered Charges

Charges for a vision examination but not more than one per insured person during a plan year

Charges for corrective lenses and frames but not more than one pair of lenses and one frame per insured person during a plan year or,

Charges for corrective contact lenses but not more than one pair per insured person during a plan year.

In-Network — The Provider agrees to accept the payment as payment-in-full for covered services. In-Network Providers bill NVA and are paid directly by NVA so no member filing is necessary.

Out-of-Network Providers — Benefits for examination, lenses and frames which are covered charges and obtained by a out-of-network provider are limited to the scheduled amounts shown. Using a out-of-network provider requires filing for reimbursement. The member must submit a fully itemized receipt showing a complete breakdown of all services and merchandise dispensed. Eligible expenses are reimbursed according to the schedules shown with payment made directly to the member.

Faculty members, their spouses, and dependent children until the end of the calendar year in which they turn age 25.

Group Term Life/Accidental Death and Dismemberment Insurance (AD and D)

Group Term Life/AD and D insurance provides a source of funds to assist your beneficiary in meeting financial responsibilities in the event of your death. It may be used to ensure the repayment of a loan or mortgage for your family. It can cover your children's college tuition or provide a source of income for your dependents. The options available to you are described in this section.

AD and D insurance refers to the payment of a percentage of the principal life insurance sum which will be made upon satisfactory proof of accidental loss. Accidental loss refers to loss of life, limb, sight, speech and/or hearing which results directly from accidental bodily injury and; a) is independent of all other causes; b) occurs within 365 days of the accidental bodily injury; and c) is not included under "Risks Not Covered" in the carrier's Summary Plan Description.

EMPLOYEE OPTIONS	CORE	OPTION I	OPTION II
	$120,000	$50,000-$48 refund	$25,000-$96 refund

- **College provided amounts in excess of $50,000 requires Internal Revenue Service taxation on a portion of the premium.**
- **An employee electing Option I or Option II will be subject to proof of good health should they elect the Core benefit at a later date.**

General Information Regarding Life Insurance (College provided and Optional)
Coverage shall be reduced at age 65 and beyond as follows:

AGE	PERCENTAGE OF AGE 64 BENEFIT COLLEGE PROVIDED	OPTIONAL LIFE
65-69	65%	100%
70-74	45%	65%
75-79	30%	45%
80-84	20%	30%
85-89	15%	20%
90 and older	10%	15%

Making Life Insurance Decisions

Employees shall have the right to convert their group term life insurance to Ordinary Life Coverage at their expense within 31 days following termination or retirement.

- Here are a few considerations to keep in mind when making life insurance selections:

- **The benefit amounts you need**—Life insurance provides protection for others in the event of your death. So, you may decide you need higher life insurance amounts if many people are depending on your income, or lower amounts if you have no dependents.
- **Other coverage**—Many people carry private life insurance protection. If you have a private plan, you may want to consider it when making your choices. You also may have life insurance coverage through your spouse's benefit plan. See Portable Whole Life Insurance.
- **Future years**—Remember, you will have to provide proof of your continued good health in order to elect a higher-benefit life insurance plan in future years.

Optional Group Term Life/Accidental Death and Dismemberment Insurance (AD and D)

If you wish, you may add to your College provided group term life insurance and AD and D coverage by purchasing Optional Group Term Life and Accidental Death and Dismemberment Insurance. Employees electing Optional Insurance will be required to provide proof of good health. The effective date of the optional insurance will be in force upon written notification from the insurance carrier.

Refer to the appropriate Master Agreement or Board Policy for the maximum allowable amount of optional life insurance you may purchase. **Optional Group Term Life and AD and D available in $10,000 increments to a maximum of $100,000 non-medical issue amount/$120,000 with approval.** Premiums used to purchase Optional Term Life and **AD and D** do not qualify as a pre-tax deduction. The premium is deducted from the first pay of each month.

AGE	**MONTHLY COST PER $1000**
Under 25	$0.08
25-29	$0.09
30-34	$0.10
35-39	$0.12
40-44	$0.16
45-49	$0.22
50-54	$0.33
55-59	$0.61
60-64	$0.87
65-69	$1.62
70 and older	$2.62

To calculate the cost of additional Term Life / AD and D Insurance:

Find your age and corresponding monthly cost per $1,000.

- Multiply cost per thousand times life/AD and D insurance amount to determine monthly cost.
- Multiply monthly cost times 12 months to determine annual cost.

Example:
38 years old and $20,000 life/AD and D insurance

- .12x20=$2.40 monthly
- $2.40x12=$28.80 annually

Short-Term Disability (STD)

Weekly benefits are provided subject to proof of loss requirements, payable to insured when employee is disabled due to illness or injury.

Your weekly benefit applies on the date the period of disability begins. However, the benefit is payable for the period the disability continues after the elimination period of 14 calendar days. Accumulated sick days, if any, will be used to satisfy the 14 calendar day elimination period for short-term disability benefits. Additional bank time may be used, however, doing so further reduces the 90 day period by each day used. The benefit will not be payable for longer than the maximum duration of 90 days for one continuous period of disability whether from one or more causes.

Notification of intent to file for STD must be received in the Human Resources Department(verbal or in writing) within 10 working days of the employee's first day off work.

Benefits are payable only while under continuous care of a licensed physician. The College and/or the insurance carrier reserves the right to designate a licensed physician in order to conduct an independent medical exam.

Sick and vacation days do not accrue while on Short Term Disability.

Evidence of insurability required to increase coverage during open enrollment.

CORE	OPTION I	OPTION II
60% of base salary per week with no cost	65% of base salary per week with $24 cost	70% of base salary per week with $48 cost

Long-Term Disability (LTD)

Long-Term Disability (LTD) benefits provide income if you are unable to work for a prolonged period. Monthly income benefits are paid while you are totally and permanently disabled because of illness or injury. When you recover, payments stop.

A significant benefit of LTD is that if you become disabled and are eligible for benefits, you continue to receive health, dental, vision and life insurance coverage for a period not to exceed two (2) years from the date of eligibility.

FOR ILLUSTRATIVE PURPOSES ONLY

EXAMPLE 1:

Employee has a seniority date of 7-1-96 and becomes disabled on 8-2-99. At time of disability, employee has 15 days of accumulated sick/vacation time that will be used to satisfy the 10 day waiting period for Short-Term Disability. Employee will also use the remaining 5 paid days beyond the waiting period.

The employee's LTD benefit is approved, effective November 2, 1999.

The employee's two (2) year continuation of insurance coverage will begin November 2, 1999 and will continue through the end of the month in which the two year benefit limitation ends (i.e., although 2 year continuation of insurance coverage ends November 1, 2001, insurance will be in effect through November 30, 2001) if employee remains disabled.

EXAMPLE 2:

Employee has a seniority date of 7-1-89 and becomes disabled on 8-2-99. At time of disability, employee has 120 days of accumulated sick/vacation time that will be used while employee is out on disability.

On February 1, 2000, employee will have exhausted all of the 120 days of accumulated sick/vacation time.

The two (2) year continuation of insurance coverage will begin February 2, 2000 and will continue through the end of the month in which the two year benefit limitation ends (i.e., although 2 year continuation of insurance coverage ends February 1, 2002, insurance will be in effect through February 28, 2002) if employee remains disabled.

Core — Your monthly benefit is 70% of your base monthly earnings at the date of disability. Benefits begin after a qualifying period which is the greater of 90 days or the applicable period of paid leave. Accumulated sick days may be used to satisfy the 90 day elimination period for long term disability benefits. The minimum monthly benefit is $100.

The benefits continue throughout the period of disability pending required proof of disability from your physician. The duration of benefits is as follows:

AGE AT DISABILITY	BENEFIT DURATION
Under age 60	To age 65 but not less than 5 years
60-64	5 years
65-69	To age 70 but not less than 1 year

AGE AT DISABILITY	BENEFIT DURATION
70 and over	1 year

The College and/or the insurance carrier reserves the right to designate a licensed physician in order to conduct an independent medical exam.

A survivor's benefit is paid to spouse or children under age 25 when proof is received that the insured died while receiving benefits and if disability had continued for 180 consecutive days.

The benefit will be an amount equal to three times the insured's gross monthly benefit.

LTD benefits are coordinated with other benefits such as family Social Security, Workers' Compensation and the MPSERS pension.

Sick and vacation days do not accrue while on Long-Term Disability.

Employee Flexible Spending/Reimbursement Account

Overview
One of the most attractive features of the Flexible Compensation Program is your Employee Flexible Spending/Reimbursement Account. It enables you to pay a portion of your out-of-pocket Health Care and Dependent Care expenses with pre-tax dollars.

Normally, you have to pay health and dependent care expenses with your after-tax dollars. By using your Flexible Spending/Reimbursement Account, you save the taxes you were paying on this income. The end result is more spendable income for you.

The Employee Flexible Spending/Reimbursement Account has three parts: one for out-of-pocket Health Care expenses, one for Dependent Care expenses and one for adoption expenses. Just before the beginning of each plan year, you will have the opportunity to elect to fund your Flexible Spending/Reimbursement Account for the coming year. The amount that you select will be deducted from your gross salary through automatic payroll deductions. Then, during the plan year, you may submit claims to the Administrator to reimburse yourself for Dependent Care expenses and/or Health Care expenses not reimbursed by your insurance plans.

There are no loan provisions under this plan. Reimbursements are made from the account only when proper claim forms are submitted. However, since expenses generally are incurred on a regular basis, money deposited into your account will be reimbursed in a timely manner.

Contributions may change during the plan year if there is a change in family status (marriage, birth, divorce, death, etc.)

Notes About Your Account
During the year, you should keep receipts for all qualified expenses. To receive reimbursements, fill out an Employee Flexible Spending/Reimbursement Account claim form, attach your receipts, and submit them to the Reimbursement Account Claim Administrator listed in the Carrier's Directory. You may fax your claims or scan receipts along with the claim form and e-mail the claims to: Flexclaims@groupresources.com. When submitting for uninsured health care expenses, it is essential that you provide the explanation of benefits from the insurance carrier. You may submit claims anytime. The option is also available to pay for your expenses using the Visa Take Care Card. And with it, you will not have to pay qualified expenses out of your personal funds and then wait for reimbursement.

Making Flexible Spending/Reimbursement Account Decisions
You can be reimbursed for most medical expenses not covered by insurance. So, you should consider the health, vision and dental plan you choose when making your Flexible Spending/Reimbursement Account decisions. If you choose a plan with a high deductible, for example, you may want to put more money in your Flexible Spending/Reimbursement Account than if the plan you choose has a low deductible.

You can be reimbursed from your Flexible Spending/Reimbursement Account for the following expenses each year:

Health Care Reimbursement Account

The portion of medical, vision and dental expenses that are not paid by your insurance plans - up to $2,650—Depending on what medical plan you choose, examples of these expenses could include deductibles, copayments, routine physical and hearing aids, along with your share of eye examinations, glasses, prescriptions, psychiatric care, and nursing home service. Just about any medical, vision or dental expenses that you pay may be reimbursable.

Dependent Care Reimbursement Account

Work-related day care expenses - up to $5,000—You can qualify for reimbursement of these expenses if day care service for dependent children, parents, or other family members is necessary for you (or, if you are married, you and your spouse) to be employed. You also may qualify if day care service is necessary for you to work and your spouse to go to school on a full-time basis. A dependent is defined as a child under age 13 who lives with you. An adult who is your IRS dependent, living with you, and who needs full-time care, also qualifies. However, you cannot use your Flexible Spending/Reimbursement Account to pay your older child to watch your younger ones or a dependent adult.

Adoption Reimbursement Account

Adoption assistance expenses that do qualify for reimbursement include—up to $13,840-Home study and application fees, reasonable and necessary legal adoption fees, court cost, attorney fees, agency fees, medical services and counseling, travel and lodging fees, other expenses which are directly related to, and the principal purpose of which is for, the legal adoption of an eligible child.

In making decisions about your account, keep in mind that you can be reimbursed for covered expenses only up to the stated annual maximum in each category. So, you will want to limit the dollars going into this account to the amounts you are likely to spend in each of these areas.

Please keep these important considerations in mind:

Use "Use it or Lose It Rule"

Under the IRS Code, a requirement applicable to Cafeteria Plan under which employees must forfeit any contributions from a Plan Year that are not used to reimburse expenses incurred during that Plan Year unless an exception applies (e.g., because the plan provides for grace period or health FSA carryovers)
"Carryovers"

IRS guidance issued in October 2013 allows health FSAs to offer carryover of unused balances of up to $500.00 remaining at the end of the plan year, to be used for qualified medical expenses incurred in subsequent plan years. A Plan cannot offer the Carryover and the Grace Period (FSE). This exception to the use-or-lose rule offers the potential to reduce health FSA forfeitures to participants. Carryovers cannot be cashed out or converted to any other taxable or nontaxable benefit, and will not count against or otherwise affect the $2,650 (indexed) limit on the annual health FSA salary reductions. Unused amount in excess of $500 that remains at the end of any run-out period are forfeited. Carryovers of $500.00 or less will roll over for two (2) plan years, starting with the 2016 plan,

or until termination of employment. Upon termination of employment, any unused money is considered forfeiture monies after the run out grace period of 45 days.
The Plan Year begins January1st of each year and ends December 31st of that same year. During the current Plan Year, expenses are considered incurred on the date the service is rendered. The last day to incur an expense is December 31st. The IRS does not allow for services incurred in a prior year to be paid for with current year funds. If this does happen, the participant must re-pay back the funds to the plan. With the exception of orthodontic services the date paid is used as the date incurred. Any expenses incurred in a prior plan year paid with current plan funds will require re-payment to plan by the participant.

With the Carryover adopted into the Plan, up to $500.00 of unused balance, will roll over into the New Plan year and can be used for expenses incurred in the new Plan Year. These carryover funds will be reimbursed first, then the election amount is used once the carryover amount has been fully disbursed.

At the end of the Plan year, if there are funds of more than $500.00 left, the difference is considered forfeited funds and the Use It or Lose It Ruling applies. (e.g., Jane Doe elected $2,600 for the 1/1/15 Plan year. As of midnight 12/31/15, she has an available fund balance of $1,500. The $500.00 is a carryover for the 2016 plan year and $1,000.00 is forfeited due to the Use It or Lose It ruling, if Jane does not have any additional services rendered in the 2015 plan year to submit for reimbursement within 90 days of 12/31/15).

1. If you elect to participate, the amount you designate will be withheld automatically from your paycheck in equal installments. The minimum contribution to the account is $10 per month.
2. The annual re-enrollment period is the only time you may change your selections unless you have a change in "family status". Qualifying status changes for benefits provided under this plan are subject to approval of your employer, must be on account of a particular event, and satisfy any specific consistency rules that may apply to the particular benefit. Please reference your summary plan description for a detailed list of qualified "status changes". Examples include:
   - Change in your legal marital status, on account of marriage, divorce, death of your spouse, legal separation or annulment;
   - Change in the number of your dependents, due to birth, adoption, placement for adoption, or death of a dependent;
   - Change in employment status for you, your spouse, or a dependent;
   - Change because your dependent satisfies (or ceases to satisfy) the eligibility requirements;
   - Significant cost increases in a qualifying benefit (other than Uninsured Health Care accounts);
   - A change in coverage in a spouse's or dependent's Section 125 Plan;
   - A change under the Family Medical Leave Act;

   It is very important for you to understand that you must notify the Human Resources Specialist in the Human Resource Department within 30 days of a "status change" in order to be allowed to select different benefit options. This includes adding dependent coverage. If you have a status change, the new coverage becomes effective as of the date you notify the Human Resources Specialist of the change or, if administratively possible, the date of the status change. It will always be to your advantage to notify the Human Resource Specialist as soon as possible.

3. Although you have only one Flexible Spending/Reimbursement Account, the Health Care portion and Dependent Day Care portion are entirely separate. Only Health Care expenses may be reimbursed from the Health Care portion; only Dependent Day Care expenses may be reimbursed from the Dependent Day Care portion and only Adoption Care expenses may be reimbursed from the Adoption portion. Once a given portion is used up for the year, no more expenses may be reimbursed for that year. You cannot transfer funds from one portion of the Account to the other.

4. The Adoption expense and the Dependent Day Care portion of the Account cannot reimburse you for more money than has been deposited into it by the date you make a claim. Remember, your contributions are deducted each pay, so funds build up gradually in your Account at that time, any excess will be held for reimbursement until sufficient funds have accumulated.

5. If you should terminate employment during the plan year, you may continue to file for a period of 45 days from your termination date for reimbursable expenses incurred while you were employed at OCC.

6. Keep in mind that the funds you contribute to your Flexible Spending/Reimbursement Account are deducted before taxes are withheld, so you have not paid any taxes on them. Therefore, any items submitted through your Employee Flexible Spending/Reimbursement Account cannot be used as either a tax credit or deduction.

7. When you use dollars from your Flexible Spending/Reimbursement Account to pay for eligible expenses, these dollars are nontaxable. In other words, you never owe federal income taxes on them. And, under current law, FICA, state, and local taxes are permanently waived as well.

These statements are made with the consideration that each situation is different and it is highly recommended that you consult with a tax advisor with regard to your own situation.

Example:

The following example (assuming Single taxpayer) illustrates how the payment of after-tax expenses on a pre-tax basis creates a pay raise for the employee.

COSTS	WITH ACCOUNT	WITHOUT ACCOUNT
Annual Gross Salary	$24,000	$24,000
Dependent Care	$1,800	0
Health Care Expenses	$700	0
Taxable Income	$21,500	$24,000
Federal Tax (18.57% blended	$3,978	$4,440
FICA (7.65%)	$1,645	$1,836
State Tax (3.9%)	$839	$936
After Tax Income	$15,038	$16,788
After Tax Dependent Care	0	$1,800
After Tax Health Care	0	$700
Spendable Income	$15,030	$14,288

Since contributions to your Employee Flexible Spending/Reimbursement Accounts are treated as reduction in income, there will be a slight reduction in Workers' Compensation and Social Security disability and survivorship benefits.

Health Care Expenses

You may contribute up to $2,650 of your earned income per plan year to the Health Care portion of the Account to reimburse yourself for expenses incurred by you or an eligible dependent. You may submit claims for expenses through the end of the plan year provided that you have made all required payments. Common examples include:

- Plan deductibles
- Medical, Dental and Vision expenses not reimbursed by your plan.

* Please note, an eligible expense must be a medically necessary expense incurred for diagnosis, cure, treatment, mitigation, or prevention of disease, or for the purpose of affecting any bodily function or structure. Drugs must be prescription drugs or insulin.

The following is a *representative* list of Health Care expenses allowable under the Internal Revenue Code:

SERVICE	ALLOWABLE EXPENSES
Acupuncture	Performed by a licensed practitioner
Alcoholism or drug dependency	Payment to a treatment center
Ambulance	Ambulance
Birth Control Pills	Birth Control Pills
Car Controls	Special controls for the handicapped
Chiropractors	Services within the scope of license
Contact Lenses	Balances not paid by other vision insurance
Copayments	Balances not paid by other health insurance
Cosmetic Surgery	For medically necessary procedures
Crutches	Purchase or rental
Deductibles and coinsurance	Balances not paid by other health insurance
Dental Fees	X-rays, fillings, braces, extractions, false teeth, orthodontia services, treatments, (non cosmetic procedures only), etc. Cosmetic teeth whitening is not reimbursable.
Doctor's fees excess charges	Charges not paid by other health insurance
Eyeglasses	Prescription lenses, frames, examinations
Eye Care	RK/LASIK Surgery
Guide Dog	Purchase for blind or deaf
Halfway House	Care to help individual adjust from life in a mental hospital to community living
Health Care Equipment (household items or appliances)	Not of general use as articles of furniture
Hearing Aids (hospitalization)	Including private room coverage

The following are examples of health care expenses for which you may NOT claim reimbursement from your Health Care Reimbursement account:

- expenses that you deduct on your income tax return
- insurance premiums for whole life policies, insurance premiums for group term life coverage
- insurance premiums for medical and dental
- cosmetic treatments , surgeries, procedures

IMPORTANT
Currently, in order to receive a tax deduction for medical expenses on your tax return, expenses must exceed 7.5% of your adjusted gross income. Therefore, your Health Care expense account provides you with the only opportunity to receive full credit for ALL medical expenses incurred regardless of income.

Estimating Health Care Expenses For You and Your Family

(You should refer to the sections entitled "Medical/Dental/Vision Options" to help you accurately estimate your expenses.)
Please log onto http://takecareplans.com/ebcmichigan/

This web site provides a lot of information on **"How the plan works"**, which can be found under the **"Employee"** tab. This location also provides the interactive
"Worksheet" which will help determine the amount of your tax savings by using a FSA program.

The **"Hot Topics"** tab provides information for the **"Dependent Care Credit vs. Dependent Care FSA for 2015".**

Dependent Care Expenses

The Employee Flexible Spending/Reimbursement Account can be used to pay for Dependent Care expenses that enable you and your spouse to work or to search actively for work.

Reimbursement Limitations: A married employee may only be reimbursed for Dependent Care expenses up to the lesser of:

- $5,000 ($2,500 if married filing a separate return); or
- 50% of the employee's compensation; or
- the earned income of the employee's spouse.

Therefore, a married employee whose spouse does not work is generally not entitled to Dependent Care assistance reimbursement. However, if the employee's spouse is a full-time student or incapable of caring for himself or herself, then the employee will be allowed a limited benefit under the plan. The allowable limit of reimbursement for each month the spouse is a full-time student is $250 if the employee has one dependent or $500 if the employee has two or more. If the employee's spouse is incapacitated, the allowable limit is $250 per month if the employee has one or more additional dependents.

An unmarried employee may be reimbursed for all Dependent Care expenses up to the lesser of:

- $5,000; or
- 50% of the employee's compensation

For the purpose of Dependent Day Care expenses, a dependent includes anyone you claim as a dependent on your income tax return and who is:

- Age 12 or younger; or

- Physically or mentally incapable of caring for himself or herself (for example, a disabled spouse or an elderly parent). A person other than your spouse must rely on you for more than one-half of their support to qualify as a dependent.

Important

Changing the amount of my contributions:

IRS regulations require that your annual enrollment be irrevocable. The annual re-enrollment period is the only time you may change your selections unless you have a change in "family status". Qualifying "status changes" for benefits provided under this plan are subject to approval of your employer, must be on account of a particular event, and satisfy any specific consistency rules that may apply to the particular benefit. Please reference your summary plan description for a detailed list of qualified "status changes". Examples include:

- Change in your legal marital status, on account of marriage, divorce, death of your spouse, legal separation or annulment;
- Change in the number of your dependents due to birth, adoption, placement for adoption, or death of a dependent;
- Change in employment status for you, your spouse, or a dependent;
- Change because your dependent satisfies (or ceases to satisfy) the eligibility requirements;
- Significant cost increases in a qualifying benefit (other than Uninsured Health Care accounts);
- A change in coverage in a spouse's or dependent's Section 125 Plan;
- A leave under the Family Medical Leave Act.

Eligible Dependent Care expenses include:

Payments made for services provided in your home (babysitters, for example). These services cannot be provided by someone you claim as a dependent or someone who is a relative.

Payment made for dependent child care services outside your home. If you use the services of a dependent care center that provides care for at least six people (other than residents), the center must be in compliance with state and local laws.

Payments made for care outside your home for a dependent (other than a child), if the dependent spends at least eight hours a day in your home. (For example, 24-hour nursing home care for a dependent parent would not qualify).

If you utilize a Dependent Day Care Reimbursement Account, you must furnish the name, address and tax identification (social security number or corporate tax ID) number for the provider of dependent day care services to Employee Benefit Concepts when a claim is made.

Important

The worksheet is designed to help you decide whether it is more beneficial to pay those expenses from the Dependent Care Reimbursement Account or take the income tax credit. You may want to consult with a tax advisor to determine which option is best for you.

Dependent Care Tax Credit

Besides the dependent care FSA that is included in most cafeteria plans, there is a federal child and dependent care tax credit. One of the Bush tax cuts included an increase in the expenses that can be taken into consideration for the tax credit, beginning January 1, 2003. Here's a table showing the changes in the amount of employment-related child care expenses that can be taken into account for the child and dependent care tax credit:

Number of Children	2018	2019
One child	$3,000	$3,000
Two or more children	$3,600	$6,000

Over-The-Counter Medicines and Drugs

The IRS issued its initial guidance with respect to the new rule included in the Affordable Care Act that requires a doctor's prescription for the reimbursement of over-the-counter (OTC) drugs and medicines from a tax-advantaged health care account. While the guidance offers little in the way of new information, it does confirm the generally accepted interpretation of how the change will be applied.

In summary, the guidance confirms the following:

- Participants will still be able to use their tax-advantaged health care accounts for purchases of ALL OTC drugs and medicines, as long as they have a doctor's prescription.
- The rule applies to all tax-advantaged health care accounts, including Flexible Spending Accounts (FSAs).
- The rule takes effect January 1, 2011 and applies to all purchases on or after January 1, 2011, regardless of plan year.
- The only acceptable forms of documentation for reimbursement for OTC drugs and medicines are a receipt indicating the Rx number in addition to date purchased, purchaser and amount or if the receipt does not contain the Rx number, you must also include the doctor's prescription, as regulated by state law.
- Insulin, medical devices (crutches, blood sugar monitors, etc.) and items such as bandages, contact lens solution, denture bond, etc. will not require a prescription.
- Generally, health care debit cards cannot be used to purchase OTC drugs and medicines.

The IRS has posted a helpful FAQ, about the OTC rule change on its Affordable Care Act website at:

https://www.irs.gov/newsroom/affordable-care-act-questions-and-answers-on-over-the-counter-medicines-and-drugs

Adoption Care Expenses

The employee Flexible Spending/Reimbursement Account can be used to pay for Adoption expenses that enable you and your spouse to be reimbursed for qualified adoption expenses.

Reimbursement limitations: An employee may be reimbursed for Adoption expenses up to the lessor of:

$13,840 IRS maximum amount for the 2019 Plan year which will adjust as the IRS makes changes.

Credit is phased out for participants with a household modified adjusted gross income over $207,580 (2018) and no credit is allowed to participants with a household modified adjusted gross income of $247,580 (2018) or more.

Although you won't save on FICA contributions you will save federal and state tax (where applicable). Consult your tax advisor for details.

Adoption assistance expenses that qualify for reimbursement include:

Home study and application fees, reasonable and necessary legal adoption fees, court costs, attorney fees, agency fees, medical services and counseling, travel and lodging fees, other expenses which are directly related to, and the principal purpose of which is for, the legal adoption of an eligible child.

Adoption assistance expenses that do not qualify:

Adoption of a child belonging to the participant's spouse, illegal adoption fees, surrogate parenting arrangements, legal adoption expenses for which another deduction or credit is allowed.

Reimbursement is made as eligible claims are submitted and contributions are posted to your account.

IMPORTANT

Changing the amount of my contributions:

IRS regulations require that your annual enrollment be irrevocable. The annual re-enrollment period is the only time you may change your adoption assistance election. Please base your election amount on costs you are sure to incur.

PLEASE NOTE THAT AN EMPLOYEE <u>CAN NOT</u> BE ENROLLED IN BOTH AN HSA AND A FLEXIBLE SPENDING ACCOUNT.

Oakland Community College 403(b)
Plan Highlights

Oakland Community College is pleased to offer the 403(b) Plan to eligible employees in order to help save for retirement. The plan allows you to save on a tax deferred basis. Plan oversight and administration is provided by MidAmerica.

This page outlines the key provisions of the plan as well as who to contact to sign up, for plan or investment related questions, or other information. We encourage you to seriously consider taking advantage of this valuable benefit to help enhance your financial future.

Eligibility – All employees are eligible to contribute to the 403(b) plan.

Employees are able to enroll in the Plan immediately upon commencing employment with Oakland Community College.

Generally, you can contribute up to 100% of your income up to $19,000 (in 2019). You may be eligible to contribute an additional $6,000 if you are age 50 or older. You may be eligible to contribute an additional amount if you have 15 or more years of service.

You are always 100% vested in your own contributions, plus earnings.

Withdrawal is subject to each vendor's policies. Check with your vendor for availability. There is a possible 10% penalty if you separate and you are under the age of 59 ½. You may take a withdrawal for financial hardships. Hardship withdrawals are limited to the amount you have contributed to the plan and are only permitted for limited financial circumstances that must be substantiated.

Funds will be invested with one of the following vendors:

VENDOR	PHONE	WEBSITE
Consolidated Financial Corporation	800-232-2383	www.consolidated-financial.com
Fidelity Investments	800-835-5097	www.fidelity.com
Voya Financial	800-525-4225	www.voya.com
Lincoln Financial	800-454-6265	www.lfg.com
VALIC	800-448-2542	www.valic.com
TIAA	800-842-2776	www.tiaa.org
AXA Equitable	800-628-6673	www.axaonline.com

Please contact vendor for account balances and to transfer funds.

All employees must contact MidAmerica Administrative and Retirement Solutions, Inc. for any plan related questions or to request forms such as distribution, loans or hardships. Please call 866-873-4240 for information.

The address to mail in forms is:

MidAmerica Administrative and Retirement Solutions, Inc., Attn: 403(b) TPA, 211 E. Main Street, Suite 100, Lakeland, FL 33801 and the website is www.midamerica.biz. Click "Participant Login" then "403(b) TPA Services" and select the employer name from the drop menu.

Refer to the Plan Document for more information on the Plan. In the event of a discrepancy the Plan Document will prevail.

Tax-Deferred Retirement Plans

As an employee of OCC you are eligible to participate in IRS authorized 403(b) programs. You are now eligible to participate in a 457(b) program, as well. These plans are regulated by the Federal government under Section 403(b) and 457(b) of the Internal Revenue Code. Using pre-tax contributions, they are designed to help people prepare for the future, with special emphasis on retirement. Even if retirement is far from your thoughts at this time, the decisions you make early in your career will affect your financial security in your later years.

Federal (and under current law, state and local) taxes on these savings are postponed until the funds are withdrawn from the plans. Also, earnings on these savings are not taxed until payout.

So, when you save through a 403(b) or 457(b) plan, you postpone taxes to a later time–for example, retirement, when your tax obligation may be lower.

While there are several advantages to 403(b) and 457(b) accounts, there are IRS restrictions involving withdrawals, age, hardship, disability, etc., specific to each plan. Eligible employees may not enroll with more than two (2) vendors at one time.

The College offers various 403(b) investment options. Current vendors include and are limited to:

Consolidated Financial Corporation
Fidelity Investments
Voya Financial
Lincoln Financial
VALIC
TIAA
AXA Equitable

The current vendor for the college's 457(b) program is TIAA.

Tax-Deferred Retirement Plans Maximum Contributions

YEAR	403(b) ANNUAL LIMIT	457(b) LIMIT
2019	$19,000	$19,000

Catch-Up Contributions – Age 50 and over

YEAR	403(b) ANNUAL LIMIT	457(b) LIMIT
2019	$25,000	$25,000

Due to the passage of Economic Growth and Tax Relief Reconciliation Act (EGTRRA), participants may contribute the maximum allowed to both plans. Information provided here is for general purposes only. For specific details, refer to plan documents.

Contributions made by you through salary reductions are taxable for Social Security purposes. The benefits you receive at retirement will not reduce the level of social security compensation to which you are entitled.

Important
While the College will provide as much information on these programs as possible, OCC does NOT provide legal, tax or accounting advice. It is strongly suggested that you seek the advice of competent legal or tax counselors with regard to the applicable laws for participation in 403(b) and/or 457(b) programs. IT IS THE RESPONSIBILITY OF THE EMPLOYEE TO CONTACT THE VENDOR REPRESENTATIVE. Toll-free phone numbers are listed in the Carrier Directory section of this booklet.

Other Benefits

Direct deposit is a program in which your pay is automatically deposited into your checking or savings account. Direct deposit is the safest, most confidential way to get your money into your checking or savings account. With direct deposit, your money is in your account ON payday!! Whether you're on vacation, sick, or traveling out of town on business, your pay will automatically be deposited and available for your use.

Accidental death dismemberment insurance is for employees and eligible family members. Economical rates. Coverage provided regardless of health history. Employee pays 100% of the premium through payroll deduction.

MetLaw provides you, your spouse and dependents with fully covered legal services from experienced attorneys at a low monthly group rate which is automatically deducted from your paycheck monthly. Exclusions apply.

Portable Whole Life is an economical, flexible life insurance program to help provide financial security for you and your family. Employee, spouse and dependents may be eligible for coverage.

The employee pays 100% of the premium through payroll deduction. Portability - You'll own the policy, so you can keep your coverage in force, at the same low premium, when you retire or change employers. Individual Counseling - Since participants needs are not always the same a benefits counselor will meet with you privately to help select the coverage that is right for you. Contact The McLeod Agency at 248.540.1020 for more information.

The College supports **Employee Assistance Programs** through The Hartford. Contact 1800-96 HELPS (1-800-964-3577) or visit thehartford.com/employeebenefits

Oakland Community College believes in recognizing employees for their **years of service** to the College. Awards are given to employees starting with their tenth year of service and in five-year increments.

Notification will be sent to those employees who have met, or will meet, their service requirements by December 31 of each calendar year. Service requirements will be determined by the Human Resources Department.

RETIREMENT PLANS

Retirement. You look forward to it as a time to enjoy the good life you've earned during your active career. But to do that, you need financial security. The state of Michigan established a retirement plan to begin building that security for you. Together with Social Security contributions and your personal savings, this retirement plan can help ensure a secure and rewarding life during your retirement years.

The Michigan Public School Employees Retirement System (MPSERS) retirement plan is designed to provide you with a monthly income, called a pension, when you retire. Along with the retiree health benefits and survivor benefits, this plan helps protect you and your family.

Your contribution rate depends on when you first begin working for a Michigan public school reporting unit.

The Office of Retirement Services (ORS) offers two Defined Benefit (DB) pension retirement plans within the Michigan Public School Employees Retirement System for members who first worked in the Michigan Public School Employees Retirement System before July 1, 2010. In addition to a pension benefit, members in these plans also have access to retiree healthcare plans and death and disability benefits.

Plans prior to July 1, 2010 are Basic and MIP (Graded, Plus, Fixed)

Plans July 1, 2010 or after are Pension Plus and Defined Contribution (DC)

ORS Website http://www.michigan.gov/orsschools

From outside the Lansing area: call 800 381-5111 and in the Lansing area call 517-322-5103,

Office of Retirement Services, P.O. Box 30171, Lansing, MI 48909-7671

Optional Retirement Plan (ORP)

The Optional Retirement Plan (ORP) is offered through TIAA-CREF. The ORP is a defined contribution plan where the contributions made by you and Oakland Community College are invested in a retirement annuity contract in your name.

Employees who elect to participate in ORP in place of MPSERS will contribute 4% with employer portion of 11%.

First $5,000 of salary	3.0% of gross wages
$5,001 through $15,000	3.6% of gross wages
Over $15,000	4.3% of gross wages

Retirement vesting is immediate.

The pension formula is based on the amount of funds contributed, the investment earnings of those funds, your age at the time you begin receiving benefits and the type of payment arrangement you choose.

Tuition Waivers

Dependent children of a faculty member or retired faculty member, who is the parent or legal guardian, can enroll in Oakland Community College credit courses and shall be granted Tuition Authorization, upon request, prior to registration. Children to age twenty-five (25) of deceased Oakland Community College continuing contract faculty shall be extended the same benefits. Such requests shall be made to the Business Manager. **Faculty members and spouses and retired faculty members and spouses shall be granted tuition reimbursement upon completion of a course.** Faculty members shall not be compensated for their spouses or dependent children enrolled in their own sections.

The spouse, if any, (as of the date of death of a deceased faculty member shall remain eligible for the tuition reimbursement benefit provided above for a period of six (6) years following the date of the faculty member's death. At the expiration of the six-year period, the benefit shall be available for course sections that have actually met, but the benefit shall not be available for course sections for which the spouse has merely registered.

To have the tuition waived, the dependent will need to follow the procedure outlined below:

1. Obtain the Employee/Dependent Tuition Authorization Affidavit form. The forms will be available at each campus in Enrollment Services and the Business Office.

2. For dependents, the Employee/Dependent Tuition Authorization Affidavit form must be completed and signed by both the employee and their dependent every semester.

3. The employee/dependent will give the completed Affidavit form to a Student Services Specialist, (SSS) **before** the payment deadline.

4. The SSS will update the employee/dependent student record in order to have the eligible tuition and associated fees waived.

5. The employee/dependent will go to the cashier's office **only if there is a remaining balance due.**

6. The SSS will forward the Affidavit to the Human Resources Department who will verify the information.

The College reserves the right to request documentation supporting dependency which may include appropriate IRS tax forms. If dependency cannot be verified, a letter will be sent by the Human Resources Specialist to the employee requesting proof of dependency or full payment for the classes. Verification or full payment must be received by the due date stated in the letter.

If registration is during regular registration and verification or full payment is not received by the due date stated in the letter, full payment for all related tuition and fees will be deducted through payroll deduction.

Eligibility is upon full-time hire date. Dependents must be residing with the employee.

Tuition Reimbursement

The College shall appropriate $60,000 dollars each year in its operating budget to be used to pay bargaining unit members' tuition for course work which satisfies all of the following conditions:

A. Coursework or a program of study must be pertinent to the needs of the College and/or duties of the employee. The Coursework or program of study must be taken at an accredited institution of higher education. The Coursework must provide the employee with additional areas of competence. Employees may receive prior approval of Coursework by completing the Tuition Reimbursement Application and submitting it to the Dean/Supervisor for signature before registering for courses that will be submitted upon completion for tuition reimbursement.

B. All Coursework applied for under this article must be taken outside of regular work hours on the employee's own time. However, courses may be authorized during normal working hours if approved in writing by the immediate supervisor and the appropriate member of Chancellor's Council.

C. Reimbursement is for tuition and fees but does not include reimbursement for books, or any other related expenses.

D. The tuition reimbursement period will be for the fiscal year (July 1 to June 30).

E. Employees applying for tuition reimbursement must provide to the Human Resources Department a completed tuition reimbursement application, a completed check request, an official grade report/or copy and receipt for tuition and fee paid in order to receive any reimbursement under their plan of work. Such courses must have grade(s) of a "B" or higher and the courses must be completed within the academic year.

F. Incomplete ("I") grades must be made up within the same or following academic year in order to receive reimbursement. Incomplete grades not made up in the same or following academic year shall not be eligible for reimbursement in future years.

G. The maximum total of tuition and fees paid to any individual will be equal to $800 per credit hour up to a maximum of $8,000 per academic year. If tuition and fees are less than $800 per credit hour, reimbursement will be for the amount of the actual receipt.

H. Continuing education courses will be reimbursed only if a grade is awarded.

I. Courses at other colleges and universities that are equivalent to Oakland Community College classes are not eligible for tuition reimbursement.

J. Receipts and official/or copy of grade report with check request must be submitted within 30 days of course completion. When possible, reimbursement will be made 20 days following submission of official grade report/or copy and valid tuition receipt.

K. All faculty members will receive, in full, their requested tuition and fee reimbursement amounts according to the guidelines listed above and subject to the maximum fees shown above.

COBRA Continuation

A. ELIGIBILITY

1. Employees -

If you are an employee of Oakland Community College covered by a group health plan, you may elect to pay for continuation coverage if you lose your group health coverage due to:

a. a reduction in your hours of employment;
b. termination of employment for reasons other than gross misconduct on your part.

2. Spouses -

If you are the spouse of an employee of Oakland Community College covered by a group health plan, you may elect to pay for continuation coverage if you lose your group health coverage due to:

a. a reduction in your spouse's hours of employment;
b. termination of your spouse's employment for reasons other than gross misconduct on your spouse's part;
c. death of your spouse;
d. divorce or legal separation from your spouse.

3. Dependent Children -

Children that are eligible dependents of an OCC employee who is covered by a group health plan may elect to pay for continuation coverage. Adopted and newborn children may also be added to the continuation coverage if the Human Resources Department is notified within 30 days. Dependent children are eligible for group health coverage continuation due to:

a. a reduction in your parent's hours of employment;
b. termination of a parent's employment for reasons other than gross misconduct on your parent's part;
c. you cease to be a "dependent child" under the group health plan.

B. HOW IT WORKS

In the event of divorce, legal separation or loss of dependent status, you must notify OCC's Human Resources Department within 60 days of the day you would lose group health coverage. Upon your notification, OCC's Human Resources Department will supply you all further necessary information and forms.

In the event of hours reduction or termination of employment for reasons other than gross misconduct, OCC's Human Resources Department will automatically supply all necessary information and forms.

C. CONTINUATION COVERAGE DESCRIPTION

1. You may or may not elect continuation coverage. If you do not elect continuation coverage, your group health insurance coverage will end. You may have a right of conversion

2. If you do elect continuation coverage, you must pay the full premium cost. You may elect either:

    a. continuation of your current medical coverage only, or
    b. continuation of your current medical, dental and vision case (if any) as a package.

You and/or your eligible dependents may continue coverage:

    a. for up to 18 months in the event of hours reduction or termination not due to gross misconduct; **or**
    b. (b) for up to 29 months if you and/or your eligible dependents become disabled under the Social Security Act during the first 60 days of COBRA coverage. Please note that premium rates will be increased to 150% of normal rates during this period as per the Federal Law; **or**
    c. (c) for up to 36 months for other qualifying events.

3. The College may cancel your continuation coverage for any of the following reasons:

    a. Oakland Community College no longer provides group health coverage to any of its employees;
    b. The premium for your continuation coverage is not paid;
    c. You become covered under another group health plan, unless your new group health plan contains an exclusion or limitation with respect to pre-existing conditions in which case you may continue coverage for the maximum period;
    d. You become eligible for Medicare.

D. RESERVATION OF RIGHTS

Oakland Community College reserves the right to change the terms and conditions of continuation coverage pursuant to any changes in relevant law, group health plan coverage, or group health plan premiums.

Workers' Compensation

A work related injury or illness is defined as: a personal injury or illness arising out of and in the course of employment. An injury incurred in pursuit of a social or recreational activity is not covered.

Summary of Compensation

Compensation is weekly wage benefits provided upon establishment of disability and within the terms of the state of Michigan Workers' Disability Compensation Act.

Compensation shall consist of a percentage of average weekly earnings and shall be fixed at the time of injury. Sick and vacation time does not accrue during a disability and shall be included for the purpose of determining average weekly wage.

No compensation shall be paid for any injury which does not incapacitate the employee from earning full wages for a period of at least one week, but if incapacity extends beyond the period of one week, compensation shall begin on the eighth day after the injury. If incapacity continues for two weeks or longer, compensation shall be computed from the date of the injury.

Summary of Medical Services

The employee must accept the doctor and medical services provided by the employer at the time of the injury and up to 28 days from the inception of such medical care.

However, after 28 days of such medical care the employee may treat with a physician of his/her own choice by providing to the employer the name and address of the physician and his/her intention to treat with that physician. The employee must have authorization from District Office Human Resources Department or Broadspire to guarantee payment for a physician other than approved clinics.

A list of the approved Workers' Compensation Medical Facilities are listed below.

A chart is provided to show what facilities are in closest proximity to each campus location. However, any employee can utilize any of the facilities for a work related injury.

Workers' Compensation-Campus Locations and Approved Medical Facilities

APPROVED MEDICAL FACILITY	CAMPUS
Concentra Medical Centers 1915 N. Perry Street Pontiac, MI 48340 Phone (248)276-3999 Fax (248)276-3998 7:30-am-10:00pm (Mon-Fri) 8:00-am-4:00pm (Sat)	Auburn Hills District Office Highland Lakes
Concentra Medical Centers 26185 Greenfield Rd Southfield, MI 48075 Phone (248)569-2040 Fax (248)569-2048 7:30-am-10:00pm (Mon-Fri) 8:00-am-4:00pm (Sat)	Orchard Ridge Royal Oak/Southfield
Concentra Medical Centers 42875 Grand River Ave , Suite 105 Novi, MI 48375 Phone (248)478-1616 Fax (248)478-9450 8:00-am-10:00pm (Mon-Fri) 8:00-am-4:00pm (Sat)	Orchard Ridge Royal Oak/Southfield

Glossary of Terms

Adoption Reimbursement Account is an account that is funded by the employee's pre-tax dollars which may then be utilized to pay for specific adoption expenses.

Benefit Period is a 12 month calendar period Jan-Dec during which the terms and provisions of the coverage(medical, dental, vision) apply.

Compensation Reduction Agreement is the election form whereby the employee indicates their choice of benefit selections, and by signature, authorizes the reduction in salary to "pay" for the options selected.

Coordination of Benefits is when an employee or dependent is eligible to receive benefits through another plan, a coordination of benefits payment is followed so that between the two insurance plans, not more than 100% of the expense is reimbursed.

Co-Pay is a set amount the insured member is liable for based upon the benefit plan's payment as outlined in the Summary Plan Description.

Cost-Sharing is a percent of the reasonable charge that the covered member is liable for based upon the benefit plan's payment as outlined in the Summary Plan Description.

Core is the basic dental/vision/life/disability benefit coverage and/or plan offered to the employee at no cost.

Declination of Medical Coverage is a signed statement wherein the employee receives cash in lieu of OCC medical coverage. The employee must show proof of other coverage.

Deductible is the amount of covered expenses required to be paid by the covered member before benefits are payable under the plan.

Dental Coverage is services for the care of teeth and gums.

Dependent Care Reimbursement Account is a portion of the Flexible Spending/Reimbursement Account wherein an employee may be reimbursed for specific work related dependent care expenses.

Dependent Care Tax Credit is a tax credit allowed by the IRS for costs associated with child care. When associated with a Flexible Spending/Reimbursement Account, the value of the tax credit must be compared to the value of the tax savings available through the Dependent Care Reimbursement Account.

Elimination Period is an elapsed period of time required to be completed before benefits are payable to the employee (STD and/or LTD).

Enhanced Benefits are benefits that provide a greater level of coverage, services, and less co-pay over the core benefits.

Flexible Compensation is a program that allows employees to elect benefits that best fit their needs with the ability to enhance the benefits package at a prescribed cost or to reduce coverage where appropriate in return for cash.

Flexible Spending/Reimbursement an account that is funded by the employee's pre-tax dollars which may then be utilized to pay for specific health, dependent care or adoption expenses

Full-Time Employee is defined by policy established by the Board of Trustees.

Group Term Life/AD&D provides coverage only during the term of your employment. Once employment is terminated the term life insurance ceases. (AD&D)Accidental Death and Dismemberment insurance provides coverage in the event of an accidental death or dismemberment of a covered individual.

Health Care Reimbursement Account is a portion of the Flexible Spending/Reimbursement Account wherein an employee may be reimbursed for specific health care expenses not covered under the benefit plans.

Health Savings Account (HSA) is a pre-tax savings account for medical, dental and vision. The money in this account belongs to the employee for the rest of their life.

Life-Threatening Medical Emergency – when provided in an outpatient department of a hospital, the initial examination and treatment of conditions determined to be medical emergencies are paid at the level of coverage provided by your plan.

A medical emergency is an illness that is a life-threatening condition which requires immediate attention and treatment. The condition must have severe symptoms that occur suddenly and unexpectedly, and be such that failure to render immediate treatment could result in significant impairment of bodily functions, cause permanent damage to your health, or place your life in jeopardy. Final diagnosis determines if condition is life-threatening.

Long-Term Disability is a salary continuance program that provides an ongoing income in the event of a long-term sickness or injury. There is a 90-day elimination period before coverage applies.

Medical Coverage is various health care coverage options from which the employee may make their selection.

Medically Necessary Benefits are available for services which are determined to be a medical necessity. This includes services, supplies or care provided by a hospital, doctor or other covered health care provider to diagnose or treat the patient's medical condition, illness or injury. Services must be consistent with accepted standards for good medical practice, and must not be primarily for the convenience of the member, physician or family.

Opt Out is a selection choice of the employee wherein the individual chooses to opt out of OCC medical coverage. The college requires proof of coverage under another health care plan as an enrolled member {other than OCC coverage}.

Optional Coverage is a selection choice of the employee wherein coverage is different from the core coverage.

Pre-Admission Review is a provision of the plan which authorizes medically necessary admissions to the hospital. You or your doctor must request prior approval from your medical provider for admissions to a hospital or other medical facility. If these guidelines are not followed you may have additional financial responsibilities in excess of the deductible and co-payment requirements.

Portable Whole Life Insurance is personal life insurance purchased by the employee who owns the policy and retains the coverage even if employment terminates.

Pre-Tax Dollars are not subject to state or federal income taxes.

Proof of Good Health is a statement of proof of your medical history upon which the insurance provider or benefit administrator will determine your acceptance for coverage.

Qualifying Period – please see elimination period.

Qualifying Status Change-In the event of a change in family status (i.e., birth, divorce, death, etc.) you may elect to change your contributions to your Health Care and/or Dependent Care Reimbursement Accounts.

Second Surgical Option is a provision of the plan which covers up to 100% of the reasonable amount toward the cost of a second surgical opinion when required by your medical plan provider.

Short-Term Disability is a salary continuance program that provides a percentage of weekly income in the event of a short-term sickness or injury. There is a 14-day elimination period before coverage begins and a maximum duration of 13 weeks of benefits.

Total Disability is an insured member covered on a disability insurance plan is considered totally disabled if wholly and continuously unable to perform any and every duty pertaining to his/her regular occupation, while under the care of a physician, up to a specified maximum period, usually two years. Total disability continues thereafter if the member is unable to engage in any occupation or perform work for compensation for which he/she is reasonably fitted by training, education, or experience.

Vision Coverage are services for vision care, i.e. exam, lenses, frames, etc.

Carrier Directory

COVERAGE	CONTACT INFORMATION	WEBSITE
WMHIP/BCBS	Phone – 877-752-1233	www.bcbsm.com
NVA Vision Plan	Phone -800-672-7723	www.e-nva.com
Dental ADN P.O. Box 610 Southfield, MI 48037	Phone – 888-236-1100 Fax- 248-901-3711 Group Number 9422	www.adndental.com
The Hartford Group Term Life Insurance AD and D Optional Life	Phone-800-331-7234	www.thehartfordatwork.com
MetLaw	Phone-800-821-6400	www.legalplans.com
Short-Term and Long-Term Disability	Phone-800-549-6514	www.thehartfordatwork.com
Flexible Spending Accounts E.B.C. 2882 Orchard Lake Rd, Suite 140 Farmington Hills, MI 48334	Phone-248-855-8040 Fax- 248-855-2454	www.myflexonline.com www.takecareplans.com/ebcmichigan
Health Savings Account (HSA) Health Equity	Phone- 866-382-3510	https://healthequity.com/learn/hsa/member-guide/member-portal
Portable Whole Life The McLeod Agency, Inc. 6001 N. Adams Rd., Suite 201 Bloomfield Hills, MI 48304	Phone-248-540-1020	
Tax Deferred Annuities Consolidated Financial Corporation Fidelity Investments Voya Financial Lincoln Financial VALIC TIAA AXA Equitable	Phone 800-232-2383 800-835-5097 800-525-4225 800-454-6265 800-448-2542 800-842-2776 800-628-6673	Website www.consolidated-financial.com www.fidelity.com www.voya.com www.lfg.com www.valic.com www.tiaa.org www.axaonline.com
MidAmerica Administrative and Retirement Solutions, Inc. Attn: 403(b) TPA 211 E. Main Street, Suite 100 Lakeland, FL 33801	866-873-4240	www.midamerica.biz
Michigan Public School Employees Retirement System(MPSERS)	800-381-5111	www.michigan.gov/ors