



MICHIGAN OFFICE OF RETIREMENT SERVICES

Big Plans. Small Steps.

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www.michigan.gov/ors

Insurance Option Summary – Michigan Public School Retirees

Your Health Plans

The Michigan Office of Retirement Services (ORS) strives to be good stewards of your pension and healthcare dollars. We work with the Michigan Public School Employees' Retirement System Board yearly to maintain a quality plan and remain fiscally responsible for the future of

our retirement system. We offer several comprehensive insurance options to choose from, with the current options listed below. Plan offerings are updated annually, so check the ORS website for the most current information.

Enrolling in or Changing Insurance after Retirement

Enrolling after retirement. If you are enrolling yourself, your spouse, or dependents in insurance after retirement, your coverage will begin on the first day of the sixth month after ORS receives all required forms and proofs. For example, if we receive your request on Feb. 10, your coverage would begin Aug. 1.

If you or a dependent has a qualifying event and ORS gets the request and proofs within 30 days of the event, coverage can begin sooner. For retirees who do not have Medicare, coverage can begin the first of the month after the month we receive your completed application and proofs. For retirees with Medicare, your coverage can begin the first day of the second month after we receive your request and any required proofs, including proof of the qualifying event.

For example, if ORS receives your application and proofs on July 10, your coverage will begin Sept. 1.

Personal Healthcare Fund (PHF). If you have PHF, you cannot enroll in insurance after you have retired. You can only change plans. If you're

not sure if you have PHF, check miAccount www.michigan.gov/orsmiaccount.

If you chose PHF, you opted out of the Premium Subsidy benefit and you will not be eligible for any insurances through the retirement system as a deferred retiree. If you disenroll from the plan at any time, you, your spouse, and any eligible dependents will not be able to re-enroll. If your spouse or your dependents are disenrolled from the plan at any time, they will not be able to re-enroll.

Changing plans. If you are currently enrolled in any health insurance plan with the retirement system, you can change your enrollment to another plan regardless of your Medicare status. Your change in coverage will be effective the first day of the second month after your request and required proofs are received. For example, if ORS receives your change request and any required proofs on Jan. 10, your coverage with the new plan will begin on March 1.

For More Information

This is a summary document to help you compare plans. For detailed plan information, and answers to benefit and coverage questions, contact the insurance carriers at the phone numbers listed on the following pages.

Please note: the information in this summary may change throughout the year. Your insurance carrier will provide the most up to date

information on coverage areas and benefit levels. Review the *Insurance Information (R0058C)* sheet for details about how to enroll, who can be enrolled, insurance cards, effective dates of coverage, required proofs, the effects of Medicare and other group insurance coverage. This sheet can be found at www.michigan.gov/orsschools.

Insurance Plans Available

The following list is current at the date of printing. If you are interested in enrolling in an HMO, you

should contact the HMO directly to receive the most current coverage area listing.

Insurance Carriers by County

Effective January 1, 2021

NON-MEDICARE

CARRIERS

COUNTIES

Blue Preferred PPO
(BCBSM) 800-422-9146
bcbsm.com/mpsers

No county restrictions.

OptumRx® 866-288-5209
optumrx.com/enroll/mpser

Blue Care Network
800-662-6667
bcbsm.com/mpsers

All 83 Michigan counties covered.

Priority Health
800-446-5674
priorityhealth.com/mpsers

Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Delta (only 49807), Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Mackinac (only 49757 and 49775), Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, and Wexford.

MEDICARE

CARRIERS

COUNTIES

Medicare Plus Blue PPO
(BCBSM) 800-422-9146
bcbsm.com/mpsers
OptumRx® 855-577-6517
optumrx.com/enroll/mpser

No county restrictions.

BCN Advantage
800-450-3680
bcbsm.com/mpsers

Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Mackinac, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee, St. Clair, St. Joseph (only the following zip codes: 49011, 49030, 49052, 49072, 49093, 49097), Tuscola, Van Buren, Washtenaw, Wayne and Wexford.

Priority Health Medicare
888-389-6648
priorityhealth.com/mpsers

All 83 Michigan counties covered.



Non-Medicare Summary Comparison Sheet*			Effective Jan. 1, 2021
HEALTH CARE BENEFIT	Blue Preferred PPO (BCBSM) 800-422-9146 bcbsm.com/mpsers OptumRx® 866-288-5209 optumrx.com/enroll/mpser	Blue Care Network 800-662-6667 bcbsm.com/mpsers	Priority Health 800-446-5674 priorityhealth.com/mpsers
Office Visits	10% coinsurance plus deductible	\$25 copay Primary \$35 copay after deductible Specialist	\$25 copay Primary \$40 copay Specialist, deductible does not apply
Online Visits	10% coinsurance plus deductible	\$25 copay	\$0 copay, deductible does not apply
Routine Physical Exams	Covered in full once annually	\$25 copay Primary \$35 copay after deductible Specialist	Covered in full, deductible does not apply
Routine Pap Smears	Covered in full at in-network independent labs and doctor offices in Michigan, otherwise 10% coinsurance plus deductible	Covered in full	Covered in full, deductible does not apply
Routine Mammograms	10% coinsurance plus deductible	Covered in full	Covered in full, deductible does not apply
Screening Colonoscopy	10% coinsurance plus deductible	Covered in full	Covered in full, deductible does not apply
Allergy Testing and Treatment	10% coinsurance plus deductible	50% coinsurance after deductible \$5 copay for allergy injections	Included in office visit, deductible does not apply
Chiropractic Visits	10% coinsurance plus deductible, up to 26 visits annually	\$35 copay after deductible	\$30 copay, maximum benefit 30 visits/year with PT & OT, deductible does not apply
Hospital Inpatient Care	10% coinsurance plus deductible	10% coinsurance after deductible	10% coinsurance after deductible
Hospital Outpatient Care (inc. diagnostic services)	10% coinsurance plus deductible	10% coinsurance after deductible \$150 copay after deductible for high tech imaging services	10% coinsurance after deductible \$150 copay, deductible does not apply for high tech imaging services
Surgical Services	10% coinsurance plus deductible	10% coinsurance after deductible	10% coinsurance after deductible
Emergency Room Care	10% coinsurance plus deductible, \$120 copay/visit after coinsurance maximum met.** Waived if admitted within 72 hours.	\$150 copay after deductible, waived if admitted	\$150 copay, waived if admitted. Deductible does not apply
Urgent Care	10% coinsurance plus deductible, \$65 copay/visit after coinsurance maximum met**	\$65 copay	\$60 copay. Deductible does not apply
Home Health Care	Deductible	\$35 copay after deductible	10% coinsurance after deductible
Skilled Nursing Facility	10% coinsurance plus deductible up to 100 days (can be renewed)	10% coinsurance after deductible up to 120 days per calendar year	10% coinsurance, 100 days (can be renewed) after deductible

Non-Medicare Summary Comparison Sheet (continued)*			Effective Jan. 1, 2021
HEALTH CARE BENEFIT	Blue Preferred PPO (BCBSM) 800-422-9146 OptumRx® 866-288-5209	Blue Care Network 800-662-6667	Priority Health 800-446-5674
Hospice	Covered in full	Covered in full after deductible; inpatient hospice care requires prior authorization	10% coinsurance after deductible
Outpatient Mental Health Services	10% coinsurance plus deductible	50% coinsurance, up to 20 visits/calendar year	\$25 copay, deductible does not apply
Durable Medical Equipment Supplier	In Network 10% coinsurance plus deductible; Out of Network 30% coinsurance plus deductible and difference in cost between provider's charge and the BCBSM approved amount	50% coinsurance of the Approved Amount when authorized and obtained from a participating provider	20% coinsurance after deductible
Hearing Benefits	Hearing Exam: \$45 copay** Hearing Aids: \$499 copay** per hearing aid for advanced aids \$799 copay** per hearing aid for premium aids Initial hearing exam and hearing aids for both ears covered once every 36 months, exclusively through TruHearing providers	Hearing Exam: Covered in full. One exam every 36 months Hearing Aids: Covered in full. One hearing aid every 36 months.	Hearing Exam: Covered in full. One hearing exam, one audiometric exam every 24 months Hearing Aids: \$499 copay per hearing aid for advanced aids, \$799 copay per hearing aid for premium aids. One basic hearing aid per ear every 12 months Exclusively through TruHearing providers
Care Outside Michigan	Same in U.S. and its territories; emergency and urgent care outside U.S., member pays cost of care up front and files for reimbursement	Routine, urgent & follow-up care through BlueCard	Emergency & Urgent Care same as in-network. Most other covered services, travel deductible and coinsurance apply.
Care in Michigan, but Outside the Network	Additional 20% coinsurance, waived if member has referral from Blue Preferred PPO physician. If provider does not participate with BCBSM, member also pays difference between the approved amount and provider's charge. Routine hearing care is only covered when members use TruHearing providers.	Emergency & urgent care covered; other care not covered unless member has prior authorization on file	Emergency & Urgent Care same as in-network
Deductible	\$1,000 Individual ***	\$400 Individual/\$800 Family	In-network: \$750 Individual/\$1,500 Family Out-of-network: \$1,500 Individual/\$3000 Family
Medical Maximum	Coinsurance maximum: \$900 Individual	Coinsurance maximum: \$750 Individual/\$1,500 Family	Coinsurance maximum: In-network: \$1,000 Individual/\$2,000 Family Out-of-network: \$2,000 Individual/\$4,000 Family
Prescription Drugs	Preferred Brand & Generic: 20% coinsurance + \$15 minimum /\$45 maximum (30 day); \$37.50 minimum /\$112.50 maximum (90 day). Non-Preferred Brand: 40% coinsurance + \$15 minimum / No maximum (30 day); \$37.50 minimum / no maximum (90 day). Preferred Specialty: 20% coinsurance + \$50 minimum / \$100 maximum (30 day). Non-Preferred Specialty: 40% coinsurance + \$50 minimum / no maximum. Additional 10% coinsurance on 30-day supply of maintenance drugs on and after 4th refill at retail. Exclusive Specialty pharmacy medications through Optum Specialty Pharmacy.	\$20 copay Generic \$60 copay Preferred Brand \$80 copay Non-Preferred Brand 50% coinsurance sexual dysfunction drugs (30-day supply) Specialty: 20% coinsurance (\$200 maximum per prescription Tier 4, \$400 maximum per prescription Tier 5) Mail Order: Up to 90-day supply for 2 copays	Deductible does not apply \$10 copay Tier 1 \$50 copay Tier 2 \$80 copay Tier 3 Specialty: 20% coinsurance (\$150 maximum per prescription) Mail Order: 90-day supply for 2 copays
Pharmacy Maximum	Coinsurance maximum: \$1,750 Individual	Specialty only: \$4,800 Individual pharmacy out of pocket maximum	No pharmacy out of pocket maximum

*This document is only a summary. For complete plan details, contact the individual providers. Benefit levels are subject to change.

**Copays are not included in the medical coinsurance maximum.

***BCBSM Members enrolled in the LivingWell program have the opportunity to reduce their deductible.

Medicare Summary Comparison Sheet*			Effective Jan. 1, 2021
HEALTH CARE BENEFIT	Medicare Plus Blue PPO (BCBSM) bcbsm.com/mpsers 800-422-9146 OptumRx® 855-577-6517 optumrx.com/enroll/mpser	BCN Advantage 877-396-2025 bcbsm.com/mpsers	Priority Health Medicare 888-389-6648 priorityhealth.com/mpsers
Office Visits	10% coinsurance plus deductible	\$25 copay Primary. \$45 copay after deductible Specialist. \$40 copay outpatient therapy services	\$10 copay Primary \$35 copay Specialist, deductible does not apply
Online Visits	10% coinsurance plus deductible	\$25 copay in network	\$0 copay, deductible does not apply
Routine Physical Exams	Covered in full once annually	Medicare Wellness Exam covered in full once annually	Covered in full, deductible does not apply
Routine Pap Smears	Covered in full	Covered in full	Covered in full, deductible does not apply
Routine Mammograms	Covered in full	Covered in full	Covered in full, deductible does not apply
Colorectal Cancer Screening	Covered in full	Covered in full (screening colonoscopy or screening barium enema as an alternative) every 24 months Not high risk of colorectal cancer: Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	Covered in full, deductible does not apply
Allergy Testing and Treatment	10% coinsurance plus deductible	Covered in full Office visit copay may apply after deductible	Covered in full. Office visit copay may apply, deductible does not apply
Chiropractic Visits	10% coinsurance plus deductible	\$20 copay after deductible when referred	\$10 copay, deductible does not apply
Hospital Inpatient Care	10% coinsurance plus deductible	10% coinsurance after deductible	10% coinsurance after deductible
Hospital Outpatient Care (inc. diagnostic services)	10% coinsurance plus deductible	10% coinsurance after deductible. Office visit copay may apply \$150 copay after deductible for high tech imaging services	10% coinsurance after deductible. Diagnostic labs, pathology, x-rays \$10 copay after deductible. \$150 copay, deductible does not apply for high tech imaging services
Surgical Services	10% coinsurance plus deductible	10% coinsurance after deductible	10% coinsurance after deductible
Emergency Room Care	\$120 copay, waived if admitted within 72 hours	\$100 copay after deductible, waived if admitted	\$90 copay, waived if admitted. Deductible does not apply
Urgent Care	\$65 copay	\$50 copay	\$45 copay. Deductible does not apply
Home Health Care	Covered in full	Covered in full after deductible; copay may apply for physician's visit	Covered in full, deductible does not apply
Skilled Nursing Facility	10% coinsurance plus deductible, up to 100 days (can be renewed)	Covered in full after deductible for 100 days (can be renewed after 60 days)	10% coinsurance 100 days (can be renewed after 60 days) after deductible

Medicare Summary Comparison Sheet*			Effective Jan. 1, 2021
HEALTH CARE BENEFIT	Medicare Plus Blue PPO (BCBSM) 800-422-9146 OptumRx® 855-577-6517	BCN Advantage 877-396-2025	Priority Health Medicare 888-389-6648
Hospice	Covered by Original Medicare	Covered by Original Medicare	Covered by Original Medicare
Outpatient Mental Health Services	10% coinsurance plus deductible	Covered in full	\$10 Copay, deductible does not apply
Durable Medical Equipment Supplier	In network 10% coinsurance plus deductible. Out of network 30% coinsurance plus deductible	20% coinsurance	20% coinsurance after deductible
Hearing Benefits	Hearing Exam: \$45 copay** Hearing Aids: \$499 copay** per hearing aid for advanced aids. \$799 copay** per hearing aid for premium aids Initial hearing exam and hearing aids for both ears covered once every 36 months, exclusively through TruHearing providers	Hearing Exam: Covered in full. One exam every 36 months Hearing Aids: Covered in full. One hearing aid per ear every 36 months.	Hearing Exam: Covered in full. One hearing exam, one audiometric exam every 24 months Hearing Aids: \$499 copay per hearing aid for advanced aids, \$799 copay per hearing aid for premium aids. One basic hearing aid per ear every 12 months Exclusively through TruHearing providers.
Care Outside of Michigan	Same in U.S. and its territories; emergency and urgent care outside U.S., member pays cost of care up front and files for reimbursement.	Routine, urgent and follow-up care through BlueCard.	Emergency & Urgent Care same as in-network. Out of state benefit covers out of state care the same as in-network when you visit a Multiplan Medicare participating provider.
Care in Michigan, But Outside the Network	Same as in network, except Durable Medical Equipment. Routine hearing care is only covered when members use TruHearing providers.	Emergency and Urgent care covered. Other care not covered unless member has prior authorization on file.	Emergency & Urgent Care same as in-network. Most other covered services, travel deductible and coinsurance apply.
Deductible	\$800 Individual ***	\$400 Individual	\$300 Individual
Medical Maximum	Coinsurance/copay maximum**: \$900 Individual Total medical out-of-pocket maximum** (Deductible + Coinsurance/copay maximum): \$1,700 Individual	Total medical out-of-pocket maximum: \$2,100 Individual (deductible \$400 + \$1700 out of pocket maximum).	Total medical out-of-pocket maximum: (Deductible, medical coinsurance, and medical copays) \$2,100 Individual
Prescription Drugs	Preferred Brand and Generic: 20% coinsurance + \$15 minimum/\$45 maximum (30 day); \$37.50 min/\$112.50 max (90 day) Non-Preferred Brand: 40% coinsurance + \$15 minimum / no maximum (30 day) \$37.50 minimum/no maximum (90 day). Preferred Specialty: 20% coinsurance + \$50 minimum / \$100 maximum (30 day). Non-Preferred Specialty: 40% coinsurance + \$50 minimum / no maximum (30 day) Additional 10% coinsurance on 30-day supply of maintenance drugs on and after 4th refill at retail Preferred Specialty medications through Optum Specialty Pharmacy	Preferred Pharmacy: \$12 copay Generic. \$55 copay Preferred Brand. \$80 copay Non-Preferred Drugs. 50% coinsurance sexual dysfunction drugs (31-day supply) Standard Pharmacy: \$20 copay Generic \$75 copay Preferred Brand \$100 copay Non-Preferred Drugs Mail Order: 32 day to 90-day supply for 2 copays Specialty: 20% coinsurance (\$200 maximum per prescription)	Deductible does not apply Preferred Pharmacy: \$9 Copay Tier 1 Generic. \$40 Copay Tier 2 Preferred Brand. \$70 Copay Tier 3 Non-Preferred Brand Non-Preferred Pharmacy: \$15 Copay Tier 1 Generic. \$45 Copay Tier 2 Preferred Brand. \$75 Copay Tier 3 Non-Preferred Brand Mail Order: Up to 90-day supply for 2 Copays. Tier 1 generic \$0 copay Specialty: 20% coinsurance (\$100 maximum per prescription)
Pharmacy Maximum	Coinsurance maximum: \$1,750 Individual	No pharmacy out of pocket maximum	No pharmacy out of pocket maximum

*This document is only a summary. For complete plan details, contact the individual providers. Benefit levels are subject to change.

** Copays for routine hearing care are not included in the medical out-of-pocket maximum.

***BCBSM Medicare Members are automatically enrolled in the LivingWell Program and receive the lower deductible for being a part of the program.