MICHIGAN OFFICE OF RETIREMENT SERVICES
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Insurance Options Summary – Michigan Public School Retirees

Your Health Plan

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 Board yearly to maintain a quality healthcare 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 February 10, your coverage will begin August 1. If you, your spouse, 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 July 10, your coverage will begin September 1.

Personal Healthcare Fund (PHF). If you have the PHF, you cannot enroll in insurance after you retire. You can only change plans. If you're not sure if you have the PHF, check in miAccount at **Michigan.gov/ORSmiAccount.**

If you disenroll from the plan at any time, you, your spouse, and any eligible dependents will not be able to reenroll. If your spouse or your dependents are disenrolled from the plan at any time, they will not be able to reenroll.
If you're a deferred retiree who chose the PHF, this selection opted you out of the premium subsidy benefit and you will not be eligible for any insurances through the retirement system.

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 January 10, your coverage with the new plan will begin 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)* document 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 document can be found at **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, 2025

Non-Medicare

CARRIERS	COUNTIES
Blue Preferred PPO (Blue Cross) 800-422-9146 BCBSM.com/MPSERS **Optum Rx 866-288-5209 OptumRx.com/EnrolI/MPSER**	No county restrictions.
Blue Care Network (BCN) HMO 800-662-6667 BCBSM.com/MPSERS	All 83 Michigan counties covered.
Health Alliance Plan (HAP) HMO 800-422-4641 HAP.org/MPSERS	Arenac, Barry, Bay, Branch, Clare, Clinton, Crawford, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Iosco, Isabella, Jackson, Kent, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Ottawa, Roscommon, Saginaw, St. Clair, Sanilac, Shiawassee, Tuscola, Washtenaw, and Wayne.
Priority Health HMO 844-403-0847 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 Group PPO (Blue Cross) 800-422-9146 BCBSM.com/MPSERS **Optum Rx 855-577-6517 OptumRx.com/Enroll/MPSER**	No county restrictions.
Blue Care Network (BCN) Advantage HMO 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, Tuscola, Van Buren, Washtenaw, Wayne, and Wexford.
Health Alliance Plan (HAP) Medicare Advantage HMO 800-801-1770 HAP.org/MPSERS	Allegan, Arenac, Barry, Bay, Berrien, Branch, Calhoun, Cass, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kent, Lake, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Ottawa, Saginaw, St. Clair, Sanilac, Shiawassee, Tuscola, Van Buren, Washtenaw, and Wayne.
Priority Health Medicare Advantage HMO 844-403-0847 PriorityHealth.com/MPSERS	All 83 Michigan counties covered.

HEALTHCARE BENEFIT	Blue Preferred PPO (Blue Cross) 800-422-9146 Optum Rx 866-288-5209	Blue Care Network (BCN) HMO 800-662-6667	Health Alliance Plan (HAP) HMO 800-422-4641	Priority Health HMO 844-403-0847
Hospital Care				
Inpatient hospital care	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.
Outpatient hospital care, including diagnostic services	10% coinsurance, after deductible.	10% coinsurance, after deductible. $150 copay, after deductible, for high-tech imaging services.	10% coinsurance, after deductible. $150 copay per test — deductible does not apply — for high-tech imaging services.	10% coinsurance, after deductible. $150 copay — deductible does not apply — for high-tech imaging services.
Alternatives to Hospital Care				
Home healthcare	Deductible.	$35 copay, after deductible.	Deductible. Up to 100 visits per benefit period (combined in network and out of network).	10% coinsurance, after deductible.
Skilled nursing facility	10% coinsurance, after deductible, up to 100 days (can be renewed).	10% coinsurance, after deductible. Coverage for 120 days per calendar year (can't be renewed in the same calendar year).	10% coinsurance, after deductible. Covered for authorized services. Up to 100 days per benefit period, renewable after 60 days of non-confinement (combined in network and out of network).	10% coinsurance, after deductible, up to 100 days. Can be renewed after 60 days.
Hospice	Covered in full.	Covered in full, after deductible. Inpatient hospice care requires prior authorization.	Covered in full.	10% coinsurance, after deductible.
Emergency Services				
Emergency room care	10% coinsurance, after deductible. $140 copay/visit after coinsurance maximum is met.** Waived if admitted within 72 hours.	$150 copay after deductible, waived if admitted within 72 hours.	$150 copay, waived if admitted.	$150 copay, waived if admitted.
Urgent care	10% coinsurance, after deductible. $65 copay/visit after coinsurance maximum met.**	$65 copay.	$60 copay.	$60 copay.
Surgical Services				
Surgical services	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.
Doctor Office Visits and Services				
Office visits	10% coinsurance, after deductible.	Primary doctor: $25 copay. Specialist: $35 copay, after deductible.	Primary doctor: $25 copay. Specialist: $40 copay.	Primary doctor: $25 copay. Specialist: $40 copay.
Online visits	10% coinsurance, after deductible.	$25 copay.	Covered in full through Amwell. Virtual visits through HAP providers will take the appropriate office visit copay.	Covered in full.

HEALTHCARE BENEFIT	Blue Preferred PPO (Blue Cross) 800-422-9146 Optum Rx 866-288-5209	Blue Care Network (BCN) HMO 800-662-6667	Health Alliance Plan (HAP) HMO 800-422-4641	Priority Health HMO 844-403-0847
Allergy testing and treatment	10% coinsurance, after deductible.	50% coinsurance, after deductible. $5 copay for allergy injections.	Covered, after deductible, for injections. All other treatments, 10% coinsurance, after deductible.	Included in office visit.
Chiropractic visits	10% coinsurance, after deductible, up to 26 visits annually.	$35 copay, after deductible.	$25 copay. Up to 30 visits per benefit period (combined in network and out of network).	$30 copay. Maximum benefit 30 visits per year with PT and OT.
Physical, occupational, speech therapy	10% coinsurance, after deductible.	$35 copay, after deductible, limited to 60 consecutive days per episode.	$25 copay. Per calendar year, up to 30 visits for PT/OT and 30 visits for ST.	$30 copay. Maximum benefit 30 visits per year with PT and OT.
Preventive Services				
Annual routine physical exams	Covered in full.	Primary doctor: $25 copay. Specialist: $35 copay, after deductible.	Covered in full.	Covered in full.
Routine pap smears	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Routine mammograms	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Screening colonoscopy	Covered in full.	10% coinsurance, plus deductible.	Covered in full.	Covered in full.
Mental Health				
Outpatient mental health services	10% coinsurance, after deductible.	50% coinsurance, up to 20 visits per calendar year.	$25 copay.	$25 copay.
Substance Use Disorder Treatment				
Outpatient facility	10% coinsurance, after deductible.	50% coinsurance.	$25 copay.	$25 copay.
Durable Medical Equipment				
Durable medical equipment	**Approved provider:** 10% coinsurance, after deductible. **Non-approved provider:** 30% coinsurance, after deductible, and difference in cost between supplier's charge and the Blue Cross approved amount.	50% coinsurance of the approved amount when authorized.	10% coinsurance, after deductible, for approved equipment only.	20% coinsurance, after deductible.

HEALTHCARE BENEFIT	Blue Preferred PPO (Blue Cross) 800-422-9146 Optum Rx 866-288-5209	Blue Care Network (BCN) HMO 800-662-6667	Health Alliance Plan (HAP) HMO 800-422-4641	Priority Health HMO 844-403-0847
Hearing				
Routine hearing care	**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. For additional exams, a $40 specialist office visit copay would apply. **Hearing aids:** $499 copay per hearing aid for advanced aids. $799 copay per hearing aid for premium aids. Limited to two hearing aids per year. Exclusively through NationsHearing providers.	**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.
Alternatives to Hospital Care				
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 Blue Cross, member also pays difference between the approved amount and provider's charge. 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.	Out-of-network benefit would apply, which is 30% coinsurance, after deductible.	Emergency and urgent care same as in network.
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, and follow-up care through BlueCard.	Emergency and urgent care same as in network. For all other benefits, out-of-network benefit would apply, which is 30% coinsurance, after deductible.	Emergency and urgent care same as in network. Most other covered services, travel deductible, and coinsurance apply.
Medical Deductible				
Deductible The amount you pay each year before the plan pays.	$1,000 individual.***	$400 individual/$800 family.	**In network:** $600 individual/ $1,200 family. **Out of network:** $1,500 individual/$3,000 family.	**In network:** $750 individual/$1,500 family. **Out of network:** $1,500 individual/$3,000 family.
Medical Maximum				
Medical coinsurance maximum The maximum amount of coinsurance paid in a calendar year for in-network services.	$900 individual.	$600 individual/$1,200 family.	Not applicable in network or out of network.	**In network:** $5,000 individual/$10,000 family. **Out of network:** $10,000 individual/$20,000 family.

HEALTHCARE BENEFIT	Blue Preferred PPO (Blue Cross) 800-422-9146 Optum Rx 866-288-5209	Blue Care Network (BCN) HMO 800-662-6667	Health Alliance Plan (HAP) HMO 800-422-4641	Priority Health HMO 844-403-0847
Prescription Drugs				
Traditional prescription drugs	**Generic and preferred brand:** 20% coinsurance with $15 minimum/$45 maximum (31 day); $37.50 minimum/$112.50 maximum (90 day). **Non-preferred brand:** 40% coinsurance with $15 minimum/no maximum (31 day); $37.50 minimum/no maximum (90 day).	**Generic:** $20 copay. **Preferred brand:** $60 copay. **Non-preferred brand:** $80 copay. 50% coinsurance for sexual dysfunction drugs (30-day supply). **Mail order** Up to 90-day supply for two copays.	**Select generic, generic, and select brand:** $10 copay (30 day), $20 copay (90 day). **Preferred:** $50 copay (30 day), $100 copay (90 day). **Non-preferred brand and non-preferred generic:** $80 copay (30 day), $160 copay (90 day). A 90-day supply of non-maintenance drugs must be filled at the designated mail order pharmacy.	**Generic:** $10 copay. **Preferred brand (may include some high-cost generics):** $50 copay. **Non-preferred brand (may include some high-cost generics):** $80 copay. **Mail order** 90-day supply for two copays.
Specialty prescription drugs	**Optum Specialty Pharmacy** **Preferred:** 20% coinsurance with $50 minimum/$100 maximum (30 day). **Non-preferred:** 40% coinsurance with $50 minimum/no maximum (30 day). **Non-preferred pharmacy** 40% coinsurance with $50 minimum/no maximum.	**Preferred:** 20% coinsurance, with $200 maximum per prescription. **Non-preferred:** 20% coinsurance, with $400 maximum per prescription.	20% coinsurance with $150 maximum per prescription (30 day) at specialty pharmacy only. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.	20% coinsurance, with $150 maximum per prescription.
Prescription Drug Maximum				
Prescription drug coinsurance maximum	$1,750 individual.	**Specialty only:** $4,800 individual pharmacy out-of-pocket maximum.	$1,750 individual/$3,500 family (this does accrue toward the annual in-network out-of-pocket limit).	No pharmacy out-of-pocket maximum.

*This document is only a summary. For complete plan details, contact the insurance carriers. Benefit levels are subject to change.
**Copays are not included in the medical coinsurance maximum.
***Members enrolled in the LivingWell program have the opportunity to reduce their deductible.

HEALTHCARE BENEFIT	Medicare Plus Blue Group PPO (Blue Cross) 800-422-9146 Optum Rx 855-577-6517	Blue Care Network (BCN) Advantage HMO 800-450-3680	Health Alliance Plan (HAP) Medicare Advantage HMO 800-801-1770	Priority Health Medicare HMO 844-403-0847
Hospital Care				
Inpatient hospital care	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.
Outpatient hospital care, including diagnostic services	10% coinsurance, after deductible.	10% coinsurance, after deductible. Office visit copay may apply. $150 copay or 50% coinsurance, after deductible for high-tech imaging services.	10% coinsurance, after deductible. Diagnostic labs covered in full; pathology covered in full, after deductible; X-rays $10 copay, after deductible.	10% coinsurance, after deductible. Diagnostic labs, pathology, and X-rays $10 copay, after deductible.
Alternatives to Hospital Care				
Home healthcare	Covered in full.	Covered in full, after deductible.	Covered in full, after deductible.	Covered in full.
Skilled nursing facility	10% coinsurance after deductible, up to 100 days. Can be renewed.	Covered in full, up to 100 days per benefit period. Can be renewed after 60 days.	Days 1-20: Covered in full. Days 21-100: 10% coinsurance, after deductible. Combined in network and out of network. Limited to 100 days per benefit period, renewable after 60 days of non-confinement. Hospital stay is not required. Authorization rules apply.	10% coinsurance, after deductible, for up to 100 days. Can be renewed after 60 days.
Hospice	Covered by Original Medicare.	Covered by Original Medicare.	Covered by Original Medicare.	Covered by Original Medicare.
Emergency Services				
Emergency room care	$140 copay. Waived if admitted within 72 hours.	$100 copay. Waived if admitted within 72 hours.	$135 copay. Waived if admitted.	$120 copay. Waived if admitted within 24 hours for the same condition.
Urgent care	$65 copay.	$50 copay.	$45 copay.	$45 copay.
Surgical Services				
Surgical services	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.	10% coinsurance, after deductible.
Doctor Office Visits and Services				
Office visits	10% coinsurance, after deductible.	Primary doctor: $10 copay. Specialist: $35 copay.	Primary doctor: Covered in full. Specialist: $35 copay.	Primary doctor: Covered in full. Specialist: $35 copay.
Online visits	10% coinsurance, after deductible.	Covered in full.	Covered in full through Amwell. Virtual visits through HAP providers will take the appropriate office visit copay.	Covered in full.
Allergy testing and treatment	10% coinsurance, after deductible.	Covered in full, after deductible. Office visit copay may apply per member, per visit.	Covered in full for allergy injections. All other treatments, 10% coinsurance, after deductible. Office visit copay may apply.	Covered in full. Office visit copay may apply.
Chiropractic visits	10% coinsurance, after deductible.	$20 copay, after deductible.	$10 copay.	$10 copay.
Physical, occupational, speech therapy	10% coinsurance, after deductible.	$35 copay, after deductible.	$10 copay.	$35 copay.

HEALTHCARE BENEFIT	Medicare Plus Blue Group PPO (Blue Cross) 800-422-9146 Optum Rx 855-577-6517	Blue Care Network (BCN) Advantage HMO 800-450-3680	Health Alliance Plan (HAP) Medicare Advantage HMO 800-801-1770	Priority Health Medicare HMO 844-403-0847
Preventive Services				
Annual routine physical exam	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Routine pap smears	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Routine mammograms	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Colorectal cancer screenings	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Mental Health				
Outpatient mental health services	10% coinsurance, after deductible.	Covered in full, unlimited days.	$20 copay.	$10 copay.
Substance Use Disorder Treatment				
Outpatient facility	10% coinsurance, after deductible.	Covered in full, unlimited days.	$20 copay.	$10 copay.
Durable Medical Equipment				
Durable medical equipment	**In network:** 10% coinsurance, after deductible. **Out of network:** 30% coinsurance, after deductible.	20% coinsurance.	10% coinsurance, after deductible.	20% coinsurance, after deductible.
Hearing				
Routine hearing care	**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. **Hearing aids:** $499 copay per hearing aid for advanced aids. $799 copay per hearing aid for premium aids per year. Exclusively through NationsHearing providers.	**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.

HEALTHCARE BENEFIT	Medicare Plus Blue Group PPO (Blue Cross) 800-422-9146 Optum Rx 855-577-6517	Blue Care Network (BCN) Advantage HMO 800-450-3680	Health Alliance Plan (HAP) Medicare Advantage HMO 800-801-1770	Priority Health Medicare HMO 844-403-0847
Location of Care				
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 and urgent care same as in network. For other services, deductible and coinsurance apply.	Emergency and urgent care same as in network. Most other covered services, travel deductible, and coinsurance apply.
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, and follow-up care through BlueCard.	Emergency and urgent care same as in network. Other 49 states outside Michigan covered same as in network when using the visitor/traveler benefit for covered benefits through a Medicare participating provider.	Emergency and 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.
Medical Deductible				
Deductible The amount you pay each year before the plan pays.	$800 individual.***	$400 individual.	**In network:** $550 individual. **Out of network:** $725 individual.	**In network:** $650 individual. **Out of network:** $725 individual.
Medical Maximum				
Medical coinsurance maximum The maximum amount of coinsurance paid in a calendar year for in-network services.	$900 individual.	No medical coinsurance maximum.	Not applicable in network or out of network.	**In network:** $2,250 individual. **Out of network:** $2,475 individual.
Total medical out-of-pocket maximum Deductible + coinsurance / copay maximum.	$1,700 individual.**	$2,100 individual.	**In network:** $2,500 individual. **Out of network:** $5,000 individual.	**In network:** $2,900 individual. **Out of network:** $3,200 individual.

Medicare Summary Comparison Sheet* Effective January 1, 2025

HEALTHCARE BENEFIT	Medicare Plus Blue Group PPO (Blue Cross) 800-422-9146 Optum Rx 855-577-6517	Blue Care Network (BCN) Advantage HMO 800-450-3680	Health Alliance Plan (HAP) Medicare Advantage HMO 800-801-1770	Priority Health Medicare HMO 844-403-0847
Prescription Drugs				
Traditional prescription drugs	**Generic and preferred brand:** 20% coinsurance with $15 minimum/$45 maximum (30 day); $37.50 minimum/$112.50 maximum (90 day). **Non-preferred brand:** 40% coinsurance with $15 minimum/no maximum (30 day); $37.50 minimum/no maximum (90 day).	**Preferred pharmacy** **Generic:** $9 copay. **Preferred brand:** $55 copay. **Non-preferred brand:** $85 copay. **Standard pharmacy** **Generic:** $15 copay. **Preferred brand:** $60 copay. **Non-preferred brand:** $90 copay. **Mail order** **Generic:** $0 copay. **Non-generic:** 32- to 90-day supply for two copays.	**Preferred pharmacy** **Preferred generic:** $5 copay. **Non-preferred generic:** $11 copay. **Preferred brand:** $55 copay. **Non-preferred brand:** $85 copay. **Standard pharmacy** **Preferred generic:** $10 copay. **Non-preferred generic:** $16 copay. **Preferred brand:** $60 copay. **Non-preferred brand:** $90 copay. **Retail/mail order** 30-day supply for one copay; 31- to 90-day supply for two copays. Preferred generics are available at a 100-day supply at retail and mail order.	**Preferred pharmacy** **Generic:** $9 copay. **Preferred brand:** $55 copay. **Non-preferred brand:** $85 copay. **Standard pharmacy** **Generic:** $15 copay. **Preferred brand:** $60 copay. **Non-preferred brand:** $90 copay. **Mail order** Up to 90-day supply for two copays. Tier 1 generic $0 copay.
Specialty prescription drugs	**Optum Specialty Pharmacy** **Preferred:** 20% coinsurance with $50 minimum/$100 maximum (30 day). **Non-preferred:** 40% coinsurance with $50 minimum/no maximum (30 day). **Non-preferred pharmacy** 40% coinsurance with $50 minimum/no maximum.	20% coinsurance, with $120 maximum per prescription.	20% coinsurance, with $120 maximum per prescription.	20% coinsurance, with $120 maximum per prescription.
Prescription Drug Maximum				
Prescription drug coinsurance maximum	$1,750 individual.	No pharmacy out-of-pocket maximum.	$750 individual.	No pharmacy out-of-pocket maximum.

*This document is only a summary. For complete plan details, contact the insurance carriers. Benefit levels are subject to change.
**Copays for routine hearing care are not included in the medical maximums.
***Medicare members are automatically enrolled in the LivingWell program and have a lower deductible for being a part of the program.