

**A Summary of Benefits Available Under Your
PriorityMedicareSM (Employer HMO) Plan**

PriorityMedicare (Employer HMO)

Summary of Benefits for the State of Michigan

October 1, 2010 through September 30, 2011

Medicare Sales Phone Numbers:

888 389-6676

TTY/TDD 888 551-6761

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Welcome!

The following information is provided as a summary of benefits available under your **Priority Medicare** plan. This summary is not intended as a substitute for your Evidence of Coverage (EOC). It is not a binding contract. Limitations and exclusions apply to benefits as listed below.

This Summary of Benefits tells you some features of the plan. It doesn't list every service we cover or list every limitation, or every exclusion. To get a complete list of our benefits, please call Priority Health Medicare and ask for the Evidence of Coverage.

Can I choose my doctors?

Priority Health Medicare has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the number at the end of this introduction.

Please be advised: The Priority Health Medicare network of providers is different than the Priority Health commercial network. Please refer to the Priority Health Medicare Provider Directory for a list of participating doctors.

Does My Plan Cover Medicare Part B Or Part D Drugs?

Priority Health Medicare covers both Medicare Part B prescription drugs and Part D prescription drugs.

Where can I get my prescriptions if I join this plan?

Priority Health Medicare has formed a network of pharmacies. You can use any pharmacy in our network. In some cases, you may also go to pharmacies outside of our network. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Directory. Our number is listed at the end of this introduction.

What is s prescription drug formulary?

Priority Health Medicare uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at www.prioritymedicare.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with prescription drug plan costs?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office

What are my protections in this plan?

As a member of **Priority**Medicare, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Michigan Peer Review Organization, 248 465-7300.

As a member of **Priority**Medicare, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your

state, Michigan Peer Review Organization, 248 465-7300.

What is a medication therapy management (MTM) program?

A medication therapy management (MTM) program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Priority Health Medicare for more details.

What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Priority Health Medicare for more details.

- **Some antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin** (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia clotting factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some oral cancer drugs:** If the same drug is available in injectable form.
- **Oral anti-nausea drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and infusion drugs** provided through DME.

Plan ratings

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at (888) 389-6676 to obtain a copy of the plan ratings for this plan. TTY users call (888) 551-6761.

What if I have additional questions?

Please call Priority Health Medicare with questions related to the **Priority**Medicare Employer Group plan:

616 464-8850 or toll-free 888 389-6676
TTY/TDD 616 464-8485 or toll-free 888 551-6761

Medicare Sales hours:

Monday – Friday, 8:30 a.m. – 5:00 p.m.

Or, visit us on the web at *prioritymedicare.com*

For more information about Medicare, please call 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

Summary of Benefits for PriorityMedicare Employer Group Plan

Prior authorization: Your primary care provider (PCP) will coordinate prior authorization of your services under the HMO benefits of this plan. Services requiring prior authorization are:

- All elective admissions, including mental health or substance abuse services
- Home health care and parenteral/enteral feedings
- Skilled nursing home facility and inpatient rehabilitation care
- Transplants and transplant evaluations
- Certain non-emergent outpatient radiology services: MRI, MRA, CT and PET scans
- Medical weight loss programs and surgery for obesity treatment
- Durable medical equipment (DME) over \$1,000 and all DME rentals
- Prosthetics and orthotics over \$1,000
- Infusion pumps (implantable and external)
- Non-emergent ambulance transportation
- Deep brain stimulation
- Automatic implantable cardioverter defibrillator (AICD)
- Radiofrequency catheter ablation for cardiac arrhythmia
- Stereotactic radiotherapy
- Nuclear cardiology
- Certain oral surgery services
- Certain injectable drugs
- All cosmetic and reconstructive surgery
- Experimental or investigational services
- Outpatient substance abuse services
- Virtual colonoscopy

Benefits	HMO Benefits
Deductibles	No deductible.
Out-of-pocket maximums	Not applicable.
Maximum individual lifetime benefit	Not applicable.
Other important information	<p>You must elect a primary care provider (PCP). You must coordinate all your care through your PCP and receive prior authorization from Priority Health Medicare, when required, in order to receive benefits.</p> <p>This plan replaces your current Medicare Parts A & B coverage. You must continue to pay the Medicare Part B premium each month.</p>
Fee schedules	Benefits are covered at the Medicare published fee schedule (or at Priority Health Medicare's negotiated fee schedules, when applicable).
Assignment of benefits	If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
<p>Doctor and hospital choice</p> <p>For more information, see Emergency and Urgently needed care below.</p>	<p>No referral is required for doctors, specialists, and hospitals. If you choose to go to a practitioner outside of our Priority Health Medicare network, you must pay 100% for these services yourself. Neither Priority Medicare nor the Original Medicare plan will pay for these services.</p> <p>You may have to pay a separate copay for certain doctor office visits.</p>

Benefits**HMO Benefits****SUMMARY OF BENEFITS****INPATIENT CARE****Inpatient hospital care**

Includes rehabilitation services.

Includes related facility charges.

No limit to the number of days covered by the plan.

Except in an emergency, prior authorization is required.

100% coverage for Medicare-covered inpatient hospital services received at a network hospital.

Inpatient mental health

Except in an emergency, your provider must obtain authorization from Priority Health Medicare.

Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime.

Contact the Behavioral Health department at 616 464-8500 or 800 673-8043 to prior authorize services.

100% coverage for Medicare-covered inpatient mental health services.

100% coverage for Medicare-covered partial hospitalization mental health services.

Inpatient substance abuse

Includes related facility charges. Except in an emergency, your provider must obtain authorization from Priority Health Medicare

Contact the Behavioral Health department at 616 464-8500 or 800 673-8043 to prior authorize services.

100% coverage for Medicare-covered inpatient substance abuse services.

100% coverage for Medicare-covered partial hospitalization substance abuse services.

Benefits	HMO Benefits
<p>Skilled nursing facility (SNF) or inpatient rehabilitation care</p> <p>In a Medicare-certified skilled nursing facility.</p> <p>A "benefit period" starts the day you go into a SNF. It ends when you go for 60 days in a row without skilled nursing care. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p> <p>No prior hospital stay is required.</p> <p>Authorization rules may apply for services.</p>	<p>100% coverage for Medicare-covered skilled nursing facility stays.</p> <p>You are covered for 100 days each benefit period, renewable after 60 days of non-confinement.</p>
<p>Home health services</p> <p>Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.</p> <p>Authorization rules may apply for services.</p>	<p>100% covered for Medicare-covered home health visits.</p>
<p>Hospice care</p>	<p>You must get care from a Medicare-certified hospice.</p>
<p>OUTPATIENT CARE</p>	
<p>Doctor office visits</p> <p>See "Routine physical exams," for more information.</p>	<p>You pay \$10 for each primary care physician or specialist office visit for Medicare-covered services.</p>
<p>Chiropractic services</p> <p>Coverage is for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>You pay \$10 for each Medicare-covered visit.</p>
<p>Podiatry services</p> <p>Medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>Routine care not covered.</p>	<p>100% coverage for Medicare-covered podiatry services.</p> <p>An office visit copay may apply.</p>

Benefits	HMO Benefits
<p>Outpatient mental health care</p>	<p>You pay \$10 for each social worker or psychologist visit for Medicare-covered outpatient mental health care.</p> <p>You pay \$10 for each Medicare-covered psychiatrist visit including medication management.</p>
<p>Outpatient substance abuse care</p> <p>Authorization rules may apply for services.</p>	<p>You pay \$10 for each social worker or psychologist visit for Medicare-covered outpatient substance abuse care.</p> <p>You pay \$10 for each Medicare-covered psychiatrist visit including medication management.</p>
<p>Outpatient services/surgery</p> <p>Authorization rules may apply for certain services.</p>	<p>100% coverage for each Medicare-covered outpatient hospital facility visit or ambulatory surgical center visit.</p>
<p>Ambulance services</p> <p>Medically necessary ambulance services.</p> <p>Non-emergent ambulance services require prior authorization.</p>	<p>100% coverage for each Medicare-covered ambulance service.</p>
<p>Emergency care</p> <p>Worldwide coverage.</p> <p>You may go to any emergency room if you reasonably believe you need emergency care.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.</p>
<p>Urgently needed care</p> <p>This is NOT emergency care, and in most cases, is out of the service area.</p>	<p>You pay \$10 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.</p>
<p>Outpatient rehabilitation services</p> <p>Occupational therapy, physical therapy, speech, and language therapy, and cardiac therapy</p>	<p>You pay \$10 for each Medicare-covered covered for physical, speech, and occupational therapy visit up to a maximum out of pocket of \$200 per coverage period.</p> <p>100% coverage for Medicare-covered cardiac therapy.</p>

Benefits	HMO Benefits
OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
<p>Durable medical equipment</p> <p>Includes wheelchairs, oxygen, etc.</p> <p>Authorization rules apply for purchases over \$1,000 and all rentals.</p>	<p>100% coverage for Medicare-covered durable medical equipment.</p>
<p>Prosthetic devices</p> <p>Includes braces, artificial limbs and eyes, etc.</p> <p>Authorization rules apply for purchases over \$1,000 and all rentals.</p>	<p>100% coverage for Medicare-covered prosthetic devices.</p>
<p>Diabetes self- monitoring training, and supplies</p> <p>Includes coverage for glucose monitors, test strips, lancets, screening tests, and self - management training.</p>	<p>100% coverage for Medicare-covered test strips and lancets and for other Medicare-covered diabetes self-monitoring, training and diabetes supplies from a plan provider.</p>
<p>Medical nutrition therapy</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>100% coverage for Medicare-covered nutrition therapy.</p>
<p>Diagnostic tests, x-rays, and laboratory services</p> <p>Lab services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a clinical laboratory improvement amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p> <p>Authorization rules may apply for services.</p>	<p>100% coverage for Medicare-covered diagnostic tests, x-rays, therapeutic radiology services and laboratory services.</p>

Benefits	HMO Benefits
<p>Imaging services— (includes MRI, MRA, CT scans, PET scans and nuclear cardiac studies)</p> <p>Prior authorization required for non-emergent outpatient services.</p>	<p>100% coverage for Medicare-covered imaging services.</p>
PREVENTIVE CARE	
<p>Bone mass measurement</p> <p>For people with Medicare who are at risk.</p>	<p>100% coverage for Medicare-covered bone mass measurement.</p> <p>An office visit copay may apply.</p>
<p>Colorectal screening</p> <p>For people with Medicare, age 50 and older.</p>	<p>100% coverage for Medicare-covered colorectal screening.</p> <p>An office visit copay may apply.</p>
<p>Immunizations</p> <p>Flu vaccine, hepatitis B vaccine - for people with Medicare who are at risk, and pneumonia vaccine.</p>	<p>100% coverage for Medicare-covered immunizations.</p> <p>An office visit copay may apply.</p>
<p>Mammograms - annual screening</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare, between age 35 and 39.</p>	<p>100% coverage for Medicare-covered mammograms.</p>
<p>Routine pap smears and pelvic exams</p> <p>Covered once every 2 years.</p> <p>Covered once a year for women with Medicare at high risk.</p>	<p>100% coverage for Medicare-covered routine pap smears and pelvic exams.</p> <p>An office visit copay may apply.</p>
<p>Prostate cancer screening exams</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>100% coverage for Medicare-covered prostate cancer screening exams.</p> <p>An office visit copay may apply.</p>
FAMILY PLANNING/INFERTILITY SERVICES	
<p>Infertility counseling & treatment</p> <p>Limitations and exclusions apply.</p>	<p>80% coverage.</p> <p>An office visit copay may apply.</p>

Benefits	HMO Benefits
<p>Vasectomy</p> <p>Covered only when performed in a physician's office or when in connection with other covered inpatient or outpatient surgery.</p>	<p>100% coverage.</p> <p>An office visit copay may apply.</p>
<p>Tubal Ligation (See below)</p>	
<p>Physician service.</p>	<p>100% coverage.</p>
<p>Outpatient facility services.</p>	<p>100% coverage.</p>
<p>Inpatient facility charges (covered only when in connection with delivery or other covered inpatient surgery).</p>	<p>100% coverage.</p>
<p>OTHER SERVICES</p>	
<p>Hemodialysis/end stage renal diseases (ESRD)</p>	<p>100% coverage for Medicare-covered hemodialysis.</p>
<p>Dental services</p> <p>Prior authorization applies.</p> <p>Preventive dental services (such as cleaning) not covered.</p>	<p>In general, you pay 100% for dental services.</p>
<p>Temporomandibular joint syndrome (TMJS) treatment</p>	<p>80% coverage.</p>
<p>Orthognathic treatment</p>	<p>80% coverage.</p>
<p>Certain oral surgery services</p> <p>Prior authorization applies.</p> <p>Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.</p>	<p>100% coverage for Medicare-covered oral surgery services.</p>
<p>Hearing services</p>	<p>100% coverage for routine hearing tests, including Medicare-covered diagnostic hearing exams.</p> <p>An office visit copay may apply.</p> <p>You are covered for up to \$500 for hearing aids/hearing aid services every three years obtained from any hearing provider. There is no copay for hearing aids/hearing aid services.</p>

Benefits	HMO Benefits
Vision services	<p>You pay \$10 for each Medicare-covered eye exam for diagnosis and treatment of diseases and conditions of the eye.</p> <p>You pay 100% for up to routine eye exams.</p> <p>100% coverage for one pair of Medicare covered eyeglasses or contact lenses after each cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>
Physical examinations	<p>You pay \$10 for each exam.</p> <p>You are covered for up to 1 exam every year.</p>

Prescription Drug Benefits	HMO Benefits
<p>Drugs covered under Part B (original Medicare)</p> <p>Some outpatient prescription drugs may be covered under Medicare Part B. See the introduction to this Summary of Benefits for examples of these drugs.</p>	<p>100% coverage for the cost for Part B-covered chemotherapy drugs.</p> <p>Other Part B drugs:</p> <p>Obtained in plan provider’s office:</p> <ul style="list-style-type: none"> • 100% coverage for other Part B-covered drugs. Office visit copay may apply. <p>Obtained in a plan pharmacy or plan mail order service:</p> <ul style="list-style-type: none"> • 100% coverage for other Part B-covered drugs.
<p>Home infusion drugs</p>	<p>100% coverage for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.</p>

Prescription Drug Benefits

Drugs covered under Medicare Part D prescription drug benefit

This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes (and the change applies to you), you will be notified, in writing, before the change. For additional information about the drug formulary contact Priority Health Medicare.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long-term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service).

The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total coverage period drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Priority Health Medicare for certain drugs.

Basic coverage

Before your coverage period out-of-pocket drug costs reach \$4,550 for Medicare Part D Drugs:

Retail pharmacy:

- \$5 copay for a one-month (31-day) supply of generic drugs.
- \$15 copay for a three-month (90-day) supply of generic drugs.
- \$10 copay for a one-month (31-day) supply of brand drugs.
- \$30 copay for a three-month (90-day) supply of brand drugs.

Long-term care pharmacy:

- \$5 copay for a one-month (31-day) supply of generic drugs.
- \$10 copay for a one-month (31-day) supply of brand drugs.

Prescription Drug Benefits

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.

If you request a formulary exception for a drug and Priority Health Medicare approves the exception, you will pay non-preferred brand cost-sharing for that drug.

Mail order pharmacy:

- \$5 copay for a three-month (90-day) supply of generic drugs.
- \$10 copay for a three-month (90-day) supply of brand drugs.

Prescription Drug Benefits

Catastrophic coverage

After your coverage period out-of-pocket drug costs reach \$4,550 for Medicare Part D Drugs:

Retail pharmacy:

- For generic drugs (including brand drugs treated as generic) for a one-month (31-day) supply, you pay the greater of \$2.50 copay **or** 5% coinsurance up to a maximum of \$5.
- For generic drugs (including brand drugs treated as generic) for a three-month (90-day) supply, you pay the greater of \$2.50 copay **or** 5% coinsurance up to a maximum of \$15.
- For all other drugs for a one-month (31-day) supply, you pay the greater of \$6.30 copay **or** 5% coinsurance up to a maximum of \$10.
- For all other drugs for a three-month (90-day) supply, you pay the greater of \$6.30 copay **or** 5% coinsurance up to a maximum of \$30.

Mail order pharmacy:

- For generic drugs (including brand drugs treated as generic) for a three-month (90-day) supply, you pay the greater of \$2.50 copay **or** 5% coinsurance up to a maximum of \$5.
- For all other drugs for a three-month (90-day) supply, you pay the greater of \$6.30 copay **or** 5% coinsurance up to a maximum of \$10.

Prescription Drug Benefits

Non-Medicare drugs covered under your prescription drug benefit

- Drugs when used to promote fertility
- Barbiturates and Benzodiazepines
- Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction
- Drugs used for the symptomatic relief of cough and colds

Retail pharmacy:

- \$5 copay for a one-month (31-day) supply of generic drugs.
- \$15 copay for a three-month (90-day) supply of generic drugs.
- \$10 copay for a one-month (31-day) supply of brand drugs.
- \$30 copay for a three-month (90-day) supply of brand drugs.
- 50% coinsurance for a one-month (31-day) or a three-month (90-day) supply of infertility drugs.

Long-term care pharmacy:

- \$5 copay for a one-month (31-day) supply of generic drugs.
\$10 for a one-month (31-day) supply of brand drugs.
- 50% coinsurance for a one-month (31-day) supply of infertility drugs.

Mail order pharmacy:

- \$5 copay for a three-month (90-day) supply of generic drugs.
\$10 copay for a three-month (90-day) supply of brand drugs.
- 50% coinsurance for a three-month (90-day) supply of infertility drugs.

All covered drugs

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You pay more than the normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.