

# HIGHLIGHTS OF MPS HEALTH PLAN DESIGN CHANGES

November 21, 2011

## MEDICARE ELIGIBLE RETIREES

*This summary is intended to provide highlights of the changes to your MPS benefits effective July 1, 2012 or July 1, 2013 (upon expiration of your respective contract). It is not a complete description of covered benefits and exclusions under the Plans. This summary is subject to change upon the issuance of future regulations and other governmental guidance under the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Educational Reconciliation Act of 2010.*

HEALTH PLAN	PPO/INDEMNITY PLAN	EPO PLAN
Third Party Administrator	UnitedHealthcare	UnitedHealthcare
Network	UnitedHealthcare Choice Plus Nationwide	UnitedHealthcare Choice Nationwide
Lifetime Maximum Per Covered Individual	No Lifetime Limit	No Lifetime Limit

### HOW THE PLANS WORK

**Deductible:** A flat-dollar amount of covered expenses that you pay per calendar year before coinsurance benefits are payable.

**Coinsurance:** After the deductible is met, the plan pays a percentage of most covered expenses and you pay a percentage; your percentage is coinsurance.

After you pay the annual (calendar year) deductible, the Plan pays a percentage (coinsurance) of eligible expenses in-network or out-of-network up to the annual coinsurance limits as listed below. Once the single or family coinsurance limit is met, the plan will pay 100% of eligible expenses for the remainder of the calendar year for covered services that are subject to coinsurance. Note: The EPO Plan is in-network only.

**Co-pay:** In addition to your annual deductible and coinsurance, co-pay is a flat dollar amount or percentage paid by you each time you use services that are subject to co-pay. Co-pay has no annual cap (maximum).

ANNUAL DEDUCTIBLE	CURRENT PPO/Indemnity	NEW PPO/Indemnity	CURRENT In-Network Only EPO	NEW In-Network Only EPO
Individual	\$326	\$1,500	\$ 50	\$ 350
Family (3 Individuals)	\$500	\$4,500	\$150	\$1,050
<b>ANNUAL COINSURANCE</b>	<b>70%</b>	<b>50%</b>	<b>90%</b>	<b>80%</b>
Individual	\$1,100	\$3,000	\$150	\$1,000
Family (3 Individuals)	\$2,800	\$9,000	\$450	\$3,000
<b>Calendar Year Deductible and Coinsurance Limits</b>	The annual coinsurance limit does NOT include the deductible or co-pays.		The annual coinsurance limit does NOT include the deductible or co-pays.	

<b>COINSURANCE ITEMS</b> Subject to Medical Necessity and Medicare Coordination	<b>CURRENT PPO/INDEMNITY – CHOICE PLUS</b>	<b>NEW PPO/INDEMNITY – CHOICE PLUS</b>	<b>CURRENT EPO – CHOICE UnitedHealthcare</b>	<b>NEW EPO – CHOICE UnitedHealthcare</b>
	<b>UnitedHealthcare</b>	<b>UnitedHealthcare</b>	<b>In-Network Only</b>	<b>In-Network Only</b>
<b>HOSPITAL SERVICES</b> Inpatient Outpatient  <b>SURGERY</b>  <b>PHYSICIAN IN-HOSPITAL SERVICES</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.
<b>ALCOHOL AND DRUG ABUSE</b> Inpatient Outpatient <b>MENTAL HEALTH SERVICES</b> Inpatient Outpatient  (Transitional Treatment included in outpatient coverage.)	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year. Prior authorization through UHC Designee is required.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year. Prior authorization through UHC Designee is required.
<b>SPECIALIST (Office Visits)</b>  <b>ALLERGY TESTING</b>  <b>EYE CARE (Accident/Disease Only)</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% after \$10 co-pay.	100% after \$20 co-pay.
<b>ALLERGY INJECTIONS</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% - injection without office visit. 100% after \$10-co-pay – injection with office visit.	100% - injection without office visit. 100% after \$35-co-pay – injection with office visit.
<b>IMMUNIZATIONS AND INJECTIONS</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% after \$10-co-pay – immunizations at 100% with co-pay waived for children, birth to age 6.	100% after \$35-co-pay – immunizations at 100% with co-pay waived for children, birth to age 6.
<b>PODIATRIST SERVICES</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Routine foot care not covered.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Routine foot care not covered.	100% after \$10 co-pay. Routine foot care not covered.	100% after \$35 co-pay. Routine foot care not covered.
<b>PHYSICAL / SPEECH OCCUPATIONAL THERAPY</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% after \$10 co-pay subject to calendar year limits of 20 visits physical therapy, 20 visits occupational therapy, and 20 visits speech therapy.	100% after \$20 co-pay subject to calendar year limits of 20 visits physical therapy, 20 visits occupational therapy, and 20 visits speech therapy.
<b>DIAGNOSTIC X-RAY AND LAB</b>  <b>RADIATION THERAPY</b>  <b>CHEMOTHERAPY</b>  <b>BLOOD/BLOOD PLASMA</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.

COINSURANCE ITEMS Subject to Medical Necessity and Medicare Coordination	CURRENT PPO/INDEMNITY – CHOICE PLUS	NEW PPO/INDEMNITY – CHOICE PLUS	CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	UnitedHealthcare	UnitedHealthcare	In-Network Only	In-Network Only
<b>CHIROPRACTIC (Spinal Manipulation)</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year, up to 50 visits per calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year, up to 26 visits per calendar year.	100% after \$10 co-pay.	100% after \$20 co-pay.
<b>DURABLE – MEDICAL EQUIPMENT</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year only for a single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination. Benefits are limited to \$2,500 per calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year only for a single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination. Benefits are limited to \$2,500 per calendar year.
<b>ROUTINE MAMMOGRAM</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. 1 mammogram per calendar year for covered females age 40 and over.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. 1 mammogram per calendar year for covered females age 40 and over.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.
<b>MATERNITY</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; includes voluntary sterilization and voluntary abortion.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; includes voluntary sterilization and voluntary abortion.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. (\$10 co-pay initial office visit) – coverage includes voluntary sterilization and voluntary abortion.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. (\$20 co-pay initial office visit) – coverage includes voluntary sterilization and voluntary abortion.
<b>CONTRACEPTIVES</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar, including injectable contraceptives that are not self-administered and inserted and implanted contraceptive devices.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar, including injectable contraceptives that are not self-administered and inserted and implanted contraceptive devices.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for non-self injectable contraceptives and implanted contraceptive devices in doctor offices.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for non-self injectable contraceptives and implanted contraceptive devices in doctor offices.
<b>INFERTILITY</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – artificial insemination (6 cycle’s lifetime maximum). Advanced reproductive technology including in vitro fertilization to lifetime maximum of \$30,000.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – artificial insemination. Advanced reproductive technology including in vitro fertilization to lifetime maximum of \$30,000.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for up to lifetime maximum of \$2,000. (Any related office visit will be subject to \$10 co-pay.)	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for up to lifetime maximum of \$2,000. (Any related office visit will be subject to \$35 co-pay.)
<b>ORGAN TRANSPLANTS</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; in conjunction with National Program for Medical Excellence.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; in conjunction with National Program for Medical Excellence.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limited to bone marrow, cornea, liver, kidney, heart, lung, heart/lung, liver/small bowel, pancreas, small bowel, kidney/pancreas, peripheral stem cell, and cornea transplants when authorized by UHC Care Coordination.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limited to bone marrow, cornea, liver, kidney, heart, lung, heart/lung, liver/small bowel, pancreas, small bowel, kidney/pancreas, peripheral stem cell, and cornea transplants when authorized by UHC Care Coordination.

COINSURANCE ITEMS Subject to Medical Necessity and Medicare Coordination	CURRENT PPO/INDEMNITY – CHOICE PLUS	NEW PPO/INDEMNITY – CHOICE PLUS	CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	UnitedHealthcare	UnitedHealthcare	In-Network Only	In-Network Only
<b>HEARING AIDS, COCHLEAR IMPLANTS Coverage for Children Under 18 Years of Age</b>	70% subject to deductible and co-insurance. Limit of one hearing aid per ear every three years.	50% subject to deductible and co-insurance. Limit of one hearing aid per ear every three years.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.
<b>TEMPOROMANDIBULAR JOINT DISORDER</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – surgical and non-surgical diagnosis and treatment.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – surgical and non-surgical diagnosis and treatment.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Diagnostic and non-surgical treatments are limited to a maximum of \$1,250 per calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Diagnostic and non-surgical treatments are limited to a maximum of \$1,250 per calendar year.
<b>PROSTHETIC/ORTHOTIC APPLIANCES</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for a single purchase of each type of prosthetic device once every three calendar years as specified and approved through UHC Care Coordination. Benefits are limited to \$2,500 per calendar year. Orthotics not covered.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for a single purchase of each type of prosthetic device once every three calendar years as specified and approved through UHC Care Coordination. Benefits are limited to \$2,500 per calendar year. Orthotics not covered.
<b>WEIGHT LOSS</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	Not covered.	Not covered.
<b>ORAL SURGERY</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – specific oral procedures covered by UHC.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – specific oral procedures covered by UHC. Dental implants excluded.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year limited to surgical removal of impacted wisdom teeth <u>only</u> .	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year limited to surgical removal of impacted wisdom teeth <u>only</u> .
<b>PRIVATE DUTY NURSING</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 70 eight-hour shifts per calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 70 eight-hour shifts per calendar year.	See Home Health Care.	See Home Health Care.
<b>SKILLED NURSING FACILITY</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 days per calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 days per calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; maximum of 30 days per inpatient stay for care in conjunction with discharge from hospital and 60 days per calendar year for inpatient rehabilitation facility.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; maximum of 30 days per inpatient stay for care in conjunction with discharge from hospital and 60 days per calendar year for inpatient rehabilitation facility.
<b>SHORT-TERM REHABILITATION</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year (acute conditions only).	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year (acute conditions only).	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; subject to calendar limits of 20 visits pulmonary rehabilitation therapy and 36 visits cardiac rehabilitation therapy.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; subject to calendar limits of 20 visits pulmonary rehabilitation therapy and 36 visits cardiac therapy.

COINSURANCE ITEMS Subject to Medical Necessity and Medicare Coordination	CURRENT PPO/INDEMNITY – CHOICE PLUS	NEW PPO/INDEMNITY – CHOICE PLUS	CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	UnitedHealthcare	UnitedHealthcare	In-Network Only	In-Network Only
<b>HOME HEALTH CARE</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 visits per calendar.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 visits per calendar.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; up to maximum of 60 visits when approved in advance by UHC Care Coordination.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; up to maximum of 60 visits when approved in advance by UHC Care Coordination.
<b>HOSPICE CARE</b>			Subject to 360 days limit for entire period you are covered under plan:	Subject to 360 days limit for entire period you are covered under plan:
Inpatient	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 45 days.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 45 days.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.
Outpatient	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year up to a maximum benefit of \$10,000.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year up to a maximum benefit of \$10,000.	90% until after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% until after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.
<b>AMBULANCE</b>	100% (deductible waived)	100% (deductible waived)	100%	100%
CO-PAY ITEMS Subject to Medical Necessity and Medicare Coordination	CURRENT PPO/INDEMNITY – CHOICE PLUS	NEW PPO/INDEMNITY – CHOICE PLUS	CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	UnitedHealthcare	UnitedHealthcare	In-Network Only	In-Network Only
<b>PHYSICIAN SERVICES</b> Office Visits (Non-Surgical)	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% after \$10 co-pay.	100% after \$20 co-pay.
Routine Physicals	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% with co-pay waived.	100% with \$20 co-pay per visit.
Immunizations	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. (Deductible waived for children, birth to age 6.)  Well baby care to age 2 (up to 10 routine exams annually); children age 2+ to age 7 (2 routine exams annually; children age 7+ to adult (1 routine exam annually); adults (1 routine exam annually).	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. (Deductible waived for children, birth to age 6.)	100% after \$10 co-pay. (co-pay waived for children, birth to age 6)  Well baby care to age 2 (up to 10 routine exams annually); children age 2+ to age 7 (2 routine exams annually; children age 7+ to adult (1 routine exam annually); adults (1 routine exam annually).	100% after \$35 co-pay. (co-pay waived for children, birth to age 6)
<b>PREVENTIVE CARE</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% of eligible expenses.	100% of eligible expenses.

CO-PAY ITEMS Subject to Medical Necessity and Medicare Coordination	CURRENT PPO/INDEMNITY – CHOICE PLUS		NEW PPO/INDEMNITY – CHOICE PLUS		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare		
	UnitedHealthcare		UnitedHealthcare		In-Network Only	In-Network Only		
<b>URGENT CARE/ WALK-IN CLINIC</b>	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.		50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.		100% after \$35 co-pay for designated urgent care centers and physician offices.	100% after \$35 co-pay for designated urgent care centers and physician offices.		
<b>HOSPITAL EMERGENCY ROOM</b>	100% after \$50 co-pay.		100% after \$150 co-pay.		100% after \$50 co-pay.	100% after \$125 co-pay.		
<i>The following is a penalty paid in addition to the annual deductible and coinsurance limit:</i>								
<b>Hospital Service Non-Emergency Use Of Emergency Room</b>	50% after deductible.		50% after deductible.		50% after deductible.	50% after deductible.		
<b>Retail Pharmacy (In-Network Only)</b>	100% after the following co-pay for up to a 30-day supply <u>at Medco participating pharmacies</u> : <b>Tier 1:</b> Generic \$3 <b>Tier 2:</b> Preferred Brand-name 10% with a \$15 Minimum <b>Tier 3:</b> Non-preferred Brand-name 20% with a \$30 Minimum 30% co-pay – <u>out-of-network</u> . (not on preferred name-brand drug list)		100% after the following co-pay for up to a 30-day supply <u>at Medco participating pharmacies</u> : <b>Tier 1:</b> Generic \$8 <b>Tier 2:</b> Preferred Brand-name 10% with a \$25 Minimum <b>Tier 3:</b> Non-preferred Brand-name 20% with a \$50 Minimum No out of network benefit		100% after the following co-pay for up to a 30-day supply <u>at Medco participating pharmacies</u> : <b>Tier 1:</b> Generic \$3 <b>Tier 2:</b> Preferred Brand-name 10% with a \$15 Minimum <b>Tier 3:</b> Non-preferred Brand-name 20% with a \$30 Minimum		100% after the following co-pay for up to a 30-day supply at Medco participating pharmacies: <b>Tier 1:</b> Generic \$8 <b>Tier 2:</b> Preferred Brand-name 10% with a \$25 Minimum <b>Tier 3:</b> Non-preferred Brand-name 20% with a \$50 Minimum (not on preferred name-brand drug list)	
<b>MAIL ORDER PHARMACY (In-Network Only)</b>	100% after the following co-pays for a 90-day supply at Medco mail order pharmacy: <b>Tier 1:</b> Generic \$6 <b>Tier 2:</b> Preferred Brand-name \$30 <b>Tier 3:</b> Non-preferred Brand-name \$60 (not on preferred name-brand drug list)		100% after the following co-pays for a 90-day supply at Medco mail order pharmacy: <b>Tier 1:</b> Generic \$16 <b>Tier 2:</b> Preferred Brand-name \$50 <b>Tier 3:</b> Non-preferred Brand-name \$100 (not on preferred name-brand drug list)		100% after the following co-pays for a 90-day supply at Medco mail order pharmacy: <b>Tier 1:</b> Generic \$6 <b>Tier 2:</b> Preferred Brand-name \$30 <b>Tier 3:</b> Non-preferred Brand-name \$60 (not on preferred name-brand drug list)		100% after the following co-pay for a 90-day supply at Medco mail order pharmacy: <b>Tier 1:</b> Generic \$16 <b>Tier 2:</b> Preferred Brand-name \$50 <b>Tier 3:</b> Non-preferred Brand-name \$100 (not on preferred name-brand drug list)	
OTHER	CURRENT PPO/INDEMNITY – CHOICE PLUS		NEW PPO/INDEMNITY – CHOICE PLUS		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare		
	NVA In-Network	Out-of-Network	NVA In-Network	Out-of-Network	NVA In-Network Only	NVA In-Network Only		
<b>National Vision Administrators Routine Vision Coverage</b>	None.	None.	None.	None.	None.	None.		

This publication provides information in general terms only as of the publication date indicated and is not intended to be a complete description of coverage. This publication is subject to the terms and conditions of the master contract of each plan, MPS Board policies, and federal or state statute.