2025

READY TO HELP

Blue Care Network℠ HMO

Benefits-at-a-Glance

The benefit information provided in this guide is a summary of covered services and what you pay. It's not a contract. Limitations, exclusions, copayments and restrictions may apply. Benefits, formulary, pharmacy network, provider network, deductible amounts, copayments and coinsurance may change on January 1 of each year. Contact the plan for more information. For a complete description of benefits, please see the applicable *Blue Care Network Certificate of Coverage* and accompanying riders. You can access them online by logging in to your account at **bcbsm.com/mpsers**.

Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and copayment amounts required by the plan. This coverage is provided pursuant to a contract entered into in Michigan and is subject to the laws of Michigan.

Services must be provided or arranged by your primary care provider (PCP) or health plan. The formulary, provider network and pharmacy network may change at any time. Your PCP provides your care or manages it through a referral process. Only your PCP can refer you to specialist care. If your PCP doesn't refer you, you're responsible for the charges. Certain services must also be authorized by BCN.

EFFECTIVE DATE: JANUARY 1, 2025
Certificate of coverage: BCN 5 with deductible
Riders: CO25, 35RP, ER150, UR65, SN120, IMG150, PSCR, VACR50, 400DED, BCN10%, 600ECM, RETDIS, HA, 2060CS, PDCSR and MOPD20

Michigan Public School Employees' Retirement System

bcbsm.com/mpsers

000172582
0001
0001/C001

MICHIGAN PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM
2025 BENEFITS AT A GLANCE

Deductible, copayments and dollar maximums	
Deductible	$400 per individual/$800 per family per calendar year
Copays	$5 for allergy injections $25 for office visits $25 for virtual visits by designated BCN participating providers $35 for specialist visits after the deductible $65 for urgent care visits $150 for emergency room visits after the deductible (waived if admitted as inpatient)
Coinsurance	50% or 10% for select services as noted below
Annual coinsurance maximum — applies to medical services; excludes services with a copay or 50% coinsurance	$600 per individual/$1,200 per family per calendar year
Preventive services	
Annual gynecological exam	Covered — copay $25 for physician office visit $35 copay for specialist care when referred
Health maintenance exam	Covered — copay $25
Immunizations — pediatric and adult	Covered — 100%
Mammography screening	Covered — 100%
Pap smear screening	Covered — 100%
Prostate specific antigen (PSA) screening	Covered — 100%
Screening colonoscopy	Covered — 90%, with a 10% coinsurance after deductible
Well-baby and child care	Covered — copay $25
Physician office services	
Chiropractic spinal manipulation — when referred	Covered — copay $35 after deductible
Consulting specialist care — when referred	Covered — copay $35 after deductible
Office visits	Covered — copay $25 per primary care physician office visit
Virtual visits Note: Some services delivered virtually are considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	Covered — copay $25 for a designated online BCN participating provider
Outpatient physical, speech and occupational therapy — limited to 60 consecutive days per episode	Covered — copay $35 after deductible
Emergency medical care	
Ambulance services — medically necessary	Covered — 90% for ground and air services, with 10% coinsurance after deductible
Hospital emergency room — copay waived if admitted, inpatient hospital benefits apply	Covered — copay $150 after deductible
Urgent care center	Covered — copay $65
Diagnostic services	
Diagnostic tests and X-rays	Covered — 90%, with a 10% coinsurance after deductible
High-technology radiology imaging	Covered — copay $150 after deductible
Laboratory and pathology tests	Covered — office visit copay may apply per member, per visit
Radiation therapy	Covered — 90%, with a 10% coinsurance after deductible

MICHIGAN PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM
2025 BENEFITS AT A GLANCE

Hospital care	
Inpatient physician care, general nursing care, hospital services and supplies	Covered — 90% for unlimited days, with a 10% coinsurance after deductible
Outpatient surgery	Covered — 90%, with a 10% coinsurance after deductible
Alternatives to hospital care	
Home health care	Covered — copay $35 after deductible
Hospice care	Covered — 100% after deductible, when authorized
Skilled nursing care	Covered — 90%, with 10% coinsurance after deductible, up to 120 days per calendar year
Surgical services	
Human organ transplants (subject to medical criteria)	Covered — 90% coinsurance, with a 10% coinsurance after deductible
Male mastectomy (subject to medical criteria)	Covered — 50% coinsurance after deductible
Orthognathic surgery (subject to medical criteria)	Covered — 50% coinsurance after deductible
Reduction mammoplasty (subject to medical criteria)	Covered — 50% coinsurance after deductible
Surgery — includes all related surgical services and anesthesia	See *Hospital Care* for surgical copay, after deductible
Temporomandibular joint syndrome (subject to medical criteria)	Covered — 50% coinsurance after deductible
Voluntary sterilization	Covered — Male: 50% on all associated costs after deductible Female: 100%
Behavioral health, mental health and substance use disorder services	
Inpatient mental health care	Covered — 100%, up to 30 days per calendar year
Inpatient substance use disorder	Covered — 50% coinsurance: one program per 12-month period (A program of treatment may include outpatient or intermediate services or both.)
Outpatient mental health care	Covered — 50% coinsurance, up to 20 visits per calendar year
Outpatient substance use disorder	Covered — 50% coinsurance
Autism spectrum disorders, diagnoses and treatment	
Applied behavioral analyses (ABA) treatment	Covered — copay $25 after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Covered — copay $35 after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See *Outpatient mental health care and Physician office service*
Durable medical equipment (DME)	
Durable medical equipment	Covered — 50% coinsurance, when authorized
Prosthetic and orthotics	Covered — 50% coinsurance
Maternity services provided by a physician	
Delivery and nursery care	Covered — 100% for professional services (See *Hospital Care* for facility charges after deductible.)
Prenatal and postnatal care	Covered — $25 copay

MICHIGAN PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM
2025 BENEFITS AT A GLANCE

Additional services		
Allergy injections	Covered — copay $5	
Allergy testing and therapy	Covered — 50% coinsurance, after deductible	
Breast pumps (DME guidelines apply) — limited to no more than one every 24 months	Covered only when medically necessary	
Hearing aid	Covers one hearing aid and exam every 36 months	
Infertility counseling and treatment (excludes in-vitro fertilization)	Covered — 50% coinsurance on all associated costs, after deductible	
Weight reduction procedures	Covered — 100%, after deductible	
Prescription drugs		
Prescription drug deductible	None	
Specialty annual coinsurance maximum (Tiers 4 and 5)	$4,800 per member	
Retail (30-day supply)	Tier 1 — Generic	$20 copay
	Tier 2 — Preferred brand	$60 copay
	Tier 3 — Non-preferred brand	$80 copay
	Tier 4 — Preferred specialty	20% coinsurance (maximum copay $200 per prescription)
	Tier 5 — Non-preferred specialty	20% coinsurance (maximum copay $400 per prescription)
Mail order (up to a 90-day supply)	Tier 1 — Generic	$40 copay
	Tier 2 — Preferred brand	$120 copay
	Tier 3 — Non-preferred brand	$160 copay
	Specialty drugs are not covered through mail order pharmacies.	

Customer Service

1-800-662-6667 (TTY: **711**)
(Or the number on the back of your BCN member ID card)
8 a.m. to 5:30 p.m. Eastern time
Monday through Friday

bcbsm.com/mpsers

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association