Summary of Benefits

Medicare Plus Blue℠ Group PPO

January 1, 2025 – December 31, 2025

READY TO HELP

Michigan Public School Employees' Retirement System

bcbsm.com/mpsers

This information is a summary document and not a complete description of benefits. Call **1-800-422-9146** (TTY call **711**) for more information. To get a complete list of services covered by your retirement system, call Blue Cross Medicare Plus Blue Group PPO Customer Service and ask for the *Evidence of Coverage* (phone numbers are printed on the back of this booklet). Medicare Plus Blue[SM] is a Medicare Advantage Preferred Provider Organization (PPO) with a network of doctors, hospitals, and other providers. If you use the providers that are in our network, you may pay less for your covered services. But you can also use providers that are not in our network. For more detailed information about our providers, and our provider network, you can call Blue Cross Medicare Plus Blue Group PPO Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **bcbsm.com/providersmedicare**.

Out-of-network/non-contracted providers are under no obligation to treat you, except in emergency situations. To find out if your out-of-network service is covered, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call Blue Cross Medicare Plus Blue Group PPO Customer Service (phone numbers are printed on the back cover of this booklet) or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

To join Medicare Plus Blue Group PPO, you must meet the eligibility requirements for the Michigan Public School Employees' Retirement System, have both Medicare Part A and Medicare Part B, be a United States citizen or lawfully present in the United States, and live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. Our service area includes all 50 states and all U.S. territories.

Monthly premium, deductible and limits on how much you pay for covered services	
Monthly Plan Premium	You are required to pay a premium contribution defined by the Michigan Office of Retirement Services. You, or others on your behalf, must also continue to pay your Medicare Part B premium.
Deductible	$800 is the annual amount you're responsible for paying for covered medical expenses before your retirement system begins to pay.
Coinsurance Maximum	$900 is the maximum amount you'll pay in coinsurance during 2025.
Out-of-Pocket Maximum	$1,700 is the maximum dollar amount you'll pay in deductible, coinsurance and copays during 2025. Once you reach the maximum, you pay nothing for covered hospital and medical services for the remainder of the year. Copays for routine hearing exams and hearing aids are *not* included in the out-of-pocket maximum.

Benefits	Medicare Plus Blue Group PPO In- and out-of-network	What you should know
Note: Services with * may require prior authorization.		
Ambulance • Ground or air. • Ambulance services without transportation.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Cost sharing applies to each one-way trip.
Behavioral and Mental Health Services* • Inpatient visit. • Outpatient group therapy visit. • Outpatient individual therapy visit.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. You have unlimited days of inpatient care coverage.
Chiropractic Services* • Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position). • Chiropractic X-rays.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum.
Dental Services • Certain dental services that you get when you're in a hospital.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Services must be performed by

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• Services required for the initial treatment of an injury to the jaws, sound natural teeth, mouth or face. Your Medicare Plus Blue Group PPO plan will cover the same medically necessary services that Original Medicare covers.		a physician or dentist. The medical plan doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Injuries from biting or chewing are also not covered.
Diabetes Programs and Supplies • Glucose monitors (continuous glucose monitors must be obtained from a network pharmacy). • Test strips. • Lancets. • Screening tests. • Therapeutic shoes or inserts due to severe diabetic foot disease. • Diabetes self-management training.	You pay 10% of the approved amount for diabetes self-management training, after deductible. You pay $0 of the approved amount for diabetes supplies. Deductible **does not** apply. You pay $0 for diabetic test strips at network pharmacies. Deductible **does not** apply.	The deductible and coinsurance apply to the annual out-of-pocket maximum for diabetes self-management training. To find a network pharmacy, visit our website, **bcbsm.com/pharmaciesmedicare** or call Blue Cross Customer Service.

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Diagnostic Services/Clinical Labs/Imaging* • Clinical lab services. • Diagnostic radiology service (e.g., MRI). • Diagnostic tests and procedures. • Outpatient X-rays. • Therapeutic radiology services.	You pay $0 of the approved amount for clinical lab services. Deductible **does not** apply. For all other diagnostic services, you pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum for all other diagnostic services. *High-tech radiology (X-rays) require prior authorization.
Doctor Visits • Primary care provider visits. • Specialist visits. • Virtual care visits.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum.
Durable Medical Equipment and Supplies* • Wheelchairs. • Oxygen. • Home dialysis equipment and supplies. • Colostomy supplies. • Home infusion needles. • Surgical dressings. • Monitoring (including therapeutic continuous monitors	**In-network:** You pay 10% of the approved amount, after deductible. **Out-of-network:** You pay 30% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Northwood is the in-network durable medical equipment supplier. Northwood can be reached at **1-800-667-8496**, 8:30 a.m. to 5 p.m., Monday through Friday. TTY users call **711**.

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and supplies). • Adult diapers (including adult briefs). • Up to eight (four pair) gradient compression stockings per year.		
Emergency Room Care	You pay a $140 copay. Deductible **does not** apply.	The copay applies to the annual out-of-pocket maximum. The copay is waived if admitted to the hospital within three days. You are covered for emergency medical care worldwide.
Foot Care (podiatry) • Foot exams. • Treatment services.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. You must have diabetes-related nerve damage and/or meet certain conditions.
Hearing Aids and Routine Hearing Exams from TruHearing • TruHearing Advanced and TruHearing Premium	**TruHearing Providers** Your copay depends on the type of hearing aid you purchase. For one hearing aid, your copay will either be $499 or $799. For two	Hearing aids and routine exams are covered every 36 months. Call TruHearing at **1-855-205-6305**, 8 a.m. – 8 p.m., Monday – Friday (TTY **711**) and follow the instructions you are given.

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hearing aids. • Routine hearing exam (includes audiometric exam, hearing aid evaluation test and hearing aid conformity test performed by a TruHearing provider).	hearing aids, your copay will be either $998 or $1,598. You pay a $45 copay for routine hearing exams. Deductible **does not** apply to routine hearing care.	The copays **do not** apply to the annual out-of-pocket maximum. You have no benefits if you see a non-TruHearing provider.
Hearing Services – For Illness and Injury	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum.
Home Health Care*	You pay $0 for approved home health services. Deductible **does not** apply.	Includes medically necessary home health aide services and rehabilitation services. Custodial care is not a covered benefit.
Hospice	You pay $0 for care from a Medicare-certified hospice program.	Hospice is covered outside your Medicare Plus Blue Group PPO plan. Original Medicare covers hospice when you enroll in a Medicare-certified hospice program.
Infusion Therapy Includes home infusion therapy. Home infusion therapy includes nursing visits and related durable medical equipment and supplies.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum.

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Inpatient Hospital Care* Hospital services including: • Rehabilitation services. • Human organ transplants.	You pay 10% of the approved amount, after deductible. You pay $0 for Medicare-approved clinical lab services and preventive services. Deductible **does not** apply to these services.	The deductible and coinsurance apply to the annual out-of-pocket maximum. You have unlimited days for inpatient hospital coverage.
Outpatient Hospital Care*	You pay 10% of the approved amount, after deductible. You pay $0 for Medicare-approved clinical lab services and preventive services. Deductible **does not** apply to these services.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.
Prescription Drugs (limited)* • Chemotherapy (including certain oral anti-cancer drugs). • Injections you get in a doctor's office. • Drugs used with some types of durable medical equipment. • Immunosuppressant drugs.	You pay 10% of the approved amount, after deductible. You pay no more than $35 for one month's supply of insulin.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Self-administered drugs you normally take on your own are not covered. Step therapy may apply.

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Preventive Care Covered at 100% of the approved amount. Some limitations apply. • Abdominal Aortic Aneurysm Screening. • Alcohol Misuse Screening and Counseling. • Annual Physical Exam and Approved Related Laboratory Tests. • Bone Mass Measurement. • Breast Cancer Screening (Mammogram). • Cardiovascular Disease Behavioral Therapy. • Cardiovascular Disease Screening. • Cervical and Vaginal Cancer Screening. - Pap Exam. - Pelvic Exam. • Colorectal Cancer Screening (Blood-based Biomarker Test, Colonoscopy, Fecal Occult Blood Test, Flexible Sigmoidoscopy, Barium Enema, Multi-target Stool DNA Test). • COVID-19 Shots (Vaccine). • Depression Screening. • Diabetes Screening. • Flu Shots (Vaccine). • Glaucoma Testing for Members at Risk. • Hepatitis B Screening. • Hepatitis B Shots (Vaccine). • Hepatitis C Screening. • HIV Screening. • Kidney Disease Education. • Lung Cancer Screening with Low-Dose Computed Tomography. • Medical Nutrition Therapy Services. • Medicare Diabetes Prevention Program. • Obesity Screening and Counseling. • Pneumococcal Shot (Vaccine). • Prostate Cancer Screening. • Sexually Transmitted Infections Screening and Counseling. • Tobacco Use Cessation Counseling for People		Any additional preventive services approved by Medicare during the contract year will be covered.

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with No Sign of Tobacco-related Disease. • Welcome to Medicare Preventive Visit. • Yearly "Wellness" Visit.		
Prosthetic and Orthotic Devices* • Prosthetics (artificial limbs, mastectomy supplies, etc.). • Orthotic devices such as leg braces, back braces, and ankle or wrist supports.	**In-network:** You pay 10% of the approved amount, after deductible. **Out-of-network:** You pay 30% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum.
Rehabilitation Services • Cardiac and pulmonary rehabilitation services. • Occupational therapy. • Physical therapy. • Speech and language therapy.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Rehabilitation services are available in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities.

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Skilled Nursing Facility* (SNF)	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Your plan covers up to 100 days in a SNF. Your days renew after you've been out of a SNF or hospital for 60 consecutive days.
SilverSneakers® health and fitness benefit • SilverSneakers' in-person exercise classes. • Equipment use. • Other amenities, at thousands of participating locations nationwide. • Online exercise classes and videos.	You pay $0 for SilverSneakers' benefits. Fitness services must be provided through SilverSneakers.	SilverSneakers GO mobile app provides access to on-demand videos and live classes. Go to **silversneakers.com** to learn more or call **1-866-584-7352**, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call **711**. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.
Substance Use Disorder Services*	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Your plan covers an unlimited number of days for inpatient hospital stays.
Surgery Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers*	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum.

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Urgently Needed Services	You pay a $65 copay. Deductible **does not** apply.	The copay applies to the annual out-of-pocket maximum.
Vision Services • Exam to diagnose and treat diseases and medical conditions of the eye. • One pair of eyeglasses or contact lenses after cataract surgery.	You pay 10% of the approved amount, after deductible.	The deductible and coinsurance apply to the annual out-of-pocket maximum. Routine eye exams and eyeglasses are not covered.

Worldwide Medical Care
Your covered hospital and medical benefits, as well as the associated cost share, are the same when you travel to a foreign country as if the services were rendered in the United States. For covered services performed abroad, your plan will pay the approved amount at the rate of exchange in effect on the date of service. You are responsible for costs that exceed the Medicare Plus Blue Group PPO approved amount plus your coinsurance, copay and deductible.

2025
Customer Service for Medicare Plus Blue Group PPO

1-800-422-9146

TTY users should call 711

Monday through Friday, 8:30 a.m. – 5 p.m. Eastern time

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Michigan depends on contract renewal.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

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