2020

Medicare Plus Blue℠ Group PPO

Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

Summary of Benefits

January 1, 2020 – December 31, 2020

Michigan Public School Employees' Retirement System

www.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 **www.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 **www.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 be enrolled in Medicare Part A and Medicare Part B and live in our service area. 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 continue to pay your Medicare Part B premium.
Coinsurance Maximum	$900 is the maximum amount you'll pay in coinsurance during 2020.
Deductible	$800 is the annual amount you're responsible for paying for covered medical expenses before your retirement system begins to pay.
Maximum Out-of-Pocket Responsibility	$1,700 is the maximum dollar amount you'll pay in coinsurance, copays and deductibles during 2020. 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.
Plan Limit	Your retirement system has a $2.5 million lifetime maximum for services not covered by Original Medicare. These services are identified by ** following the benefit. If you reach the $2.5 million maximum, an additional $1,000 per calendar year will be restored as long as uninterrupted coverage is in effect. The additional $1,000 allowance is renewed on January 1 the following calendar year.

Benefits	Medicare Plus Blue Group PPO In- and out-of-network	What you should know
Note: Services with * may require prior authorization. Services with ** apply to the $2.5 million lifetime maximum.		
Ambulance	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum.
Chiropractic Services*	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. Chiropractic benefits are limited to spinal X-rays** and spinal manipulations for diagnoses related to the spine (subluxation of the spine).
Dental Services Includes coverage for certain dental services that you get when you're in a hospital. Also covers services required for the initial treatment of an injury to the jaws, sound natural teeth, mouth or face. The injury must have occurred after the effective date of your coverage with your retirement system. Services must be performed by a physician or dentist. The health plan does not cover injuries resulting from biting or chewing, or preventive or maintenance services.	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. Your Medicare Plus Blue Group PPO plan will cover the same medically necessary services that Original Medicare covers. The plan doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices.

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Diabetes Programs and Supplies Includes glucose monitors, test strips, lancets, screening tests, therapeutic shoes or inserts due to severe diabetic foot disease, and self-management training	You pay $0 of the approved amount. Deductible **does not** apply.	
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. For all other diagnostic services, you pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. *Only high-tech radiology (X-rays) require preauthorization.
Doctor Visits Includes primary and specialist visits.	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual 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. Services with ** apply to the $2.5 million lifetime maximum.		
Durable Medical Equipment and Supplies* Includes wheelchairs, oxygen, home dialysis equipment and supplies, colostomy supplies, home infusion needles, surgical dressings, monitoring (including therapeutic continuous monitors and supplies), adult briefs** and adult diapers** and up to eight (four pair) of gradient compression stockings per year **, etc.	**In-network:** You pay 10% of the approved amount, deductible applies. **Out-of-network:** You pay 30% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum.
Emergency Room Care	You pay $120 copay. Deductible **does not** apply.	Copay applies to the annual out-of-pocket maximum. Copay is waived if admitted to the hospital within three days. You may go to any emergency room if you reasonably believe you need emergency care.
Foot Care (podiatry) Includes foot exams and treatment.	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. You must have diabetes-related nerve damage and/or meet certain conditions.

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TruHearing Advanced and TruHearing Premium Hearing Aids and Routine Hearing Exams Routine hearing exam includes audiometric exam, hearing aid evaluation test, and hearing aid conformity test.	**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, your copay will be either $998 or $1,598. You pay $45 copay for routine exams.	Hearing aids and routine exams are covered every 36 months. You have no benefits if you see a non-TruHearing provider. Call TruHearing at 1-855-205-6305 (TTY 711) and follow the instructions you are given. The copay does not apply to the annual out-of-pocket maximum.
Hearing Services – For illness and injury	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum.
Home Health Care*	You pay $0 for approved home health services.	Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services. Custodial care is not a 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.

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Note: Services with * may require prior authorization. Services with ** apply to the $2.5 million lifetime maximum.		
Infusion Therapy Includes home infusion therapy **	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. Home infusion therapy includes nursing visits and related durable medical equipment and supplies.
Inpatient Hospital Care* Includes rehabilitation services, and human organ transplants.	You pay 10% of the approved amount, deductible applies. You pay $0 for Medicare-approved clinical lab services and preventive services.	The coinsurance and deductible apply to the annual out-of-pocket maximum. You have unlimited days for inpatient hospital coverage.
Mental Health Services* • Inpatient visit • Outpatient group therapy visit • Outpatient individual therapy visit	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. You have unlimited days of inpatient care coverage.
Online Visits Meeting with a health care provider through electronic forms of communication.	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to annual out-of-pocket maximum. Allows you to see a doctor when your primary care physician is not available.

Benefits	Medicare Plus Blue Group PPO In- and out-of-network	What you should know
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Outpatient Hospital Care*	You pay 10% of the approved amount, deductible applies. You pay $0 for Medicare-approved clinical lab services and preventive services.	The coinsurance and deductible apply to the annual out-of-pocket maximum.
Prescription Drugs (limited)*	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. Your plan covers a limited number of prescription drugs, like chemotherapy (including certain oral anti-cancer drugs), injections you get in a doctor's office, drugs used with some types of durable medical equipment, and immunosuppressant drugs. Self-administered drugs you normally take on your own are not covered. Step therapy may apply.
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		Any additional preventive services approved by Medicare during the contract year will be covered.

Benefits	Medicare Plus Blue Group PPO In- and out-of-network	What you should know
Note: Services with * may require prior authorization. Services with ** apply to the $2.5 million lifetime maximum.		
Preventive Care, *continued* • Cervical and Vaginal Cancer Screening - Pap Exam - Pelvic Exam • Colorectal Cancer Screening (Colonoscopy, Fecal Occult Blood Test, Flexible Sigmoidoscopy, Barium Enema, Multi-target Stool DNA Test) • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Flu Shots (Vaccine) • Glaucoma Testing for Members at Risk • 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 with No Sign of Tobacco-related Disease • Welcome to Medicare Preventive Visit • Yearly “Wellness” Visit		Any additional preventive services approved by Medicare during the contract year will be covered.

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Prosthetic and Orthotic Devices* • Prosthetics (braces, 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, deductible applies. **Out-of-network:** You pay 30% of the approved amount.	The coinsurance and deductible apply to the annual out-of-pocket maximum.
Rehabilitation Services* • Cardiac and Pulmonary rehabilitation services • Occupational therapy visits • Physical therapy • Speech and language therapy visits	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum.
Skilled Nursing Facility* (SNF)	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible 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.

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Substance Abuse Services*	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum. Your plan covers an unlimited number of days for inpatient hospital stays.
Supervised Exercise Therapy (SET) • SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. • Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to the annual out-of-pocket maximum.
Surgery Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers*	You pay 10% of the approved amount, deductible applies.	The coinsurance and deductible apply to annual out-of-pocket maximum.
Urgently Needed Services	You pay $65 copay, deductible **does not** apply.	The copay applies to annual out-of-pocket maximum.

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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, deductible applies.	The coinsurance and deductible 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.

2020

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

Medicare Plus Blue℠ is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

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