2017

Michigan Public School Employees Retirement System

Summary of Benefits

January 1, 2017 – December 31, 2017

www.bcbsm.com/mpsers

This information is a summary document and not a complete description of benefits. To get a complete list of services covered by your retirement system, call Medicare Plus Blue Group PPO Customer Service and ask for the Evidence of Coverage (phone numbers are printed on the back cover 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 if you want to, you can also use providers that are not in our network. For more detailed information about our providers, you can call 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 Medicare Plus Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

The provider network may change at any time. You will receive notice when necessary.

For more information, please call us at the phone number below or visit us at **www.bcbsm.com/mpsers**.

Medicare Plus Blue Group PPO Customer Service toll-free **1-800-422-9146**.
TTY users should call 711. You can call us Monday through Friday, from 8:30 a.m. to 5:00 p.m. Eastern time.

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 be enrolled in Medicare Plus Blue Group PPO, you must be entitled to Medicare Part A, be enrolled in 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 must continue to pay your Medicare Part B premium. In addition, you are also required to pay a premium contribution defined by Michigan Public School Employees Retirement System.
Coinsurance Maximum	The maximum amount you'll pay in coinsurance during 2017 is $900.
Deductible	The amount you're responsible for paying for covered medical expenses before your retirement system begins to pay is $800 annually.
Maximum Out-of-Pocket Responsibility	The maximum dollar amount you'll pay in coinsurance, copay and deductible during the calendar year is $1,700. Once you reach the maximum, you pay nothing for covered hospital and medical services for the remainder of the year.
Plan Limit	Your retirement system has a $1 million lifetime maximum for services not covered by Original Medicare. These services are identified by ** following the benefit. If you reach the $1 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 PPO In and out of network	What you should know
Note: Services with * may require prior authorization. Services with ** apply to the $1 million lifetime maximum.		
Ambulance	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to annual out-of-pocket maximum.
Chiropractic Services	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to 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	Your Medicare Plus Blue Group PPO plan will cover the same medically necessary services that Original Medicare covers.	For cost-sharing information for those services (surgery, office visits, X-rays), contact Customer Service.
Diabetes Programs and Supplies Includes glucose monitors, test strips, lancets, screening tests, shoes or inserts due to severe diabetic foot disease, and self-management training.	You pay $0 of the approved amount.	Deductible does not apply.

Benefits	Medicare Plus Blue PPO In and out of network	What you should know
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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. For all other diagnostic services you pay 10% of the approved amount.	Deductible applies to all services except clinical labs. The coinsurance and deductible apply to annual out-of-pocket maximum. *Only high-tech 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 annual out-of-pocket maximum.
Durable Medical Equipment and Supplies Includes wheelchairs, oxygen, home dialysis equipment and supplies, colostomy supplies, home infusion needles, surgical dressings, 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. **Out-of-network:** You pay 30% of the approved amount.	Deductible applies. The coinsurance and deductible apply to the annual out-of-pocket maximum.

Benefits	Medicare Plus Blue PPO In and out of network	What you should know
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Emergency Room Care	You pay $75 copay.	Deductible does **not** apply. Copay applies to annual out-of-pocket maximum. Copay is waived if admitted to the hospital within 3 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 annual out-of-pocket maximum. You must have diabetes-related nerve damage and/or meet certain conditions.
Hearing Aids** Includes standard monaural and binaural	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to the annual out-of-pocket maximum. Hearing aids are covered every 36 months and must be purchased from a BCBSM-approved provider.
Hearing Services – Medically Necessary	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to the annual out-of-pocket maximum.

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Hearing Services – Routine Exam** Includes audiometric exam, hearing aid evaluation test, and hearing aid conformity test	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to the annual out-of-pocket maximum. Routine hearing exams are covered every 36 months and must be performed by a BCBSM-approved provider.
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.	Hospice is covered outside your Medicare Plus Blue PPO plan. Original Medicare covers when you enroll in a Medicare-certified hospice program.
Infusion Therapy Includes home infusion therapy**	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to annual out-of-pocket maximum. Home infusion therapy includes nursing visits and related durable medical equipment and supplies.

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Inpatient Hospital Care* Includes rehabilitation services, and human organ transplants	You pay 10% of the approved amount. You pay $0 for Medicare-approved clinical lab services and preventive services.	Deductible applies. The coinsurance and deductible apply to 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 annual out-of-pocket maximum. You have unlimited days of inpatient care coverage.
Prescription Drugs (limited)*	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to 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.

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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 • 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 - Screening Fecal Occult Blood Test - Screening Flexible Sigmoidoscopy - Screening Colonoscopy - Screening Barium Enema • Depression Screenings • 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 and education • Lung cancer screening with low-dose computed tomography • Medical Nutrition Therapy Services • 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 Prevention Visits (initial preventive physical exam) • Yearly “Wellness” Visit		Any additional preventive services approved by Medicare for 2017 will be covered.

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Private Duty Nursing**	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to the annual out-of-pocket maximum. Skilled nursing services are services that must be performed by a registered nurse or licensed practical nurse in the member's home or other BCBSM–approved place of service. Private duty nursing is considered medically necessary if both general and specific clinical criteria are met.
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. **Out-of-network:** You pay 30% of the approved amount.	Deductible applies. The coinsurance and deductible apply to 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 annual out-of-pocket maximum.

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Skilled Nursing Facility* (SNF)	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to annual out-of-pocket maximum. Your plan covers up to 100 days in a SNF.
Substance Abuse Services*	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to annual out-of-pocket maximum. Your plan covers an unlimited number of days for inpatient hospital stay.
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 10% of the approved amount.	Deductible does **not** apply. The coinsurance 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 • Eyeglasses or contact lenses after cataract surgery	You pay 10% of the approved amount.	Deductible applies. The coinsurance and deductible apply to annual out-of-pocket maximum. Routine eye exams and eyeglasses are not covered.

Worldwide Medical Care
Your covered hospital and medical benefits and cost share is 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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

This document is available in other formats such as large print.

2017

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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