2025 Medicare Advantage PPO Plan
(effective January 1, 2025 - December 31, 2025)

Group: PSERS PPO

	Capital Blue Cross Custom PPO	
Medical Benefits	**In-Network (IN)**	**Out-of-Network (OON)**
Maximum Out-of-Pocket (MOOP)	$3,400 (combined IN/OON)	
Deductible	$0	$0
Inpatient Care		
Inpatient Hospital *(includes acute, rehab, MH/SA stays)*	$0 copay per stay	$0 copay per stay
Skilled Nursing Facility *copays per admission *(100 days per benefit period)*	$0 copay days (1 - 20) $30 copay days (21-100)	20% coinsurance
Home Health Care	$0 copay	30% coinsurance
Outpatient Care		
Primary Care (PCP) Office Visits[1]	$5 copay	$5 copay
Specialist Office Visits[1]	$15 copay	$15 copay
Chiropractic Visits *(Medicare-covered spinal manipulation)*	$15 copay	$15 copay
Therapy Service Visits[1] *(includes PT, OT, ST)*	$15 copay	$15 copay
Outpatient Mental Health/Substance Abuse[1] *(includes individual & group visits)*	$15 copay	$15 copay
Emergency Room Visits	$50 copay	$50 copay
Urgent Care Clinic Visits[1]	$35 copay	$35 copay
Outpatient Hospital Observation	$0 copay per stay	20% coinsurance
Outpatient Hospital Surgery	$0 copay	30% coinsurance
Diagnostic/Lab Tests	$0 copay	30% coinsurance
Standard Imaging (X-Rays)	$0 copay	30% coinsurance
Advanced Imaging (CT scans, MRI, MRA)	$0 - $25 copay	30% coinsurance
Preventive Services		
Routine Physical Exam *(in addition to the Medicare wellness exam)*	$0 copay	$0 copay
Immunizations *(includes flu, COVID-19, pneumonia, Hep B)*	$0 copay	$0 copay
Screening Exams[2] *(includes mammograms, Pap test, prostate tests, colorectal screenings)*	$0 copay	$0 copay
Additional Services		
Ambulance Services	$70 copay per one way trip	$70 copay per one way trip
Durable Medical Equipment & Prosthetics *(includes oxygen)*	20% coinsurance	20% coinsurance
DME - Continuous Glucose Monitors (CGM) and CGM Supplies	20% coinsurance Preferred Brand	50% coinsurance
	IN: Preferred brands Dexcom or Freestyle Libre must be used and purchased at a network pharmacy. OON: 50% for other brands	
Diabetic Supplies *(includes test strips, lancets, monitors)*	$0 copay Preferred Manufacturer	50% coinsurance Non-Preferred Manufacturer
	IN: Preferred brand OneTouch must be used. To get the lowest cost for diabetic supplies, please use a network pharmacy. OON: 50% for other brands/locations	
Part B Drugs/Chemotherapy Drugs	0% - 20% coinsurance	0% - 20% coinsurance
Dialysis Services (in-home)	20% coinsurance	20% coinsurance

This grid is a summary of the most common benefits. Please refer to Evidence of Coverage for a complete list of benefits

[1] *Telehealth visits are also covered at the same copay as in person visits when offered by network providers*

[2] *Plan covers all Medicare-covered preventive services. Refer to Evidence of Coverage for complete list*

Capital

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SUPPLEMENTAL BENEFITS		
Benefits	**In-Network (IN)**	**Out-of-Network (OON)**
Maximum Out-of-Pocket (MOOP)	Supplemental benefits excluded from MOOP	
Additional Supplemental Benefits	*benefits included in medical premium*	
Remote Access Technology Virtual Care Visits	$0 copay Must use Amwell for Virtual Care	
Health Education *(up to 3 - 30 minutes visits per year)*	$0 copay Must use our Health Coaches	
Over The Counter (OTC Items) *(allowance does not carry over to the next quarter)*	$45 allowance per quarter for OTC Must use our vendor (combined IN/OON)	
Routine Hearing Benefit		
Routine Hearing Exam *(1 routine exam per year - combined [1])*	$0 copay Must use our vendor	
Routine Hearing Fitting Evaluation	$0 copay Must use our vendor	
Hearing Aids (prescription) *(1 hearing aid(s) every year)*	$499/$699/$999 copay every year copay per ear Must use our vendor	
OTC Hearing Aids *(1 hearing aid(s) every year)*	$499 copay every year copay per pair Must user our vendor	
Fitness Benefit	*premium included in the medical premium*	
Fitness Vendor	$0 copay Must use our fitness vendor	
Routine Vision Benefit	*premium included in the medical premium*	
Routine Vision Exam *(1 routine exam per year - combined [1])*	$0 copay	50% coinsurance
Eyeglasses (Frames and Lenses) or contact lenses - *combined [1])*	$150 allowance every year - for eyeglasses or contact lenses (combined IN/OON)	
Basic Dental Benefit	*premium included in the medical premium*	
Routine/Preventive Dental Exam *(up to 2 routine exams per year- combined [1] includes exam, cleaning, set bitewing x-rays, fluoride treatment)*	$0 copay $1,500 Plan Maximum Allowance per year for Preventive and Comprehensive	50% coinsurance $1,500 Plan Maximum Allowance per year for Preventive and Comprehensive
Comprehensive Dental *(member is responsible for all cost once annual allowance is met)*	$1,500 Plan Maximum Allowance per year for Preventive and Comprehensive (combined IN/OON) 50% coinsurance includes: **Restorative Services:** Crowns and Teeth Fillings - Amalgam & Composite **Periodontal Services:** Perio Maint. only **Oral and Maxillofacial Surgery:** Simple Extractions only **Endodontics:** Root canals, Pulpotomy **Prosthodontics, removable:** Dentures, Partials **Prosthodontics, fixed:** Bridges Adjustments and Repairs of Prosthetics **Adjunctive General Services:** Palliative Emergency Treatment, sedation, anesthesia, and teledentistry **Diagnostics:** intra-oral radiology; problem focused dental exams	

This grid is a summary of the most common benefits. Please refer to Evidence of Coverage for a complete list of benefits

[1] *Combined visit applies to one in-network or out-of-network visit*

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Part D Prescription Drug Benefits	**Member Cost-Sharing**	
Deductible	No deductible	
Initial Coverage Stage		
Part D Vaccines (e.g., Shingles, Tetanus booster)	$0 copay	
Tier 1 - Preferred Generic Drugs	30-day supply	$0 copay
	60-day supply	$0 copay
	100-day supply	$0 copay
Tier 2 - Generic Drugs	30-day supply	$4 copay
	60-day supply	$8 copay
	100-day supply	$12 copay
Tier 3 - Preferred Brand Drugs	30-day supply	$30 copay
	60-day supply	$60 copay
	100-day supply	$90 copay
Tier 4 - Non Preferred Drugs	30-day supply	33% coinsurance
	60-day supply	33% coinsurance
	100-day supply	33% coinsurance
Tier 5 - Specialty Drugs	30-day supply (only)	33% coinsurance
IRA Insulin (Part D)	30-day supply	$30 copay
	60-day supply	$60 copay
	100-day supply	$90 copay
Initial Coverage Limit		
Out-of-Pocket Limit (TrOOP)	**$2,000**	
Catastrophic Coverage Stage		
Catastrophic Coverage Copays	Cost Sharing $0	

Capital Blue Cross: Capital Blue Cross PPO is offered by Capital Advantage Insurance Company®, a Medicare Advantage organization with a Medicare contract. Enrollment in Capital Blue Cross PPO plan depends on contract renewal. Capital Blue Cross and its subsidiary Capital Advantage Insurance Company are independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

This grid is not a contract. Plans benefits are subject to change on an annual basis and require contract renewal from the Centers for Medicare and Medicaid Services (CMS). This document is prepared for group clients/administrators to provides an overview of the most commonly used benefits and is NOT intended to be a complete description of all available benefits. Exclusions and limitations of the PPO Medicare Advantage plan follow those of Medicare (i.e., Medicare Part A and Medicare Part B). Please refer to the “Evidence of Coverage” for a complete description of all benefits, exclusions, and additional program details.