Blue Cross Blue Shield of Michigan

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

Blue Traditional Medicare Supplemental Coverage: Blue Cross Option 2, Blue Shield Option 1 with Prescription Drugs Benefits-at-a-Glance

Effective for groups on their plan year

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at **medicare.gov** or at any Social Security office).

Member's responsibility (deductibles, coinsurance, copays and dollar maximums)

Note: Medicare deductible and coinsurance amounts are effective January 1, 2015 and are subject to change yearly

	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	• **Medicare Part A** $1,260 (for days 1-60) each benefit period • **Medicare Part B** $147 per calendar year	None
Coinsurance/fixed dollar copays	• **Hospital stay** $315 per day (for days 61-90) and $630 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime) • **Skilled nursing facility stay** (a limit of 100 days each benefit period) $157.50 per day (for days 21-100)	None
Coinsurance/percent copay amounts	• 20% of Medicare approved amount for most general services • 20% of Medicare approved amount for outpatient mental health care	None

Preventive care services

Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months **Note:** Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year
Pap smear screening – laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered **Note:** Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount

* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

	Original Medicare coverage	Medicare Supplemental coverage
Preventive care services, *continued*		
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections – includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50 **Note:** A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible.	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots – for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

	Original Medicare coverage	Medicare Supplemental coverage
Physician office services		
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Emergency medical care		
Hospital emergency room (facility services) – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Clinical laboratory services		
Laboratory and pathology tests – used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – **does not** include private duty nursing • Days 1-60 of each benefit period	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance abuse)	Covers Medicare deductible
• Days 61-90 of each benefit period	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• **Lifetime reserve days** after day 90 of each benefit period (up to 60 days over your lifetime)	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Additional days	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance
Alternatives to hospital care		
Skilled nursing facility care – subject to medical criteria • Days 1-20 of each benefit period	Covered at 100% of Medicare approved amount	Covered in full by Medicare
• Days 21-100 of each benefit period	Covered at 100% of Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
• Days 101 and after	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services – must be medically necessary and must be provided by a **Medicare-certified** home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

	Original Medicare coverage	Medicare Supplemental coverage
Surgical services provided by a physician		
Surgery – includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Human organ transplants		
Note: Payment is based on medical necessity and must be rendered in an approved facility.		
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered **Note:** Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered **Note:** Covers Medicare deductible and coinsurance when covered by Medicare.
Bone marrow transplants – under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Mental health care		
Inpatient mental health care in psychiatric facility • Days 1-190 **lifetime**	See “Hospital care” benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance) **Note:** In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and daily coinsurance
• Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible **Note:** If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance
Other covered services		
Allergy testing and therapy – with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible **Note:** You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible **Note:** There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment

	Original Medicare coverage	Medicare Supplemental coverage
Other covered services, *continued*		
Durable medical equipment – must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare
Foreign travel		
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

Blue Cross Blue Shield of Michigan

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Blue Preferred® Rx SG Prescription Drug Coverage
Custom Select Prescription Drug Plan, 3-Tier Copay/Coinsurance
Benefits-at-a-Glance

Specialty Pharmaceutical Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.
We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for **each** fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs – BCBSM may limit the initial fill of **select** controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. **Subsequent fills** of the **same** medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copay and coinsurance amounts)

		90-day retail network pharmacy	*** In-network mail order provider**	**In-network pharmacy** (not part of the 90-day retail network)	**Out-of-network pharmacy**
Tier 1 – Generic drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $20 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $20 copay	You pay $20 copay	No coverage	No coverage
Tier 2 – Preferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	You pay $40 copay	You pay $40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $80 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $110 copay	No coverage	No coverage
	84 to 90-day period	You pay $110 copay	You pay $110 copay	No coverage	No coverage
Tier 3 – Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 copay	You pay $80 copay	$80 copay	You pay $80 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $160 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $230 copay	No coverage	No coverage
	84 to 90-day period	You pay $230 copay	You pay $230 copay	No coverage	No coverage

***** BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

	90-day retail network pharmacy	*** In-network mail order provider**	**In-network pharmacy** (not part of the 90-day retail network)	**Out-of-network pharmacy**
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and **select brand-name** prescription preventive drugs, supplements and vitamins (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes – when dispensed with insulin, or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

***** BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. ▪ **Tier 2 (preferred brand)** – Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand-name drugs are also safe and effective, but require a higher copay/coinsurance. ▪ **Tier 3 (nonpreferred brand)** – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires the attending physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.

Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

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Blue Vision℠ (Pediatric Only) Benefits-at-a-Glance

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Vision benefits are only available to members through the last day of the year in which they turn age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	In-network	Out-of-network
Member's responsibility (copays)		
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered – annual supply	
Elective contact lenses that **improve** vision (prescribed, but do **not** meet criteria of medically necessary) If prescription contact lenses do not meet criteria for medically necessary, members may elect one of the following quantities of lenses as covered in full: • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

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Blue Dental℠ PPO Plus 100/80/50 SG – Non-voluntary $25/$75 deductible; $1,000 annual maximum Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Note: Pediatric members are members who are age 18 or younger on the plan's effective date. They remain pediatric members through the end of the calendar year in which they turn 19.

Network access information

With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

[1] *Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.*

[2] *A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.*

Blue Par Select℠ arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com**.

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)

Deductible • Applies to Class II and Class III services only	$25 per member limited to a maximum of $75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	20%
• Class III services	50%
• Class IV services	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per non-pediatric member per calendar year. The annual benefit maximum **does not** apply to pediatric members.
• Lifetime maximum for Class IV services	Not applicable
Out-of-pocket maximum • The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum **does not** apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, or non-covered services.	$350 for one pediatric member or $700 for two or more pediatric members per calendar year. There is no out-of-pocket maximum for non-pediatric members. **Note:** This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).

Plan's responsibility

The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services

Most diagnostic and preventive services: • Routine oral examinations/evaluations – twice per calendar year	100% of approved amount
• Routine prophylaxes (cleanings) – three times per calendar year for pediatric members; two times per calendar year for all other members	100% of approved amount
• Fluoride treatments – twice per calendar year **for pediatric members only**	100% of approved amount
• Topical fluoride varnish for moderate- to high-risk caries patients – four times per calendar year **for members age 3 and younger only** and two times per calendar year **for members age 4 to 14 only** in combination with fluoride treatments For example, two fluoride treatments **or** two topical fluoride varnishes **or** one fluoride treatment and one topical fluoride varnish are payable in a calendar year for high-risk members between the ages of 4 and 14. However, two fluoride treatments **and** two topical fluoride varnishes are not payable for these members.	100% of approved amount
• Dental sealants – once per tooth per 36 months for first and second permanent molars **for pediatric members only**	100% of approved amount
Bitewing X-rays – one set (up to four films) per calendar year	100% of approved amount
Oral brush biopsy sample collection – twice per calendar year	100% of approved amount

Class II services

Other diagnostic and preventive services: • Diagnostic tests and laboratory examinations	80% of approved amount after deductible
• Space maintainers – once per quadrant per lifetime for missing posterior primary teeth **for pediatric members only** (recementation of a space maintainer is payable three times per quadrant per lifetime)	80% of approved amount after deductible
Panoramic or full-mouth X-rays – once per 60 months	80% of approved amount after deductible
Emergency palliative treatment	80% of approved amount after deductible
Minor restorative services: • Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	80% of approved amount after deductible
• Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	80% of approved amount after deductible
Extractions and surgical removal of non-impacted teeth	80% of approved amount after deductible
Non-surgical endodontic services: • Root canal treatments – once per tooth per lifetime (retreatment of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	80% of approved amount after deductible
• Therapeutic pulpotomies or pulpal debridement	80% of approved amount after deductible
• Vital pulpotomies on primary teeth	80% of approved amount after deductible
• Apexification	80% of approved amount after deductible

Class II services, *continued*

Non-surgical periodontic services:	
• Periodontal maintenance – three times per calendar year in place of routine dental prophylaxis for pediatric members; two times per calendar year in place of routine dental prophylaxis for all other members	80% of approved amount after deductible
• Periodontal scaling and root planing – once per quadrant per 24 months for pediatric members; once per quadrant per 36 months for all other members	80% of approved amount after deductible
• Localized delivery of antimicrobial agents – one surface per tooth and three teeth per quadrant with a maximum of 12 teeth per year **for non-pediatric members only**	80% of approved amount after deductible
• Limited occlusal adjustments – up to five times per 60 months **for non-pediatric members only**	80% of approved amount after deductible
• Occlusal biteguards (and relines and repairs to occlusal biteguards) – once per 60 months **for non-pediatric members only**	80% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances:	
• Relines or rebases of partial dentures or complete dentures – once per 36 months per arch	80% of approved amount after deductible
• Tissue conditioning – once per 36 months per arch	80% of approved amount after deductible
Adjunctive general services:	
• General anesthesia or IV sedation	80% of approved amount after deductible
• Office visits for observation (during regularly scheduled hours) **for non-pediatric members only**	80% of approved amount after deductible
• Office visits after regularly scheduled hours	80% of approved amount after deductible
• House and hospital calls **for non-pediatric members only**	80% of approved amount after deductible
• Antibiotic injections **for non-pediatric members only**	80% of approved amount after deductible

Class III services

Major restorative services:	
• Onlays, crowns and veneers – once per permanent tooth per 60 months **for members age 12 and older only**	50% of approved amount after deductible
• Substructures, including cores and posts	50% of approved amount after deductible
Oral surgery services other than extractions of non-impacted teeth:	
• Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible
• Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible
• Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible
• Excision of hyperplastic tissue per arch	50% of approved amount after deductible
• Soft tissue biopsies **for pediatric members only**	50% of approved amount after deductible
• Frenulectomies	50% of approved amount after deductible
Surgical endodontic services:	
• Apical surgeries on permanent teeth	50% of approved amount after deductible
Surgical periodontic services:	
• Gingivectomies and gingivoplasties	50% of approved amount after deductible
• Osseous surgeries **for non-pediatric members only**	50% of approved amount after deductible
• Gingival flap procedures	50% of approved amount after deductible
• Soft tissue grafts	50% of approved amount after deductible
• Bone replacement grafts **for non-pediatric members only**	50% of approved amount after deductible
Prosthodontic services:	
• Complete dentures – once per 84 months	50% of approved amount after deductible
• Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics – once per 84 months **for members age 16 and older only**	50% of approved amount after deductible
• Recementation and repairs of bridges	50% of approved amount after deductible
• Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible
• Endosteal implants and implant-related services – once per tooth per lifetime for teeth numbered 2 through 15 and 18 through 31 **for non-pediatric members only**	50% of approved amount after deductible

Blue Cross Blue Shield of Michigan

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

Blue Vision Adults-only SG with VSP Choice Network 24/24/24[SM] Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Vision benefits are only available to covered members (subscribers, spouses and dependent children) age 19 and older. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	In-network	Out-of-network
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $34 less $5 copay (member responsible for any difference)
	One eye exam every 24 months (calendar year basis)	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, every 24 months (calendar year basis)	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame every 24 months (calendar year basis)	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses every 24 months (calendar year basis)	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance every 24 months (calendar year basis)	