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**Lake Superior State University**

**Division 0005 Support Staff**

**Effective Date: On or after January, 2019**

**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 the Carrier's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable 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.

**Preauthorization for Select Services** - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by the Carrier except in an emergency.

**Note:**A list of services that require approval **before** they are provided is available online at [bcbsm.com/importantinfo](http://bcbsm.com/importantinfo). **Select Approving covered services.**

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your ID card and providing the procedure code. Your provider can also provide this information upon request.

# Upper Peninsula Blue<sup>SM</sup> Away from Home Care

If you or your dependents are outside of Michigan and need medical care, Blue Cross Blue Shield of Michigan will waive your out-of-network cost sharing obligation in the following situations:

- If you or your dependent are admitted to a hospital immediately following an emergency room visit.
- If you or your dependent are a full-time college student attending classes in another state.
- If you are responsible for court-ordered child care for children living in another state.
- If you or your dependent suffer an accidental injury or a medical emergency.

If one of these situations applies and your explanation of benefits statement indicates that we have charged you the out-of-network cost sharing amount, please contact the BCBSM Marquette office at 800-562-7884. This will trigger a review process and could result in the waiver of your out-of-network cost sharing amount.

In addition to the exceptions described above, you still need to follow the U. P. Blue referral process:

- Your health care provider contacts the Upper Peninsula Health Plan with a request for you to receive services outside of Michigan.
- The UPHP reviews the referral request to determine if the services cannot be performed locally by a BCBSM PPO network provider.
- The member contacts the BCBSM Marquette office for reprocessing of the claim.

If the services you seek can be performed in Michigan by a BCBSM PPO network provider, the UPHP will not approve your referral. You may still choose to have the medical services performed by the out-of-state provider, but you will be responsible for the out-of-network cost-sharing amount.



**Blue Cross  
Blue Shield**  
of Michigan

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*Upper Peninsula  
Health Plan*

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

| Benefits   | In-network   | Out-of-network  |
|--|--|---|
| <b>Deductibles</b><br><br><b>Note:</b> Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.                                  | \$5,000 for one member,<br>\$10,000 for the family (when two or more members are covered under your contract) each calendar year<br><br><b>HRA \$500 for one member, \$1,000 for the family (when two or more members are covered)</b>   | \$10,000 for one member,<br>\$20,000 for the family (when two or more members are covered under your contract) each calendar year<br><br><b>Note:</b> Out-of-network deductible amounts also count toward the in-network deductible<br><br><b>HRA \$1,000 for one member, \$2,000 for the family (when two or more members are covered)</b> |
| <b>Flat-dollar copays</b>  | <ul style="list-style-type: none"> <li>• \$40 copay for office visits &amp; office consultations <b>HRA \$25</b></li> <li>• \$40 copay for medical online visits <b>HRA \$5</b></li> <li>• \$40 copay for chiropractic and osteopathic manipulative therapy <b>HRA \$0</b></li> <li>• \$250 copay for emergency room visits <b>HRA \$50</b></li> <li>• \$40 copay per urgent care visit <b>HRA \$25</b></li> </ul> | \$250 copay for emergency room visits <b>HRA \$50</b>   |
| <b>Coinsurance amounts (percent copays)</b><br><br><b>Note:</b> Coinsurance amounts apply once the deductible has been met.  | <ul style="list-style-type: none"> <li>• 50% of approved amount for private duty nursing care</li> <li>• 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)<br/><b>HRA Zero Coinsurance</b></li> </ul>   | <ul style="list-style-type: none"> <li>• 50% of approved amount for private duty nursing care</li> <li>• 40% of approved amount for most other covered services<br/><b>HRA \$3,000 for one member, \$6,000 for the family (when two or more members are covered)</b></li> </ul>   |
| <b>Annual coinsurance maximums</b>   | None   | None  |
| <b>Annual out-of-pocket maximums</b> - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable<br><br><b>Note:</b> Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum | \$6,350 for one member,<br>\$12,700 for the family (when two or more members are covered under your contract) each calendar year<br><b>HRA \$1,000 for one member, \$2,000 for the family (when two or more members are covered)</b>   | \$12,700 for one member,<br>\$25,400 for the family (when two or more members are covered under your contract) each calendar year<br><br><b>HRA \$4,000 for one member, \$8,000 for the family (when two or more members are covered)</b>   |
| <b>Lifetime dollar maximum</b>   |  | None  |

## Preventive care services

| Benefits  | In-network  | Out-of-network |
|---|---|----------------|
| Health maintenance exam -includes chest x-ray, EKG, cholesterol screening and other select lab procedures | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br><b>Note.</b> Additional well-women visits may be allowed based on medical necessity. | Not covered    |

| Benefits  | In-network  | Out-of-network   |
|---|---|--|
| Gynecological exam  | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br><b>Note:</b> Additional well-women visits may be allowed based on medical necessity.   | Not Covered  |
| Pap smear screening -laboratory and pathology services  | 100% (no deductible or copay/coinsurance), one per member per calendar year   | Not covered  |
| Voluntary sterilizations for females  | 100% (no deductible or copay/coinsurance)   | 60% after out-of-network deductible  |
| Prescription contraceptive devices- includes insertion and removal of an intrauterine device by a licensed physician  | 100% (no deductible or copay/coinsurance)   | 100% after out-of-network deductible   |
| Contraceptive injections  | 100% (no deductible or copay/coinsurance)   | 60% after out-of-network deductible  |
| Well-baby and child care visits   | 100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul> | Not covered  |
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by the Carrier that are in compliance with the provisions of the Patient Protection and Affordable Care Act | 100% (no deductible or copay/coinsurance)   | Not covered  |
| Fecal occult blood screening  | 100% (no deductible or copay/coinsurance), one per member per calendar year   | Not covered  |
| Flexible sigmoidoscopy exam   | 100% (no deductible or copay/coinsurance), one per member per calendar year   | Not covered  |
| Prostate specific antigen (PSA) screening   | 100% (no deductible or copay/coinsurance), one per member per calendar year   | Not Covered  |
| Routine mammogram and related reading   | 100% (no deductible or copay/coinsurance)<br><br><b>Note:</b> Subsequent medically necessary mammograms performed during the <b>same</b> calendar year are subject to your deductible and coinsurance<br><br>One per member per calendar year   | 60% after out-of-network deductible<br><br><b>Note:</b> Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. |
| Colonoscopy-routine or medically necessary  | 100% (no deductible or copay/coinsurance), for the first billed colonoscopy<br><br><b>Note:</b> Subsequent colonoscopies performed during the <b>same</b> calendar year are subject to your deductible and coinsurance<br><br>One per member per calendar year  | 60% after out-of-network deductible  |

## Physician office services

| Benefits  | In-network  | Out-of-network                      |
|---|---|-------------------------------------|
| Office visits-must be medically necessary                           | • \$40 copay per office visit HRA \$25  | 60% after out-of-network deductible |
| Outpatient and home medical care visits-must be medically necessary | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible |
| Office consultations-must be medically necessary                    | • \$40 copay per office consultation HRA \$25   | 60% after out-of-network deductible |
| Online visits – must be medically necessary                         | \$40 copay for online visits HRA \$5<br>\$35 difference will be refunded automatically by check to the member | 60% after out-of-network deductible |

**Note:** Online visits by a non-Carrier selected vendor are not covered.

## Urgent care visits

| Benefits           | In-network                                | Out-of-network                      |
|--------------------|---|-------------------------------------|
| Urgent care visits | \$40 copay per urgent care visit HRA \$25 | 60% after out-of-network deductible |

## Emergency medical care

| Benefits                                       | In-network  | Out-of-network  |
|--|---|---|
| Hospital emergency room                        | \$250 copay per visit (waived if admitted or for an accidental injury) HRA \$50 | \$250 copay per visit (copay waived if admitted or for an accidental injury) HRA \$50 |
| Ambulance services-must be medically necessary | 80% HRA 100% after in-network deductible  | 80% HRA 100% after in-network deductible  |

## Diagnostic services

| Benefits                          | In-network                               | Out-of-network                      |
|-----------------------------------|--|-------------------------------------|
| Laboratory and pathology services | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible |
| Diagnostic tests and x-rays       | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible |
| Therapeutic radiology             | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible |

## Maternity services provided by a physician or certified nurse midwife

| Benefits                  | In-network                                | Out-of-network                      |
|---------------------------|---|-------------------------------------|
| Prenatal care visits      | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Postnatal care            | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Delivery and nursery care | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible |

## Hospital care

| Benefits   | In-network                               | Out-of-network  |
|--|--|---|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible<br>Unlimited days |

**Note:** Nonemergency services must be rendered in a **participating** hospital.

|                         |  |                                     |
|-------------------------|--|-------------------------------------|
| Inpatient consultations | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible |
| Chemotherapy            | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible |

## Alternatives to hospital care

| Benefits   | In-network   | Out-of-network                            |
|--|--|---|
| Skilled nursing care-must be in a <b>participating</b> skilled nursing facility  | 80% HRA 100% after in-network deductible Limited to a maximum of 120 days per member per calendar year   | 80% HRA 100% after in-network deductible  |
| Hospice care   | 100% (no deductible or copay/coinsurance)<br>Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management) | 100% (no deductible or copay/coinsurance) |
| Home health care:<br><ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>   | 80% HRA 100% after in-network deductible   | 80% HRA 100% after in-network deductible  |
| Infusion therapy:<br><ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization- consult with your doctor</li> </ul> | 80% HRA 100% after in-network deductible   | 80% HRA 100% after in-network deductible  |

## Surgical services

| Benefits  | In-network                                | Out-of-network                      |
|---|---|-------------------------------------|
| Surgery- includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible |
| Presurgical consultations   | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Voluntary sterilization for males   | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible |
| <b>Note:</b> For voluntary sterilizations for females, see "Preventive care services."  |   |                                     |
| Elective abortions  | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible |

## Human organ transplants

| Benefits  | In-network                                | Out-of-network   |
|---|---|--|
| Specified human organ transplants-must be in a <b>designated</b> facility and coordinated through the Carrier's Human Organ Transplant Program (1-800-242-3504) | 100% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) - in designated facilities <b>only</b> |
| Bone marrow transplants -must be coordinated through the Carrier's Human Organ Transplant Program (1-800-242-3504)  | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible  |
| Specified oncology clinical trials  | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible  |
| <b>Note:</b> The Carrier covers clinical trials in compliance with PPACA.   |   |  |
| Kidney, cornea and skin transplants   | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible  |

## Mental health care and substance use disorder treatment

**Note:** Some mental health and substance use disorder services are considered by the Carrier to be comparable to an office visit. When a mental health or substance use disorder service is considered by the Carrier to be comparable to an office visit, we will process the claim under your office visit benefit.

| Benefits   | In-network                               | Out-of-network  |
|--|--|---|
| <b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment  | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible<br>Unlimited days   |
| Residential psychiatric treatment facility <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>treatment must be preauthorized</li> <li>subject to medical criteria</li> </ul> | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible   |
| Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>   | 80% HRA 100% after in-network deductible | 100% after in-network deductible in participating facilities <b>only</b>                            |
| <b>Note:</b> Online visits by a non-Carrier selected vendor are not covered.   |  |   |
| <ul style="list-style-type: none"> <li>Physician's office</li> </ul>   | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible   |
| Outpatient substance use disorder treatment- in approved facilities <b>only</b>  | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network) |

## Autism spectrum disorders, diagnoses and treatment

| Benefits   | In-network                               | Out-of-network  |
|--|--|---|
| Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization   | 80% HRA 100% after in-network deductible | 80% HRA 100% after in-network deductible  |
| <b>Note:</b> Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a Carrier approved autism evaluation center (AAEC) prior to seeking ABA treatment. |  |   |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder   | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible<br>Physical, speech and occupational therapy <b>with an autism diagnosis</b> is unlimited |
| Other covered services, including mental health services, for autism spectrum disorder   | 80% HRA 100% after in-network deductible | 60% after out-of-network deductible   |

## Other covered services

| Benefits  | In-network  | Out-of-network  |
|---|---|---|
| <p>Outpatient Diabetes Management Program (ODMP)</p> <p><b>Note:</b> Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.</p> <p><b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p> | <ul style="list-style-type: none"> <li>80% HRA 100% after in-network deductible for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul> | 60% after out-of-network deductible   |
| Allergy testing and therapy   | 100% (no deductible or copay/coinsurance)   | 60% after out-of-network deductible   |
| Chiropractic spinal manipulation and osteopathic manipulative therapy   | \$40 copay per visit HRA \$0  | 60% after out-of-network deductible   |
|   | Limited to a <b>combined 24-visit</b> maximum per member per calendar year  |   |
| Outpatient physical, speech and occupational therapy-provided for rehabilitation  | 80% HRA 100% after in-network deductible  | 60% after out-of-network deductible   |
|   |   | <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered. |
|   | Limited to a <b>combined 60-visit</b> maximum per member per calendar year  |   |
| Durable medical equipment   | 80% HRA 100% after in-network deductible  | 80% HRA 100% after in-network deductible  |
| <p><b>Note:</b> DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call the Carrier.</p>  |   |   |
| Prosthetic and orthotic appliances  | 80% HRA 100% after in-network deductible  | 80% HRA 100% after in-network deductible  |
| Private duty nursing care   | 50% after in-network deductible   | 50% after in-network deductible   |





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Blue Shield  
of Michigan

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**LAKE SUPERIOR STATE UNIVERSI  
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Dental Coverage  
Effective Date: On or after January 2018  
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 coinsurance. 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.

**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.<sup>1</sup>

**Blue Dental PPO network-** Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations<sup>2</sup> 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](http://mibluedentist.com) or call 1-888-826-8152.

<sup>1</sup>Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

<sup>2</sup>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<sup>SM</sup> 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](http://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)**

| Benefits  | Coverage           |
|---|--------------------|
| Deductible                                      | None               |
| Class I services                                | 30%                |
| Class II services                               | 30%                |
| Class III services                              | 30%                |
| Class IV services                               | 50%                |
| Annual maximum for Class I, II and III services | \$1,000 per member |
| Lifetime maximum for Class IV services          | \$1,500 per member |

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## Class I services

| Benefits  | Coverage   |
|---|--|
| Oral exams  | 70% of approved amount<br><b>Note:</b> Twice per calendar year   |
| A set (up to 4 films) of bitewing x-rays  | 70% of approved amount<br><b>Note:</b> Twice per calendar year   |
| Panoramic or full-mouth x-rays  | 70% of approved amount<br><b>Note:</b> Once every 60 months  |
| Dental prophylaxis (teeth cleaning)   | 70% of approved amount<br><b>Note:</b> Twice per calendar year   |
| Pit and fissure sealants - for members age 19 and younger                             | 70% of approved amount<br><b>Note:</b> Once per tooth in any 36 consecutive months when applied to the first and second permanent molars |
| Palliative (emergency) treatment  | 70% of approved amount   |
| Fluoride treatments   | 70% of approved amount<br><b>Note:</b> Two per calendar year   |
| Space maintainers - missing posterior (back) primary teeth - for members under age 19 | 70% of approved amount<br><b>Note:</b> Once per quadrant per lifetime  |

## Class II services

| Benefits  | Coverage  |
|---|---|
| Fillings - permanent (adult) teeth  | 70% of approved amount<br><b>Note:</b> Replacement fillings covered after 24 months or more after initial filling         |
| Fillings - primary (child) teeth  | 70% of approved amount<br><b>Note:</b> Replacement fillings covered after 12 months or more after initial filling         |
| Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older | 70% of approved amount<br><b>Note:</b> Once every 60 months per tooth   |
| Recementation of crowns, veneers, inlays, onlays and bridges                                    | 70% of approved amount<br><b>Note:</b> Three times per tooth per calendar year after six months from original restoration |
| Oral surgery, except simple extractions   | 70% of approved amount  |
| Root canal treatment - permanent tooth  | 70% of approved amount<br><b>Note:</b> Once every 12 months for tooth with one or more canals                             |
| Scaling and root planing  | 70% of approved amount<br><b>Note:</b> Once every 24 months per quadrant  |
| Limited occlusal adjustments  | 70% of approved amount<br><b>Note:</b> Limited occlusal adjustments covered up to five times in any 60 consecutive months |
| Occlusal biteguards   | 70% of approved amount<br><b>Note:</b> Once every 12 months   |
| General anesthesia or IV sedation   | 70% of approved amount<br><b>Note:</b> When medically necessary and performed with oral surgery                           |
| Repairs and adjustments of a partial or complete denture  | 70% of approved amount<br><b>Note:</b> Six months or more after denture is delivered                                      |
| Relining or rebasing of a partial or complete denture   | 70% of approved amount<br><b>Note:</b> Once per arch in any 36 consecutive months   |
| Tissue conditioning   | 70% of approved amount<br><b>Note:</b> Once per arch in any 36 consecutive months   |

## Class III services

| Benefits                                  | Coverage  |
|---|---|
| Removable dentures (complete and partial) | 70% of approved amount<br><b>Note:</b> Once every 60 months |

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| Benefits   | Coverage   |
|--|--|
| Bridges (fixed partial dentures) - for members age 16 and older  | 70% of approved amount<br><b>Note:</b> Once every 60 months after original was delivered   |
| Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement | 70% of approved amount<br><b>Note:</b> Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31 |

### Class IV services - Orthodontic services for dependents under age 19

| Benefits   | Coverage               |
|--|------------------------|
| Minor treatment for tooth guidance appliances        | 50% of approved amount |
| Minor treatment to control harmful habits            | 50% of approved amount |
| Interceptive and comprehensive orthodontic treatment | 50% of approved amount |
| Post-treatment stabilization                         | 50% of approved amount |
| Cephalometric film (skull) and diagnostic photos     | 50% of approved amount |

**Note:** For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination *before* treatment begins.



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## LAKE SUPERIOR STATE UNIVERSI

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### Vision Coverage

**Effective Date: On or after January 2018**

### Benefits-at-a-glance

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Essential Vision benefits are provided by Heritage Total Services. Heritage Vision Plans is an independent company providing vision benefit services for Blues members. To find a Heritage Total Services network provider, call **1-800-252-2053** or visit Heritage Vision Plans online at [heritagevisionplans.com](http://heritagevisionplans.com).

**Note:** Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

| Member's responsibility (copays)  |                       |   |
|---|-----------------------|---|
| Benefits  | Network doctor        | Non-network provider  |
| Eye exam  | \$5 copay             | \$5 copay applies to charge   |
| Prescription glasses (lenses and/or frames)   | Combined \$7.50 copay | Member responsible for difference between approved amount and provider's charge, after \$7.50 copay |
| Medically necessary contact lenses  | \$7.50 copay          | Member responsible for difference between approved amount and provider's charge, after \$7.50 copay |
| <b>Note:</b> No copay is required for prescribed contact lenses that are not medically necessary. |                       |   |

| Eye exam  |                |   |
|---|----------------|---|
| Benefits  | Network doctor | Non-network provider  |
| 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 \$35 less \$5 copay (member responsible for any difference) |
| One eye exam in any period of 12 consecutive months   |                |   |

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## Lenses and frames

| Benefits   | Network doctor   | Non-network provider  |
|--|--|---|
| <p><b>Standard lenses</b> (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.</p> <p><b>Note:</b> Preferred pricing discounts on noncovered lens options and upgrades, and on an additional prescription eyeglass or sunglass (second pair) purchase when obtained from a network provider.</p> | <p>\$7.50 copay (one copay applies to <b>both</b> lenses and frames)</p> <p>One pair of lenses, with or without frames, in any period of 12 <b>consecutive</b> months</p>  | <p>Reimbursement up to approved amount based on lens type less \$7.50 copay (member responsible for any difference)</p> |
| <p>Standard frames</p>   | <p>\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$7.50 copay (one copay applies to <b>both</b> frames and lenses)</p> <p>One frame in any period of 12 <b>consecutive</b> months</p> | <p>Reimbursement up to \$65 less \$7.50 copay (member responsible for any difference)</p>                               |

## Contact lenses

| Benefits  | Network doctor  | Non-network provider   |
|---|---|--|
| <p>Medically necessary contact lenses (requires prior authorization approval from Heritage and must meet criteria of medically necessary)</p> | <p>\$7.50 copay</p> <p>Contact lenses up to the allowance in any period of 12 <b>consecutive</b> months</p>   | <p>Reimbursement up to approved amount less \$7.50 copay (member responsible for any difference)</p>   |
| <p>Elective contact lenses that <b>improve</b> vision (prescribed, but do not meet criteria of medically necessary)</p>                       | <p>\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p> <p>Contact lenses up to the allowance in any period of 12 <b>consecutive</b> months when services are rendered by a Heritage network provider.</p> | <p>\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p> |