LAKE SUPERIOR STATE UNIVERSITY

Support Staff

007004176 - 0005 w/ Seamless HRA

Community Blue℠ PPO LG

Effective Date: On or after January 2025

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. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **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 BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Prior authorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request prior authorization of the drugs. **If prior authorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

ADM HCR-RXOC;ADM PLANYR JAN;CB LG;CB-CSR LG;CB-EA-1 LG;CB-ET $250 LG;CB-MTC $40 LG;CB-OV $40 LG;CBC 20%-IN LG;CBC 40%-ON LG;CBD $10K-ON LG;CBD $5000-IN LG;CBOPMIN 6350 LG;CBOPMON12.7K LG;RxCO-AF LG

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

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

Benefits	In-network	Out-of-network
Deductibles **HRA In-Network:** **$500 for one member** **$1,000 for the family** **HRA Out-of-Network:** **$1,000 for one member** **$2,000 for the family**	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$10,000 for one member, $20,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible
Flat-dollar copays	• $40 copay for office visits and office consultations **HRA: $25** • $40 copay for **virtual primary care** visits **HRA: $5** • $40 copay for medical online visits **HRA: $5** • $40 copay for chiropractic and osteopathic manipulative therapy **HRA: $0** • $250 copay for emergency room visits **HRA: $50** • $40 copay for urgent care visits **HRA: $25**	• $250 copay for emergency room visits **HRA: $50**
Coinsurance amounts (percent copays) **HRA: 0% In-Network:** **$0 for one member** **$0 for the family** **HRA 40% Out-of-Network:** **$3,000 for one member** **$6,000 for the family** **Both in and out-of-network Private Duty Nursing are not reimbursed by the HRA and do not contribute to HRA deductible or coinsurance max.** **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable **HRA In-Network Max:** **$1,000 for one member** **$2,000 for the family** **HRA Out-of-Network Max:** **$4,000 for one member** **$8,000 for the family**	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

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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 **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year **Note:** 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 sterilization of female reproductive organs	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 Well-child visits	100% (no deductible or copay/coinsurance) • 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	Not covered
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	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

Benefits	In-network	Out-of-network
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance), for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note:** This includes mental health and substance use disorder services equivalent to medical office visits. **Note: Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered. ***$35 difference will be reimbursed automatically by check to member**	• $40 copay per office visit (in person or virtual) **HRA: $25 (in person only)** • $40 copay for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM selected vendor **HRA: $5***	60% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$40 copay per online visit **HRA: $5*** ***$35 difference will be reimbursed automatically by check to member**	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible **HRA: 100% after in-net ded.**	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
Urgent care visits - must be medically necessary	$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 (copay 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% after in-network deductible	80% after in-network deductible
	HRA: 100% after in-net ded.	**HRA: 100% after in-net ded.**

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Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible **HRA: 100% after in-net ded.**	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 visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible **HRA: 100% after in-net ded.**	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 **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible **HRA: 100% after in-net ded.** Unlimited days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible **HRA: 100% after in-net ded.**	80% after in-network deductible **HRA: 100% after in-net ded.**
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; 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: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible **HRA: 100% after in-net ded.**	80% after in-network deductible **HRA: 100% after in-net ded.**

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Benefits	In-network	Out-of-network
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require prior authorization - consult with your doctor	80% after in-network deductible **HRA: 100% after in-net ded.**	80% after in-network deductible **HRA: 100% after in-net ded.**

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Cornea and skin transplants	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be equivalent to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be equivalent to an office visit or medical online visit, we will process the claim under your Physician Office Services.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible **HRA: 100% after in-net ded.** Unlimited days	60% after out-of-network deductible

Benefits	In-network	Out-of-network
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment requires prior authorization • subject to medical criteria	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible **HRA: 100% after in-net ded.**	80% after in-network deductible in participating facilities **only** **HRA: 100% after in-net ded.**
• Online visits - for services equivalent to a medical online visit **Note:** Online visits by a non-BCBSM selected vendor are not covered.	$40 copay per online visit **HRA: $5*** ***$35 will be reimbursed automatically by check to member**	60% after out-of-network deductible
• Physician's office **Note:** For services equivalent to a medical office visit. See "**Physician Office Services**".	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible **HRA: 100% after in-net ded.**	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 behavior analysis (ABA) treatment - subject to prior authorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	$40 copay per office visit **HRA: $25**	60% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** 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. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies; **HRA: 100% after in-net ded.** • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Chiropractic spinal manipulation and osteopathic manipulative therapy	$40 copay per visit **HRA: $0**	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - when provided for rehabilitation	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	80% after in-network deductible **HRA: 100% after in-net ded.**	60% after out-of-network deductible
Private duty nursing care **HRA: Not covered in or out-of-network**	70% after in-network deductible	50% after out-of-network deductible

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► Pharmacy Network

Chains Available Nationwide

CVS Pharmacy
Meijer Pharmacy
Target Pharmacy
Walgreens Pharmacy
Walmart Pharmacy

ARORx's participating pharmacy network includes more than 67,000 retail pharmacies, including regional and national chains, as well as independently owned pharmacies. To locate a pharmacy near you, log on to members.arorx.com and access our online pharmacy locator. You may also contact ARORx Member Services at 833-306-4092 and speak with a Patient Advocate to assist in finding a pharmacy near you or email ARORx at Rx@arorx.com.

Contact Us

For questions concerning your prescription drug program call ARORx at:

833-306-4092

or email ARORx at RX@arorx.com

Patient Advocates are available for routine inquiries Monday through Friday from 8am to 5pm (Eastern Time) and for emergency services 24/7. No one can predict an emergency and no emergency should have to wait.
ARORx 24/7 patient advocates are there when you need help.

Your network pharmacist can also call ARORx for specific questions about your prescriptions.

For questions regarding your mail order prescription call ARORx at:

833-306-4092

or email ARORx at RX@arorx.com.

Member Services is available Monday through Friday from 8AM to 5PM (Eastern Time) and for emergency services 24/7.

***Note: To order refills, call 800-687-0707**
Monday through Friday from 8AM to 5PM (Eastern Time)
or log-on to members.arorx.com

► ARO Rx

Prescription Drug Program
0000 Support Staff

LAKE SUPERIOR STATE UNIVERSITY

► About Your Medications

Retail Medications

Medications dispensed at an ARORx participating retail pharmacy are limited to a 90-day supply. Medications dispensed between 31-83 days are excluded.

Mail Order Medications

MXP Pharmacy offers a convenient, cost effective way to order prescribed long-term medications for delivery to your home. Medications obtained through mail order are limited to a 90-day supply. Medications dispensed between 31-83 days are excluded. To maximize your savings, please ask your doctor to write, submit electronically, or fax your prescription for a 90-day supply with refills up to one year. Once MXP Pharmacy has your prescription, refills can easily be obtained. To get started, please use one of the following options:

1) Go Online - Create an ARORx member web portal account at members.arorx.com. After you have successfully created an account, select the "Sign-Up for Mail Order" feature.
2) By Phone - Call (800) 687-0707

Specialty Medications

Please call (833) 306-4092 or email ARORx at RX@arorx.com for payment assistance.

Refills

If your physician has authorized refills, you may refill your prescription once 75% of the prescription has been used.

Formulary

The ARORx Formulary will be utilized with your drug program. The formulary is a list of medications to be used as a guide for physicians when prescribing. For the comprehensive formulary, please create a member portal account by visiting our website at members.arorx.com*

How Your Formulary Works

Generic - Generic medications contain the same active ingredients as their corresponding brand-name medications. The generics on this formulary are listed in lower case letters.

Preferred - Brand-name medications listed on the formulary in all capital letters.

Non-Preferred - Brand-name medications not listed on the formulary or listed as non-preferred for example purposes.

* Not all drugs listed on the formulary are covered by all prescription drug benefit programs: check your benefit materials for the specific drugs that are covered and those which are excluded.

► Prescription Copay Amounts

0000 Support Plan

TIER	RETAIL COPAY 30 Day Supply	MAIL ORDER 90 Day Supply
Generic	$5.00	$5.00
Preferred Brand*	$25.00	$25.00
Non-Preferred Brand*	$50.00	$50.00

* If a patient or doctor requests a brand name drug when a generic equivalent exists, the patient will pay the difference between the brand and generic medication in addition to the applicable brand copay.

†Contraceptives and certain preventive medications are covered at $0 copay, as required by the Affordable Care Act.

► About Your Benefits Coverage

Covered Drugs, Limitations and Exclusions

Most prescription drugs that require a "written" prescription by a licensed physician are covered. Anti-wrinkle agents (e.g. Renova), cosmetic hair removal products (e.g. Vaniqa), hair growth stimulants, non-legend drugs other than insulin, therapeutic devices or appliances, and other non-medicinal substances, regardless of intended use, except those listed above, and charges for the administration or injection of any drug are generally not covered under your drug benefit. In addition, certain restrictions, quantity limits or prior authorization requirements may apply.* To obtain additional information about these restrictions, or for more coverage information, contact your HR Department or an ARORx Patient Advocate.

***This is not intended to be a full explanation of benefits, limitations, or exclusions. For more information, please review your benefit documents.**

Using A Non-Participating Pharmacy

This program requires eligible members to use an ARORx participating pharmacy (refer to the pharmacy network list). When an out-of-network pharmacy is used, you may be responsible for paying more than just the required copay. Prescriptions purchased at "non-participating pharmacies" are covered only in emergency situations, for example, you're out-of-town and unable to locate an ARORx participating pharmacy or you need an emergency prescription filled late at night. You will need to pay 100% of the prescription drug cost and obtain a receipt. Then you must submit a paper claim along with the receipt for reimbursement to ARORx. You can request this form from your employee benefits office or ARORx. You will be reimbursed the network-discounted rate minus your copay.

Blue Cross Blue Shield of Michigan

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

LAKE SUPERIOR STATE UNIVERSITY
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Dental Coverage
Effective Date: On or after January 2025
Benefits-at-a-glance

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Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Dentist information
With Blue Dental PPO, you can choose any licensed dentist anywhere. However, you'll get the best coverage and save the most money when you choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the country through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at **bcbsm.com** or call **1-888-826-8152.**

If you go to a non-PPO dentist, you can still save money by choosing a Tier 2 participating non-PPO (out-of-network) dentist. Tier 2 dentists participate with us on a "per claim" basis through our Blue Par Select (BPS) arrangement. They accept our BPS approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 2 participating non-PPO dentist near you, log into your member account at **bcbsm.com**. You should ask your dentist if they participate with BCBSM before every treatment.

Note: If you go to a nonparticipating dentist, you are responsible for any difference between our approved amount and the dentist's charge.

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

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

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	30%
• Class II services	30%
• Class III services	30%

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Benefits	Coverage
• Class IV services	50%
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	$1,500 per member

Class I services

Benefits	Coverage
Oral exams	70% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	70% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	70% of approved amount **Note:** Once every 60 months
Prophylaxis (cleaning)	70% of approved amount **Note:** Twice per calendar year
Sealants - for members age 19 and younger	70% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars. This period begins on the date of the member's first treatment.
Emergency palliative treatment	70% of approved amount
Fluoride treatments	70% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	70% of approved amount **Note:** Once per quadrant per lifetime
Periodontic maintenance	70% of approved amount

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	70% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	70% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older	70% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	70% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	70% of approved amount
Root canal treatment	70% of approved amount **Note:** Once per tooth per lifetime; retreatment of previous root canal therapy once per tooth per lifetime.
Scaling and root planing	70% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	70% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	70% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	70% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	70% of approved amount **Note:** Six months or more after denture is delivered

Benefits	Coverage
Relining or rebasing of a partial or complete denture	70% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	70% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	70% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	70% of approved amount **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	70% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services

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.

Blue Cross Blue Shield of Michigan

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

LAKE SUPERIOR STATE UNIVERSITY
007004176 - 0000
Vision Coverage
Effective Date: On or after January 2025
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. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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 **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

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
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.	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
Note: 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.	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $65 less $7.50 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact lenses

Benefits	Network doctor	Non-network provider
Medically necessary contact lenses (requires prior authorization approval from Heritage and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to approved amount less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
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)	$105 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 up to the allowance in any period of 12 **consecutive** months when services are rendered by a Heritage network provider.	

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