Blue Cross Blue Shield of Michigan

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

Client: SUMMIT ACADEMY NORTH

Community Blue[SM] PPO Platinum $500 Medical Coverage with Prescription Drugs Benefits-at-a-Glance - w/EA

Effective for groups on their plan year beginning on or after January 1, 2014

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/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.

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 BCBSM except in an emergency.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

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.

Preauthorization 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 preauthorization of the drugs. If preauthorization 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 disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Deductibles	$500 for one member $1,000 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.	$1,000 for one member $2,000 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	• $20 copay for office visits and office consultations with a **primary care provider** • $20 copay for office visits and office consultations with a **specialist** • $20 copay for chiropractic services and osteopathic manipulative therapy • $60 copay for urgent care visits • $150 copay for emergency room visits	$150 copay for emergency room visits

* 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. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums), *continued*		
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for bariatric surgery • 20% of approved amount for mental health care and substance abuse 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 bariatric surgery • 40% of approved amount for mental health care and substance abuse treatment • 40% of approved amount for most other covered services
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts	$1,500 for one member $3,000 for two or more members each calendar year	$3,000 for one member $6,000 for two or more members each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	
Preventive care services		
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), one 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 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) • 6 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

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	In-network	Out-of-network *
Preventive care services, *continued*		
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.	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.	60% after out-of-network deductible
	One per member per calendar year	
Physician office services		
Office visits – must be medically necessary	• $20 copay for each office visit with a **primary care provider** • $20 copay for each office visit with a **specialist**	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	• $20 copay for each office consultation with a **primary care provider** • $20 copay for each office consultation with a **specialist**	60% after out-of-network deductible
Urgent care visits – must be medically necessary	$60 copay per office visit	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic services		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

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	In-network	Out-of-network *
Hospital care		
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	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	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)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
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 preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% 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 **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	80% after in-network deductible	60% after out-of-network deductible
Elective abortions	80% after in-network deductible	60% after out-of-network deductible
Gender reassignment surgery	Not covered	Not covered
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **lifetime** maximum of one bariatric procedure per member	
Human organ transplants		
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	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

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	In-network	Out-of-network *

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will be responsible for your annual in-network deductible and you will be responsible for the member copay that applies to office visits. However, when these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Inpatient mental health care and **inpatient** substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% 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

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. ABA and AAEC services are not available outside of Michigan.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is limited to the same annual **combined** limit as for other diagnoses (limit **combined** for both rehabilitation and habilitative)	
Other covered services, including mental health services, for Autism Spectrum Disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

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 • 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
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per office visit	60% after out-of-network deductible
	Limited to a **combined** 30-visit maximum per member per calendar year (visits are **combined** with outpatient physical and occupational therapy)	

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	In-network	Out-of-network *
Other covered services, *continued*		
Outpatient physical and occupational therapy – provided for rehabilitation/habilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.**	
Outpatient speech therapy	80% after in-network deductible	60% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** 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 BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	Not covered	Not covered

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Blue Preferred® Rx Prescription Drug Coverage 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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Note: Your prescription drug copays, including mail order copays, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

		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	$10 copay	$10 copay	$10 copay	$10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	$20 copay	No coverage	No coverage
	61 to 83-day period	No coverage	$20 copay	No coverage	No coverage
	84 to 90-day period	$20 copay	$20 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	$40 copay	$40 copay	$40 copay	$40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	$80 copay	No coverage	No coverage
	61 to 83-day period	No coverage	$110 copay	No coverage	No coverage
	84 to 90-day period	$110 copay	$110 copay	No coverage	No coverage
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	$80 copay	$80 copay	$80 copay	$80 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	$160 copay	No coverage	No coverage
	61 to 83-day period	No coverage	$230 copay	No coverage	No coverage
	84 to 90-day period	$230 copay	$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	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and **select brand-name** prescription preventive drugs, supplements and vitamins	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin, or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay 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

BCBSM 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 formulary 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, 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. ▪ **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 for these drugs.
Prior authorization/step therapy	A process that requires a 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 waiver	BCBSM's drug interchange and generic copay 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. In select cases BCBSM may waive the initial copay 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.

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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 up to 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) – 1 contact lens per eye (total of 2 lenses) • Monthly (six-month supply) – 6 contact lenses per eye (total of 12 lenses) • Bi-weekly (six-month supply) – 12 contact lenses per eye (total of 24 lenses) • Dailies (two-month supply) – 60 contact lenses per eye (total of 120 lenses)	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 SG 100/80/50SM $50/$150 deductible; $1,000 annual maximum Benefits-at-a-Glance

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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 plan 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 Dental Network of America (DNoA) Preferred Network of PPO dentists.

DNoA Preferred Network – Blue Dental members have unmatched access to PPO dentists through the DNoA Preferred Network, which offers more than 230,000 dentist locations* nationwide. DNoA Preferred Network dentists agree to accept our approved amount as payment in full and participate on all claims. Members also receive discounts on noncovered services when they use PPO dentists. To find a DNoA Preferred Network dentist near you, please visit **BCBSM.com/bluedental** or call **1-888-826-8152**.

***** *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 copays and deductibles, along with any fees for noncovered services. To find a dentist who may participate with BCBSM, please visit **BCBSM.com/bluedental**.

Note: Members who go to nonparticipating dentists may be billed 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	$50 per member limited to a maximum of $150 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 plan 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, out-of-network services or non-covered services.	$700 for one pediatric member or $1,400 for two or more pediatric members per plan 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

Diagnostic and preventive services:	
• Routine oral examinations/evaluations – twice per calendar year	100% of approved amount
• Diagnostic tests and laboratory examinations	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
• 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)	100% of approved amount
Radiographs (X-rays):	
• A set (up to four films) of bitewing X-rays – once per calendar year	100% of approved amount
• A full-mouth series of X-rays or panoramic X-rays – once per 60 months	100% of approved amount
Oral brush biopsy sample collection – twice per calendar year	100% of approved amount
Emergency palliative treatment	100% of approved amount

Class II services

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
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

Class II services, *continued*

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 celluliitis 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[SM] Adults-only SG with VSP Choice Network 24/24/24 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	$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)	