

*Randy L. Thompson, Supervisor
Michelle Mohney, Clerk
Bret Padgett, Treasurer*

Charter Township of Comstock



*Jerry T. Amos, Trustee
Arthur B. Austin, Trustee
Terrance G. McIver, Trustee
Robert E. Pratt, Trustee*

Pension

- Township contributes 13% of employees salary to a defined contribution plan administered by OneAmerica
- Employee may contribute up to an additional 10% to the OneAmerica plan if they choose

Life Insurance

- Township pays the premium for a \$30,000 Life Insurance Plan through Consumer's Life Insurance Company

Disability Insurance

- Township pays the premium for short-term and long-term disability through Mutual of Omaha. In the unfortunate event an illness or injury results in a permanent disability, long-term disability insurance would continue to pay until the employee receives Social Security Disability benefits.
- The benefit is 60% of the employee's salary or \$500 per week, whichever is less.

Health/Dental/Vision Insurance

- Current the Township pays 100% of the premium for the employee and any dependents per policy
- Please refer to the attached summary of benefits for specific coverages.

Health Savings Account

- Currently the Township contributes \$5,000 for a family or \$2,500 for a single person to a Health Savings Account
- The employee may choose to contribute the maximum allowed by the IRS through payroll deduction

Deferred Compensation

- Employees may voluntarily contribute to a Deferred Compensation Plan offered through OneAmerica. There are several options including a Roth IRA.

Revised: November 21, 2016



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Location/Subgroup: MML/CHARTER TOWNSHIP OF
COMSTOCK
Group-Division: 007015146-0000

Simply BlueSM HSA PPO Silver \$3250 0% Medical Coverage with Prescription Drugs Benefits-at-a-Glance

Effective for groups on their plan year

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: 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.

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)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

	In-network	Out-of-network *
Deductibles Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage.	\$3,250 for one member, \$6,500 for the family (when two or more members are covered under your contract) each calendar year	\$6,500 for one member, \$13,000 for the family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	50% of approved amount for bariatric surgery	<ul style="list-style-type: none"> • 50% of approved amount for bariatric surgery • 20% of approved amount for most other covered services

* 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.



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In-network

Out-of-network *

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Annual out-of-pocket maximums Applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts.	\$5,500 for one member, \$11,000 for the family (when two or more members are covered under your contract) each calendar year	\$11,000 for a one-person contract or \$22,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	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)	80% 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)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care 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 provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered

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In-network

Out-of-network *

Preventive care services

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) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year.	80% 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.
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. One routine colonoscopy per member per calendar year	80% after out-of-network deductible One routine colonoscopy per member per calendar year

Physician office services

Office visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Urgent care visits

Urgent care visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
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Emergency medical care

Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services Must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
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In-network

Out-of-network *

Diagnostic services

Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

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

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care Must be in a participating skilled nursing facility	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year
Hospice care	100% after in-network deductible 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% after in-network deductible 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	100% after in-network deductible	100% 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	100% after in-network deductible	100% after in-network deductible

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In-network

Out-of-network *

Surgical services

Surgery Includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males Note: For voluntary sterilizations for females, see "Preventive care services."	100% after in-network deductible	80% after out-of-network deductible
Elective Abortions	Covered 100% after in-network deductible	Covered 80% after out-of-network deductible
Gender reassignment surgery	Not covered	Not covered
Bariatric surgery	50% after in-network deductible Limited to a lifetime maximum of one bariatric procedure per member.	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% after in-network deductible	100% after in-network deductible In designated facilities only
Bone marrow transplants Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Mental health care and substance abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: Facility and clinic	100% after in-network deductible	100% after in-network deductible In participating facilities only
Outpatient mental health care: Physician's office	100% after in-network deductible	80% after out-of-network deductible

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Mental health care and substance abuse treatment

Outpatient substance abuse treatment In approved facilities only	100% after in-network deductible	80% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)
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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.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.	80% after out-of-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% 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.	100% after in-network deductible for diabetes medical supplies	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible Limited to a combined 30-visit maximum per member per calendar year (visits are combined with outpatient physical and occupational therapy)	80% 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)

* 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.



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In-network

Out-of-network *

Other covered services

<p>Outpatient physical and occupational therapy Provided for rehabilitation/habilitation</p>	<p>100% after in-network deductible 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.</p>	<p>80% 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.</p>
<p>Outpatient speech therapy</p>	<p>100% after in-network deductible Limited to a 30-visit maximum per member per calendar year.</p>	<p>80% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.</p>
<p>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.</p>	<p>100% after in-network deductible</p>	<p>100% after in-network deductible</p>
<p>Prosthetic and orthotic appliances</p>	<p>100% after in-network deductible</p>	<p>100% after in-network deductible</p>
<p>Private duty nursing care</p>	<p>Not covered</p>	<p>Not covered</p>

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Blue Preferred[®] Rx Prescription Drug Coverage Custom Select Prescription Drug Plan, 5-Tier Copay/Coinsurance Benefits-at-a-Glance

Specialty Pharmaceutical Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider** or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for **each** fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

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

Member's responsibility (copays and coinsurance amounts)

Your **Simply Blue HSA** prescription drug benefits, including mail order drugs, are subject to the **same** deductible and **same** annual out-of-pocket maximum required under your **Simply Blue HSA** medical coverage. Benefits are not payable until after you have met the **Simply Blue HSA** annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The 20% 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	After deductible is met, you pay \$20 copay	After deductible is met, you pay \$20 copay	After deductible is met, you pay \$20 copay	After deductible is met, you pay \$20 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay \$40 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible is met, you pay \$50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay \$50 copay	After deductible is met, you pay \$50 copay	No coverage	No coverage

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



Member's responsibility (copays and coinsurance amounts), *continued*

		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 2 – Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay \$60 copay	After deductible is met, you pay \$60 copay	After deductible is met, you pay \$60 copay	After deductible is met, you pay \$60 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay \$120 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible is met, you pay \$170 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay \$170 copay	After deductible is met, you pay \$170 copay	No coverage	No coverage
Tier 3 – Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay \$80 or 50% of the approved amount (whichever is greater), but no more than \$100	After deductible is met, you pay \$80 or 50% of the approved amount (whichever is greater), but no more than \$100	After deductible is met, you pay \$80 or 50% of the approved amount (whichever is greater), but no more than \$100	After deductible is met, you pay \$80 or 50% of the approved amount (whichever is greater), but no more than \$100 plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay \$160 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible is met, you pay \$230 or 50% of the approved amount (whichever is greater), but no more than \$290	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay \$230 or 50% of the approved amount (whichever is greater), but no more than \$290	After deductible is met, you pay \$230 or 50% of the approved amount (whichever is greater), but no more than \$290	No coverage	No coverage
Tier 4 – Generic and preferred brand-name specialty drugs	1 to 30-day period	After deductible is met, you pay 20% of approved amount, but no more than \$200	After deductible is met, you pay 20% of approved amount, but no more than \$200	After deductible is met, you pay 20% of approved amount, but no more than \$200	After deductible is met, you pay 20% of approved amount, but no more than \$200 plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

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Member's responsibility (copays and coinsurance amounts), *continued*

		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 5 – Nonpreferred brand-name specialty drugs	1 to 30-day period	After deductible is met, you pay 25% of approved amount, but no more than \$300	After deductible is met, you pay 25% of approved amount, but no more than \$300	After deductible is met, you pay 25% of approved amount, but no more than \$300	After deductible is met, you pay 25% of approved amount, but no more than \$300 plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

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	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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



Covered services, *continued*

	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
Disposable needles and syringes – when dispensed with insulin, or other covered injectable legend drugs Note: Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty

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

Features of your prescription drug plan

Custom Select Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ Tier 1 (generic) – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. ▪ Tier 2 (preferred brand) – Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. ▪ Tier 3 (nonpreferred brand) – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs. ▪ Tier 4 (generic and preferred brand-name specialty) – Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay/coinsurance. ▪ Tier 5 (nonpreferred brand-name specialty) – Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay/coinsurance.
Prior authorization/step therapy	<p>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.</p>
Drug interchange and generic copay/coinsurance waiver	<p>BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Quality limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>



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Exclusions	The following drugs are not covered: <ul style="list-style-type: none">• Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service• State-controlled drugs• Brand-name drugs that have a generic equivalent available• Drugs to treat erectile dysfunction and weight loss• Prenatal vitamins (prescribed and over-the-counter)• Brand-name drugs used to treat heartburn• Compounded drugs, with some exceptions• Cosmetic drugs
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Blue Vision (Pediatric Only)SM Benefits-at-a-Glance

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

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

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



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

Effective for groups on their plan year beginning on or after January 1, 2016

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

Original Medicare coverage

Medicare Supplemental coverage

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

Note: Medicare deductible and coinsurance amounts are effective January 1, 2016 and are subject to change yearly

	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	<ul style="list-style-type: none"> • Medicare Part A \$1,288 (for days 1-60) each benefit period • Medicare Part B \$166 per calendar year 	None
Coinsurance/fixed dollar copays	<ul style="list-style-type: none"> • Hospital stay \$322 per day (for days 61-90) and \$644 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime) • Skilled nursing facility stay (a limit of 100 days each benefit period) \$161 per day (for days 21-100) 	None
Coinsurance/percent copay amounts	<ul style="list-style-type: none"> • 20% of Medicare approved amount for most general services • 20% of Medicare approved amount for outpatient mental health care 	None

Preventive care services

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

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



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Original Medicare coverage

Medicare Supplemental coverage

Preventive care services, *continued*

Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections – includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50 Note: A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible.	When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots – for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When not covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount <ul style="list-style-type: none"> • 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
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

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



Original Medicare coverage

Medicare Supplemental coverage

Physician office services

Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care

Hospital emergency room (facility services) – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services

Laboratory and pathology tests – used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare
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Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – does not include private duty nursing	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance abuse)	Covers Medicare deductible	
• Days 1-60 of each benefit period			
• Days 61-90 of each benefit period			Covers Medicare daily coinsurance
• Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)			Covers Medicare daily coinsurance
• Additional days	Not covered	Covered at BCBSM approved amount, up to an additional 275 days	
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance	

Alternatives to hospital care

Skilled nursing facility care – subject to medical criteria	Covered at 100% of Medicare approved amount	Covered in full by Medicare
• Days 1-20 of each benefit period		
• Days 21-100 of each benefit period		
• Days 101 and after	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services – must be medically necessary and must be provided by a Medicare-certified home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare



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Original Medicare coverage

Medicare Supplemental coverage

Surgical services provided by a physician

Surgery – includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
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Human organ transplants

Note: Payment is based on medical necessity and must be rendered in an approved facility.

Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered Note: Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered Note: Covers Medicare deductible and coinsurance when covered by Medicare.
Bone marrow transplants – under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

Mental health care

Inpatient mental health care in psychiatric facility • Days 1-190 lifetime	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance) Note: In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and daily coinsurance
• Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible Note: If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services

Allergy testing and therapy – with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible Note: You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible Note: There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment



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Original Medicare coverage

Medicare Supplemental coverage

Other covered services, *continued*

Durable medical equipment – must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel

Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount



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Blue Preferred[®] Rx SG Prescription Drug Coverage 3-Tier Copay 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)

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

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



Covered services

	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	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 (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins (non-self-administered drugs are not covered)	100% of approved amount less plan copay	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 are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay	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	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ 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	<p>A process that requires the attending physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at bcbsm.com/pharmacy.</p>



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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.
Exclusions	The following drugs are not covered: <ul style="list-style-type: none">• Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service• State-controlled drugs• Brand-name drugs that have a generic equivalent available• Drugs to treat erectile dysfunction and weight loss• Prenatal vitamins (prescribed and over-the-counter)• Brand-name drugs used to treat heartburn• Compounded drugs, with some exceptions• Cosmetic drugs



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Blue VisionSM (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: <ul style="list-style-type: none"> • 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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Location/Subgroup: MML/CHARTER TOWNSHIP OF
COMSTOCK
Group-Division: 007015146-0000

Blue DentalSM PPO 100/80/50 (80/50/50) Voluntary SG \$25/\$75 (\$50/\$150) deductible

Benefits-at-a-Glance

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

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

Network access information

With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll have the greatest coverage and savings when they choose a dentist who is a member of the Blue Dental PPO network.¹

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations² nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152.

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

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

Members who go to non-PPO dentists can still save money through our Blue Par Select arrangement.

Blue Par SelectSM 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 deductible amounts. To find a dentist who may participate with BCBSM, please visit mibluedentist.com.

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

PPO(In-network) Dentist

Non-PPO (Blue Par Select or Nonparticipating) Dentist

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

	PPO(In-network) Dentist	Non-PPO (Blue Par Select or Nonparticipating) Dentist
Deductibles Applies to Class II and Class III services only	\$25 per member limited to a maximum of \$75 per family per calendar year	\$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%)	20%
Class II services	20%	50%
Class III services	50%	50%
Class IV services	Not Covered	Not Covered
Dollar Maximums		
Annual maximum for Class I, II and III services	\$1000 per member The annual benefit maximum does not apply to pediatric members.	\$800 per member The annual benefit maximum does not apply to pediatric members.



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Location/Subgroup: MML/CHARTER TOWNSHIP OF COMSTOCK
 Group-Division: 007015146-0000

PPO(In-network) Dentist

Non-PPO (Blue Par Select or Nonparticipating) Dentist

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

Lifetime maximum for Class IV services	Not covered For members up to their 19th birthday	Not covered For members up to their 19th birthday
Out-of-pocket maximum The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, non-covered services, or orthodontic services.	\$350 for one pediatric member or \$700 for two or more pediatric members per calendar year. There is no out-of-pocket maximum for non-pediatric members. Note: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).	Not applicable
Waiting period	Not Applicable 12 months for Class III services (except root canals and extractions of non-impacted teeth). The Class III waiting period does not apply to pediatric members. Note: Your group's waiting period may be waived with proof of prior dental coverage. However, members who enroll after the initial enrollment period will be subject to the group's 12-month waiting period.	Not Applicable 12 months for Class III services (except root canals and extractions of non-impacted teeth). The Class III waiting period does not apply to pediatric members. Note: Your group's waiting period may be waived with proof of prior dental coverage. However, members who enroll after the initial enrollment period will be subject to the group's 12-month waiting period.

Plan's responsibility

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

Class I services

Most Diagnostic and preventive services:		
Routine oral examinations/evaluations – twice per calendar year	100% of approved amount	80% 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	80% of approved amount



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**PPO(In-network)
Dentist**

**Non-PPO (Blue Par Select or
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Class I services

Fluoride treatments – twice per calendar year for pediatric members only	100% of approved amount	80% 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	80% 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	80% of approved amount
Bitewing X-rays One set (up to four films) per calendar year	100% of approved amount	80% of approved amount
Oral brush biopsy sample collection Twice per calendar year	100% of approved amount	80% of approved amount

Class II services

Other Diagnostic and preventive services:		
Diagnostic tests and laboratory examinations	80% of approved amount after deductible	50% of approved amount after deductible
Space maintainers – once per quadrant per lifetime for missing posterior primary teeth for pediatric members only (re cementation of a space maintainer is payable three times per quadrant per lifetime)	80% of approved amount after deductible	50% of approved amount after deductible
Panoramic or full-mouth X-rays Once per 60 months	80% of approved amount after deductible	50% of approved amount after deductible
Emergency palliative treatment	80% of approved amount after deductible	50% of approved amount after deductible
Minor restorative services:		
Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	80% of approved amount after deductible	50% of approved amount after deductible



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Class II services

Adjunctive general services:		
General anesthesia or IV sedation	80% of approved amount after deductible	50% of approved amount after deductible
Office visits for observation (during regularly scheduled hours) for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Office visits after regularly scheduled hours	80% of approved amount after deductible	50% of approved amount after deductible
House and hospital calls for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Antibiotic injections for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
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	50% of approved amount after deductible

Class III services

Note: There is a 12-month waiting period for Class III benefits. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2015, the last date of the waiting period will be December 31, 2015, with benefits becoming active on January 1, 2016. This waiting period does not apply to pediatric members.

Root canals and extractions of non-impacted teeth are not subject to the 12-month waiting period.

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)	50% of approved amount after deductible	50% of approved amount after deductible
Therapeutic pulpotomies or pulpal debridement	50% of approved amount after deductible	50% of approved amount after deductible
Vital pulpotomies on primary teeth	50% of approved amount after deductible	50% of approved amount after deductible
Apexification	50% of approved amount after deductible	50% of approved amount after deductible
Apical surgeries on permanent teeth	50% of approved amount after deductible	50% of approved amount after deductible
Periodontic services:		
Periodontal scaling and root planing – once per quadrant per 24 months for pediatric members; once per quadrant per 36 months for all other members	50% of approved amount after deductible	50% of approved amount after deductible



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Root canals and extractions of non-impacted teeth are not subject to the 12-month waiting period.

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	50% of approved amount after deductible	50% of approved amount after deductible
Limited occlusal adjustments – up to five times per 60 months for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Occlusal biteguards (and relines and repairs to occlusal biteguards) – once per 60 months for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Gingivectomies and gingivoplasties	50% of approved amount after deductible	50% of approved amount after deductible
Osseous surgeries for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Gingival flap procedures	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue grafts	50% of approved amount after deductible	50% of approved amount after deductible
Bone replacement grafts for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
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	50% of approved amount after deductible
Substructures, including cores and posts	50% of approved amount after deductible	50% of approved amount after deductible
Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	50% of approved amount after deductible	50% of approved amount after deductible
Oral surgery services:		
Extractions and surgical removal of non-impacted teeth	50% of approved amount after deductible	50% of approved amount after deductible
Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible	50% of approved amount after deductible
Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible	50% of approved amount after deductible
Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible	50% of approved amount after deductible



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Class III services

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Excision of hyperplastic tissue per arch	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue biopsies for pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Frenulectomies	50% of approved amount after deductible	50% of approved amount after deductible
Prosthodontic services:		
Complete dentures – once per 84 months	50% of approved amount after deductible	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	50% of approved amount after deductible
Relines or rebases of partial dentures or complete dentures – once per 36 months per arch	50% of approved amount after deductible	50% of approved amount after deductible
Tissue conditioning – once per 36 months per arch	50% of approved amount after deductible	50% of approved amount after deductible
Adjustments, repairs and recementation	50% of approved amount after deductible	50% of approved amount after deductible
Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible	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	50% of approved amount after deductible

Class IV services – Orthodontic services for dependents under age 19

Note: There is a 12-month waiting period for Class IV benefits. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2015, the last date of the waiting period will be December 31, 2015, with benefits becoming active on January 1, 2016. This waiting period does apply to pediatric members.

Orthodontics and related services	Not Covered	Not Covered
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Blue Vision Adults-only SG with VSP Choice Network 12/12/12SM Benefits-at-a-Glance

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

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

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

	In-network	Out-of-network
Member's responsibility (copays)		
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$10 copay	Member responsible for difference between approved amount and provider's charge, after \$10 copay
Medically necessary contact lenses Note: No copay is required for prescribed contact lenses that are not medically necessary.	\$10 copay	Member responsible for difference between approved amount and provider's charge, after \$10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$5 copay	Reimbursement up to \$34 less \$5 copay (member responsible for any difference)
One eye exam every 12 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 12 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 12 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 12 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 12 months (calendar year basis)		