



Blue Cross
Blue Shield
of Michigan

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

ROCHESTER COMMUNITY SCHOOLS

0070048180003 - 09LLL

Effective Date: 01/01/2023

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

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 diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26

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

Benefits	In-network	Out-of-network
Deductible	<p>\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.</p>	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits and office consultations \$20 copay for medical online visits \$75 copay for emergency room visits \$20 copay for urgent care visits 	<ul style="list-style-type: none"> \$75 copay for emergency room visits
<p>Coinsurance amounts (percent copays)</p> <p>Note: Coinsurance amounts apply once the deductible has been met.</p>	<ul style="list-style-type: none"> 30% of approved amount for private duty nursing care 10% of approved amount for mental health care and substance use disorder treatment 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 30% of approved amount for mental health care and substance use disorder treatment 30% of approved amount for most other covered services
<p>Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts</p>	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>

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Benefits	In-network	Out-of-network
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	70% 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)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> 8 visits, birth through 12 months 6 visits, 13 months through 23 months 6 visits, 24 months through 35 months 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

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Benefits	In-network	Out-of-network
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, if applicable.	70% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	70% after out-of-network deductible
	One per member per calendar year	
CA-125 screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$20 copay per office visit	70% after out-of-network deductible
Online visits - by physician or BCBSM selected vendor must be medically necessary	\$20 copay per online visit	70% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after in-network deductible	70% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay per office consultation	70% after out-of-network deductible
Urgent care visits - must be medically necessary	\$20 copay per urgent care visit	70% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$75 copay per visit (copay waived if admitted or for an accidental injury)	\$75 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	90% after in-network deductible	90% after in-network deductible

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Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	90% after in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	70% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Delivery and nursery care	90% after in-network deductible	70% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	90% after in-network deductible	70% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	90% after in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after in-network deductible	70% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	90% after in-network deductible	90% 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:	90% after in-network deductible	90% after in-network deductible
<ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 		

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Benefits	In-network	Out-of-network
Infusion therapy: <ul style="list-style-type: none"> • 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 	90% after in-network deductible	90% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	90% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Voluntary sterilization for males	90% after in-network deductible	70% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary abortions	Not covered	Not covered

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	70% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

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

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	90% after in-network deductible	70% after out-of-network deductible
		Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria 	90% after in-network deductible	70% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient mental health care: • Facility and clinic	90% after in-network deductible	90% after in-network deductible in participating facilities only
• Online visits - by physician or BCBSM selected vendor must be medically necessary	\$20 copay per online visit	70% after out-of-network deductible
• Physician's office	90% after in-network deductible	70% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	90% after in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization 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.	90% after in-network deductible	90% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	90% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited	70% after out-of-network deductible
Other covered services, including mental health services, for autism spectrum disorder	90% after in-network deductible	70% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	<ul style="list-style-type: none"> 90% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
	Limited to a combined 24-visit maximum per member per calendar year	

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Benefits	In-network	Out-of-network
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after in-network deductible	70% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined 60-visit maximum per member per calendar year	
Durable medical equipment Note: DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible

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BCBSM Preferred RX Program

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Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, 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. AllianceRx Walgreens 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 the OptumRx home delivery pharmacy. (OptumRx 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 AllianceRx Walgreens 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 will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		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
Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$5 copay	You pay \$5 copay	You pay \$5 copay	You pay \$5 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$10 copay	No coverage	No coverage
	84 to 90-day period	You pay \$10 copay	You pay \$10 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay \$35 copay	You pay \$35 copay	You pay \$35 copay	You pay \$35 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$70 copay	No coverage	No coverage
	84 to 90-day period	You pay \$70 copay	You pay \$70 copay	No coverage	No coverage

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Benefits		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
Nonpreferred brand-name drugs	1 to 30-day period	You pay \$50 copay	You pay \$50 copay	You pay \$50 copay	You pay \$50 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$100 copay	No coverage	No coverage
	84 to 90-day period	You pay \$100 copay	You pay \$100 copay	No coverage	No coverage

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

Covered services					
Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs		100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs		100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA		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 as required by PPACA		100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive 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% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)		100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)		100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Benefits	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.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy .	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

Features of your prescription drug plan

Custom 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"> • Generic drug tier - This tier 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. • Preferred brand-name drug tier - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them • Nonpreferred brand-name drug tier - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
Maximum allowable cost drugs	<p>If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay/coinsurance regardless of whether you or your physician requests the brand-name drug. Exception: If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay/coinsurance.</p> <p>Note: This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance, or your annual out-of-pocket maximum, if applicable.</p>
Over-the-counter drugs	Excludes benefits for certain over-the-counter drugs.
Quantity of drugs	Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and quantities of drugs.

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Dental Coverage

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

Network access information

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

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and 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**.

*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 is two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO(out-of-network) 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, and members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit mibluedentist.com.

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

Eligibility information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Unmarried dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

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

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services)	None (covered at 100%)
<ul style="list-style-type: none"> Class I services 	
<ul style="list-style-type: none"> Class II services 	20%
<ul style="list-style-type: none"> Class III services 	40%
<ul style="list-style-type: none"> Class IV services 	40%
Dollar maximums	\$1,800 per member
<ul style="list-style-type: none"> Annual maximum for Class I, II and III services 	
<ul style="list-style-type: none"> Lifetime maximum for Class IV services 	\$1,800 per member

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Class I services

Benefits	Coverage
Oral exams	100% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount Note: Once every 60 months
Prophylaxis (cleaning)	100% of approved amount Note: Twice per calendar year
Pit and fissure sealants - for members age 14 and younger	100% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount Note: Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	100% of approved amount, replacement fillings covered after 12 months or more after initial filling
Fillings - primary (child) teeth	100% of approved amount Note: Replacement fillings covered after 12 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	100% of approved amount Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	100% of approved amount
Root canal treatment	80% of approved amount Note: Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	80% of approved amount Note: Once every 24 months per quadrant
Limited occlusal adjustments	80% of approved amount, Limited occlusal adjustments covered once every 36 months
Occlusal biteguards	80% of approved amount, limited occlusal adjustments covered once per lifetime
General anesthesia or IV sedation	100% of approved amount Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	100% of approved amount Note: Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	100% of approved amount Note: Once per arch in any 36 consecutive months
Tissue conditioning	80% of approved amount Note: Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	60% of approved amount Note: Once every 60 months

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Benefits	Coverage
Bridges (fixed partial dentures) - for members age 16 and older	60% of approved amount Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	60% of approved amount Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Inlays, onlays, crowns and veneer fillings - permanent teeth - for members under 19 years of age	60% of approved amount, once every 36 months per tooth
Inlays, onlays, crowns and veneer fillings - permanent teeth - for members age 19 and above	60% of approved amount, once every 60 months per tooth

Class IV services

Benefits	Coverage
Minor treatment for tooth guidance appliances	60% of approved amount
Minor treatment to control harmful habits	60% of approved amount
Interceptive and comprehensive orthodontic treatment	60% of approved amount
Post-treatment stabilization	60% of approved amount
Cephalometric film (skull) and diagnostic photos	60% of approved amount

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

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Vision Coverage

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

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

Member's responsibility (copays)

Benefits	Network doctor	Non-network provider
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay
Medically necessary contact lenses	\$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay

Note: No copay is required for prescribed contact lenses that are not medically necessary.

Eye exam

Benefits	Network doctor	Non-network provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$5 copay	Reimbursement up to \$35 less \$5 copay (member responsible for any difference)

One eye exam in any period of 12 **consecutive** months

Lenses and frames

Benefits	Network doctor	Non-network provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	\$7.50 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less \$7.50 copay (member responsible for any difference)
Note: Preferred pricing discounts on noncovered lens options and upgrades, and on an additional prescription eyeglass or sunglass (second pair) purchase when obtained from a network provider.	One pair of lenses, with or without frames, in any period of 12 consecutive months	
Standard frames	\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$7.50 copay (one copay applies to both frames and lenses)	Reimbursement up to \$45 after a \$7.50 copay (member responsible for any difference)

One frame in any period of 12 **consecutive** months

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Contact lenses

Benefits	Network doctor	Non-network provider
Medically necessary contact lenses (requires prior authorization approval from Heritage and must meet criteria of medically necessary)	\$7.50 copay	Reimbursement up to approved amount less \$7.50 copay (member responsible for any difference)
Contact lenses up to the allowance in any period of 12 consecutive months		
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Contact lenses up to the allowance in any period of 12 consecutive months when services are rendered by a Heritage network provider.		

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