



Blue Cross
Blue Shield
of Michigan

Confidence comes with every card.®



Your Benefit Guide

STATE VISION PLAN FOR EMPLOYEES
EXCLUDING MSPTA
Effective October 9, 2016

A close-up photograph of a person's hand holding a pair of black-rimmed glasses over a reflective surface. The background is blurred, showing a person in a blue shirt. The image is used as a background for the top half of the page.

WELCOME

Welcome to your State Vision Plan, administered by Blue Cross Blue Shield of Michigan under the direction of the Michigan Civil Service Commission.

The MCSC is responsible for implementing your vision benefits and future changes in benefits. Blue Cross provides certain services on behalf of the MCSC through an administrative contract. Your benefits are not insured with Blue Cross, but are paid from funds administered by the MCSC.

This booklet is a benefit guide for your vision plan. It explains what vision services are covered, as well as related out-of-pocket costs. If you have any questions about your State Vision Plan, please call VSP at 1-855-356-4362. Customer service representatives are available Monday through Sunday, excluding holidays.

This document is not a contract. Rather, it is intended to be a summary description of your State Vision Plan benefits. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, the terms and conditions of the applicable coverage documents will prevail.

This guide replaces any prior descriptions of benefit information you may have received. Please discard any prior descriptions of your benefits.

TABLE OF CONTENTS

VSP contact information.....	2	Coordination of benefits	10
Calling.....	2	How COB works.....	10
Writing	2	COB guidelines.....	11
Visiting	2	Filing COB claims.....	11
Online	3	Updating COB information – your responsibility.....	12
State of Michigan contact information	3	Your right to file a grievance.....	12
Your Blue Cross Blue Shield of Michigan ID card	4	Internal grievances.....	12
VSP Savings Statement	5	Standard internal grievance procedure.....	12
Eligibility	5	Sections 402 and 403 of Public Act 350.....	13
Your State Vision Plan benefits	6	What we may not do.....	13
Choosing your vision provider	6	What we must do.....	14
Copayments and out-of-pocket costs	6	Appeals to Civil Service	14
What is covered	7	Glossary	15
What is not covered.....	8		
State of Michigan Vision Plan Summary of Benefits	9		
Filing claims.....	10		

VISION SERVICE PLAN

CONTACT INFORMATION

You can call or write VSP when you have benefit and claims questions. To help us serve you better, here are some important tips to remember.

- Have your Blue Cross Blue Shield of Michigan ID card handy so you can provide your contract and group numbers. If you are writing, include this information in your letter.
- To inquire about a claim, please provide the following:
 - Enrollee's name
 - Enrollee's ID number
 - Patient's name
 - Provider's name
 - Date of service
 - Type of service
 - Charge for the service
- When writing, please send copies of your bills, other relevant documents and any correspondence you have received from us. Make sure you keep your originals. Include your daytime telephone number on all of your letters.

Calling

VSP's customer service hours are:

Monday through Friday, 8 a.m. to 11 p.m. • EST Saturday, 10 a.m. to 11 p.m. EST • Sunday, 10 a.m. to 10 p.m. EST

In and outside Michigan855-356-4362

Special servicing numbers

Anti-fraud hotline.....800-877-7236

Writing

Please send all correspondence to:

Vision Service Plan

3333 Quality Drive MS 321

Rancho Cordova, CA 95670-7985

For specific eligibility information and assistance:

Michigan Civil Service Commission

MI HR Service Center

P.O. Box 30002

Lansing, Michigan 48909

Local: 517-284-6460

Toll free: 877-766-6447

Michigan Civil Service Commission

Employee Benefits Division

P.O. Box 30002

Lansing, MI 48909

Local: 517-373-7977

Toll free: 800-505-5011

Online

VSP's home page: vsp.com

Provider search: vsp.com

BCBSM's site for State of Michigan employees: bcbsm.com/som

STATE OF MICHIGAN CONTACT INFORMATION

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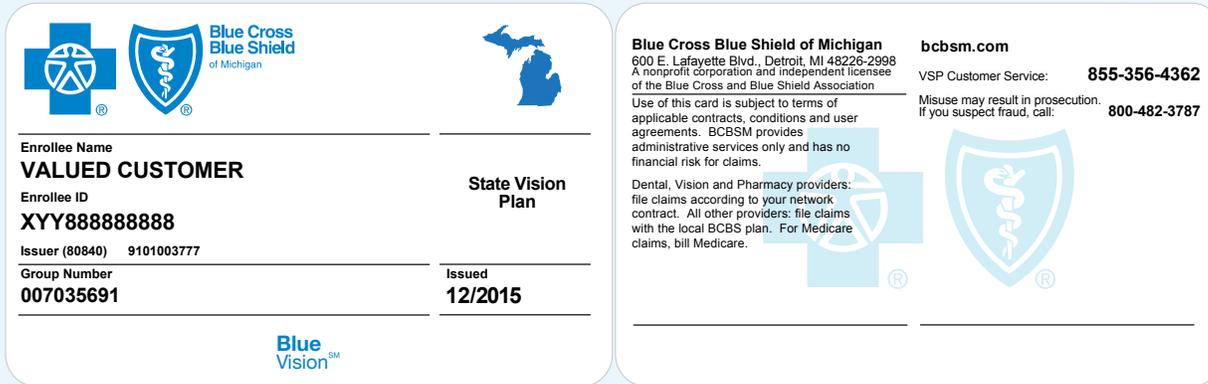
Toll free: 800-505-5011



YOUR BLUE CROSS BLUE SHIELD OF MICHIGAN ID CARD

Your Blue Cross ID card is your key to receiving quality care. It is issued once you enroll for coverage in the State Vision Plan. Present this ID card every time you seek vision services.

Your card will look similar to the one below.



1st line: Enrollee Name is the name of the person who holds the contract. All communications are addressed to this name. Only the enrollee's name appears on the ID card. However, the cards are for use by all covered members.

2nd line: Enrollee ID identifies your records in our files.

The alpha prefix preceding the enrollee ID number identifies that you have coverage through the State Vision Plan.

3rd line: Issuer identifies you as a BCBSM member. The number 80840 identifies our industry as an insurance carrier.

4th line: Group Number tells us you are a BCBSM group member.

ON THE BACK OF YOUR ID CARD, YOU WILL FIND:

- VSP's toll-free customer service telephone numbers to call us when you have a claim or benefit inquiry.

HERE ARE SOME TIPS ABOUT YOUR ID CARD:

- Carry your card with you at all times.
- If you or anyone in your family needs an ID card, please go to the secured site at bcbsm.com and request one, or call the BCBSM State of Michigan Customer Service Center at 800-843-4876 for assistance.
- Call the BCBSM State of Michigan Customer Service Center at 800-843-4876 if your card is lost or stolen. You can still receive services by giving the provider your Enrollee ID number to verify your coverage.

Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

SAVINGS STATEMENT

If you choose a VSP provider, you will receive a Savings Statement. Your Savings Statement is not a bill, but a document that details your covered benefits and your savings by using a VSP provider.

It tells you:

- The family member who received services
- Who provided the service, the services received, the date of service, the amount you paid (e.g. copays, overages) and the amount saved by using a VSP provider

You may access your VSP Savings Statement online by visiting vsp.com and signing in.

Please check your VSP Savings Statement carefully. If you see an error, please contact your provider first. If they cannot correct the error, call VSP Customer Service.

If you think your provider is intentionally billing us for services you did not receive, or that someone is using your BCBSM ID vision card illegally, contact VSP's anti-fraud toll free hotline. Your call will be kept strictly confidential.

ELIGIBILITY

For more information about the State of Michigan's eligibility requirements for employee health insurance coverage, visit www.michigan.gov/employeebenefits.

CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 requires all health plans to provide a Certificate of Creditable Coverage to any individual who loses health coverage. The certificate's rules help ensure that coverage is portable. This means that, once a person has coverage, he or she can use it to reduce or eliminate any exclusion periods due to pre-existing conditions that might otherwise apply when changing coverage. When your coverage through your employer ends, you will receive a certificate of coverage.

YOUR STATE VISION PLAN BENEFITS

CHOOSING YOUR VISION PROVIDER

Your vision coverage is designed to encourage regular eye examinations and help pay the cost of corrective eyewear. When you need vision care, it is important to find out if your provider participates with VSP.

To locate a VSP provider, visit vsp.com or call VSP at 855-356-4362.

COPAYMENTS AND OUT-OF-POCKET COSTS

When you receive vision care from a **VSP provider** you are responsible for:

- A \$5 copayment for routine vision examinations.
- A \$7.50 copayment for eyeglass lenses, frames or medically necessary contact lenses, not both.
- No copayment for cosmetic contact lenses. However, you are still responsible for any charges above the allowable maximum.
- You may have additional out-of-pocket costs for frames.*

When you receive vision services from a **nonparticipating provider**, payment to the provider is limited to:

- Eye exam reimbursement up to \$34 with a \$5.00 copay. You are responsible for any difference.
- A \$7.50 copayment for eyeglass lenses, frames or medically necessary contact lenses, not both.
- Predetermined reimbursement amounts for eyeglass lenses, contact lenses and frames. You are responsible for any additional charges above the predetermined reimbursement amounts.

**Please see the benefit summary charts on page 9 for reimbursement amounts.*

WHAT IS COVERED

Your vision benefit includes:

- **Vision testing examinations.** One examination every 12 consecutive months when an optometrist or ophthalmologist performs the examination. Includes the following:
 - Visual history
 - Visual acuity (sharpness of vision) testing
 - Internal and external examination of the eyes
 - Tonometry (testing for glaucoma) when necessary
 - Preparation of prescription for lenses
 - Medication for dilating the pupils and desensitizing the eyes for tonometry, if necessary
 - Eye refraction

When recommended by an optometrist, coverage includes an additional examination by an ophthalmologist if the additional examination takes place within 60 days of the original examination by the optometrist.

- **Eyeglass lenses.** Prescribed eyeglass lenses once every 24 consecutive months or once in every 12 months if prescription changes. Lenses must be:
 - Molded or ground glass or plastic
 - Prism, slab-off prism and special base curve lenses when medically necessary
 - Colorless or tinted with an ungraduated tint not exceeding Rose tint #2
 - Limited to a maximum diameter of 60 mm. The provider may charge you for the difference in cost between standard and oversize lenses
- **Frames.** Once every 24 consecutive months or once in every 12 months if prescription changes. Standard frames must be able to hold prescribed lenses.
- **Computer/Safety glasses (For employees ONLY).** Supervisors must submit an approval form on the requesting employee's behalf. Please refer to your union contract for more information about this benefit.
- **Contact lenses.** Prescribed contact lenses for medically necessary lenses, once every 24 consecutive months or once in every 12 months if prescription changes. This means the lenses are:
 - To correct vision to 20/70 in the better eye
 - An effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature
- **Cosmetic contact lenses.** Once every 24 consecutive months or once every 12 months if prescription changes.
 - Includes fitting and suitability exam

WHAT IS NOT COVERED

Your vision care benefit does not cover:

- Charges for designer frames and lens tinting darker than Rose tint #2
- Sunglasses or anti-reflective lenses.
- Medical and surgical treatment
- Drugs or medications other than for vision testing examinations
- Special procedures such as vision training or subnormal-vision aids
- Services ordered before the effective date of your coverage or lenses and frames delivered more than 60 days after your coverage ends
- Experimental or substandard services
- Services not prescribed by a physician or optometrist
- Replacement of lost or broken lenses or frames
- Polycarbonate lenses
- UV coating
- Scratch guard
- Oversized lenses
- Aphakic lenses when the patient lacks a natural lens

STATE OF MICHIGAN VISION PLAN SUMMARY OF BENEFITS

Service	VSP Providers	Nonparticipating Providers
Vision testing examination		
Routine eye exam	100% of VSP-approved amount \$5 copay	Reimbursement up to a maximum of \$34 \$5.00 copay Member is responsible for the difference
Once every 12 months		
Eyeglass lenses (glass, plastic or prism up to 60 mm).		
One pair of corrective lenses every 24 months, or once every 12 months if prescription changes.		
Members may obtain either eyeglasses or contact lenses, but not both.		
Single vision	100% of VSP-approved amount \$7.50 copay*	Reimbursement up to a maximum of \$17 \$7.50 copay Member is responsible for the difference
Bifocal (includes blended)	100% of VSP-approved amount \$7.50 copay	Reimbursement up to a maximum of \$30 \$7.50 copay Member is responsible for the difference
Trifocal	100% of VSP-approved amount \$7.50 copay	Reimbursement up to a maximum of \$43 \$7.50 copay Member is responsible for the difference
Special lenses	100% of VSP-approved amount \$7.50 copay	Not covered
Progressive lenses (Standard)	100% of VSP-approved amount \$7.50 copay	Reimbursement up to a maximum of \$30 \$7.50 copay Member is responsible for the difference
Rose tints # 1 and 2 or Photochromic tint	100% of VSP-approved amount \$7.50 copay	Not covered
Frames		
Eyeglass frames*	\$100 allowance \$7.50 copay Member is responsible for the difference	Maximum of \$38.25 \$7.50 copay Member is responsible for the difference
<i>*If the member has a copay for lenses, no further copay is required</i>		
Contact lenses – Members may obtain either eyeglasses or contact lenses, but not both.		
Medically necessary	100% of the VSP-approved amount \$7.50 copay Includes fitting and suitability exam.	Maximum of \$210 allowance per pair \$7.50 copay Member is responsible for the difference
Cosmetic, not medically necessary	Maximum of \$130 per pair No copay Includes fitting and suitability exam	Maximum of \$100 per pair No copay Member is responsible for the difference

This benefit chart is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail. Payment amounts are based on the VSP-approved amount, less any applicable copay amount required by the State Vision Plan. This coverage is provided pursuant to a contract entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan.

FILING CLAIMS

When you use your vision benefits, a claim must be filed before payment can be made. Participating providers should automatically file all claims for you. All you need to do is show your BCBSM ID card. However, if you receive services from nonparticipating providers, they may or may not file a claim for you.

To file your own claim, follow these steps:

1. Ask your provider for an **itemized** statement with the following information:
 - Patient's name and birth date
 - Enrollee's name, address, phone number and contract number (from your BCBSM ID card)
 - Provider's name, address, phone number and federal tax ID number
 - Date and description of services
 - Charge for each service
2. Make a copy of all items for your files.
3. Mail the itemized statement to VSP at this address:

Vision Service Plan
P.O. Box: 385018
Birmingham, AL 35238-0518

Please file claims promptly. You will receive payment directly from VSP.
The check will be in the enrollee's name, not the patient's name.

COORDINATION OF BENEFITS

Coordination of benefits is how vision carriers manage benefits when you are covered by more than one group vision plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your vision plans. Your State Vision Plan requires that your benefit payments be coordinated with those from another vision plan for services that may be payable under both plans.

HOW COB WORKS

If you are covered by more than one group vision plan, coordination of benefits guidelines determine which carrier pays for covered services first.

Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim.

COB GUIDELINES

The following guidelines determine primary and secondary plans:

- **Contract holder versus dependent coverage** – The plan that covers the patient as the employee (subscriber or contract holder) is primary and pays before a plan that covers the patient as a dependent.
- **Contract holder (multiple contracts)** – If you are the contract holder of more than one vision care plan, your primary plan is the one of which you are an active member (such as an employee) and your secondary plan is the one of which you are an inactive member (such as a retiree). If both plans are VSP plans, the plan which has been in place the longest is primary.
- **Dependents (the “birthday rule”)** – If a child is covered under both their mother’s and father’s plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.
- **Children of divorced or separated parents** – For children of divorced or separated parents, benefits are determined in the following order unless a court order places financial responsibility on one parent:
 1. Plan of the custodial parent
 2. Plan of the custodial parent’s new spouse (if remarried)
 3. Plan of the non-custodial parent
 4. Plan of the non-custodial parent’s new spouse

If the primary plan cannot be determined by using the guidelines above, then the “birthday rule” will be used to determine primary liability.

FILING COB CLAIMS

Remember to ask your vision provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier’s payment statement to the secondary carrier. When you submit claims to VSP for reimbursement of the balance, please follow these steps:

1. Obtain an Explanation of Benefits or payment statement from the primary carrier.
2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt you received from the provider.
4. Make sure the provider’s name and complete address are on your receipts.
5. Send these items to:
P.O. Box: 385018
Birmingham, AL 35238-0518
ATTN: Claims

Please make copies of all forms and receipts for your own files because VSP cannot return the originals to you.

UPDATING COB INFORMATION – YOUR RESPONSIBILITY

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify your employer immediately. We may periodically ask you to update your COB information. Please help us serve you better by responding to requests for COB information quickly.

YOUR RIGHT TO FILE A GRIEVANCE

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to one of our customer service representatives. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing an internal grievance procedure, including a managerial-level conference, if you believe we have violated **Section 402 or 403 of Public Act 350**. You will find the specific provisions of those two parts of the act at the end of this section.

INTERNAL GRIEVANCES

Standard internal grievance procedure

We will provide written acknowledgement of your complaint/grievance within 5 calendar days of receipt, and we must provide you with our final written determination within 30 calendar days of our receipt of your written grievance. The standard internal grievance procedure is as follows:

1. You may submit your grievance in writing, by telephone, online or through your VSP provider.

Mail or fax your written grievance to:

Vision Service Plan
Attn: Complaint & Appeals Department
3333 Quality Drive
Rancho Cordova, CA 95670
Fax: 916-858-5569

You may call 1-855-356-4362 if you want to provide your grievance verbally or go to vsp.com if you want to submit a grievance form.

2. If you disagree with our response to your grievance, you may submit a second request using the process described above.

SECTIONS 402 AND 403 OF PUBLIC ACT 350

What we may not do

The sections below provide the exact language in the law.

Section 402(1) provides that we may not do any of the following:

- Misrepresent pertinent facts or certificate provisions relating to coverage.
- Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.
- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.
- Refuse to pay claims without conducting a reasonable investigation based upon the available information.
- Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.
- Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear.
- Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.
- Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage.
- Make known to the member a policy of appealing from administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim.
- Attempt to settle a claim on the basis of an application which was altered without notice to, knowledge or consent of the subscriber under whose certificate the claim is being made.
- Delay the investigation or payment of a claim by requiring a member or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of verification.
- Fail to promptly provide a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement.
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate.

Section 402(2) provides that there are certain things we cannot do to induce you to contract with us for the provision of vision care benefits, or to induce you to lapse, forfeit or surrender a certificate issued by us or to induce you to secure or terminate coverage with another insurer, health maintenance organization or other person.

The things we cannot do under this section are:

- Issue or deliver to a person money or other valuable consideration.
- Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.
- Offer to give or pay, directly or indirectly, a rebate or part of a premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.
- Make issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder or the true nature thereof.
- Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization or other person.

WHAT WE MUST DO

Section 403 provides that we must, on a timely basis, pay to you or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to you will bear simple interest from a date 60 days after we have received a satisfactory claim form at a rate of 12 percent interest per year. The interest will be paid in addition to the claim at the time of payment of the claim.

We must specify in writing the materials which constitute a satisfactory claim form no later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form will be considered to be paid on a timely basis if paid within 60 days after we receive the claim form.

APPEALS TO CIVIL SERVICE

If you have exhausted the internal grievance procedures with VSP, you may appeal a VSP denial to the Employee Benefits Division of the Civil Service Commission. The complaint must be received within 14 calendar days after the date the final internal decision of VSP was issued. Additional information on appeals can be found in Civil Service Regulation 5.18, Complaints about Benefits, which is available in the Rules and Regulations section of the Michigan Civil Service Commission Web site http://www.michigan.gov/documents/Regulation_5_128248_7.18.pdf.

Appeals are sent to:

Michigan Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909

GLOSSARY

Approved amount – The VSP maximum payment level or the provider’s billed charge for the covered service, whichever is lower. Copays are deducted from the approved amount.

Benefit – Coverage for services available according to the terms of the State Vision Plan.

Blue Cross Blue Shield of Michigan – A nonprofit, independent corporation. Blue Cross Blue Shield of Michigan is one of many individual plans located throughout the U.S. committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

Coordination of benefits – A program that coordinates your vision benefits when you have coverage under more than one group plan.

Copayment – The designated dollar amount of the approved amount you are required to pay for covered services.

Covered services – Services, treatments or supplies identified as payable under the State Vision Plan.

Enrollee – The person who signed and submitted the application for vision coverage.

Member – Any person eligible for vision services under the State Vision Plan. This includes the enrollee and any eligible dependents listed in Blue Cross/VSP membership records.

Nonparticipating providers – Providers that have not signed participation agreements with VSP agreeing to accept the VSP payment as payment in full.

Ophthalmologist – A physician that specializes in ophthalmology.

Ophthalmology – A branch of medical science dealing with the structure, functions and diseases of the eye.

Optometrist – A specialist licensed to practice optometry.

Optometry – The art or profession of examining the eye for defects and faults of refraction and prescribing corrective lenses or exercises but not drugs or surgery.

Participating providers – Providers that have signed agreements with VSP to accept the VSP-approved amount for covered services as payment in full.

Patient – The enrollee or eligible dependent who is awaiting or receiving care and treatment.

We, us, our – Used when referring to Blue Cross Blue Shield of Michigan

You and your – Used when referring to any person covered under the State Vision Plan.

VSP – Vision Service Plan



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