

# Your Benefit Guide

## State Vision Plan

For Active Employees and Retirees



**Blue Cross  
Blue Shield**  
of Michigan



# Welcome

---

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

The MCSC is responsible for implementing your vision benefits and future changes in benefits. BCBSM will provide certain services on behalf of the MCSC through an administrative-service-only contract. Your benefits are not insured with BCBSM, but will be paid from funds administered by the MCSC.

BCBSM is committed to providing you with excellent value and quality service and we want you to understand how your vision coverage works. With this in mind we have designed this booklet as an easy-to-read guide to your vision program. Please read it and make sure you understand what vision services are covered and when you are responsible for out-of-pocket costs.

If you have any questions about your State Vision Plan, please call the BCBSM State of Michigan Customer Service Center. The toll free telephone number is 800-843-4876 (TTY 800-240-3050). Our customer service representatives are available Monday through Friday from 8 a.m. to 6 p.m., 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

---

<b>Blue Cross Blue Shield of Michigan Contact information .....</b>	<b>1</b>
Calling .....	1
Special servicing numbers .....	1
Writing.....	1
Visiting .....	2
Additional BCBSM walk-in centers.....	2
Internet access.....	2
<b>State of Michigan contact information.....</b>	<b>2</b>
<b>Your Blue Cross Blue Shield of Michigan ID card .....</b>	<b>3</b>
<b>Explanation of benefit payment .....</b>	<b>4</b>
<b>Eligibility guidelines.....</b>	<b>5</b>
Employees .....	5
Retirees.....	5
The State Employees Defined Benefit (DB) Plan .....	5
State Employees Defined Contribution (DC) Plan.....	5
Applying for coverage.....	6
Employees.....	6
Retirees .....	6
Dual eligibility.....	7
<b>Making coverage changes .....</b>	<b>8</b>
Employees .....	8
Retirees.....	8
Address changes.....	9
Terminating coverage .....	9
Employees.....	9
Retirees .....	9
Dependent coverage.....	9
Dependent exclusions .....	9
Terminating dependent coverage .....	10
Employees.....	10
Retirees .....	10
Continuing coverage for dependent children .....	10
Continuing coverage for incapacitated children.....	10
Continuing coverage while on a leave of absence or layoff .....	11
Certificate of creditable coverage.....	11

<b>Your State Vision Plan benefits .....</b>	<b>12</b>
Choosing your vision provider .....	12
Copayments and out-of-pocket costs .....	12
What is covered .....	13
What is not covered.....	14
<b>State of Michigan Vision Plan Summary of Benefits for Employees .....</b>	<b>15</b>
<b>State of Michigan Vision Plan Summary of Benefits for Retirees.....</b>	<b>17</b>
<b>Filing claims .....</b>	<b>19</b>
<b>Coordination of benefits .....</b>	<b>20</b>
How COB works .....	20
COB guidelines.....	20
Filing COB claims .....	21
Updating COB information – your responsibility .....	21
Subrogation .....	21
<b>Your right to file a grievance .....</b>	<b>22</b>
Internal grievances.....	22
Standard internal grievance procedure.....	22
Expedited internal grievance procedure .....	23
Sections 402 and 403 of Public Act 350 .....	23
What we may not do .....	23
What we must do.....	24
Appeals to Civil Service.....	24
<b>Glossary .....</b>	<b>25</b>

# Blue Cross Blue Shield of Michigan

## Contact information

---

You can call, write or visit the BCBSM State of Michigan Customer Service Center when you have benefit and claims questions.

To help us serve you better, here are some important tips to remember.

- Have your BCBSM 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 to us, 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

Our customer service hours are Monday through Friday from 8 a.m. to 6 p.m. We are closed on holidays.

In and outside Michigan ..... **800-843-4876**

#### Special servicing numbers

Anti-fraud hotline..... **800-482-3787**

Hearing-impaired customers..... **TTY 800-231-6921**

BlueCard® ..... **800-810-BLUE-(2583)**

### Writing

Please send all correspondence to:

State of Michigan Customer Service Center  
Blue Cross Blue Shield of Michigan  
232 S. Capitol Avenue, Mail Code L04A  
Lansing, MI 48933-1504

For specific eligibility information and assistance:

#### Employee contact

Department of Civil Service  
MI HR Service Center  
P. O. Box 30002  
Lansing, MI 48909

#### Retiree contact

Office of Retirement Services  
P. O. Box 30171  
Lansing, MI 48909-7671

## Visiting

The BCBSM State of Michigan Customer Service Center is open Monday through Friday from 8 a.m. to 6 p.m., excluding holidays. We are located at:

State of Michigan Customer Service Center  
Blue Cross Blue Shield of Michigan  
232 S. Capitol Avenue  
Lansing, MI 48933-1504

You may also receive service at our other locations:

### Additional BCBSM walk-in centers

**Detroit** 500 E. Lafayette Blvd.

**Holland** 259 Hoover Blvd., Suite 160

**Flint** 4520 Linden Creek Parkway, Suite A

**Traverse City** 1769 S. Garfield Ave.

**Grand Rapids** 86 Monroe Center NW

**Utica** 6100 Auburn Road

### Internet access

BCBSM's home page

[bcbsm.com](http://bcbsm.com)

BCBSM's website for State of Michigan employees and retirees

[bcbsm.com/som](http://bcbsm.com/som)

Anti-fraud

[bcbsm.com/antifraud](http://bcbsm.com/antifraud)

Healthy Blue Xtras\*

[healthybluextras.com/](http://healthybluextras.com/)

Network provider locator

[bcbsm.com](http://bcbsm.com)

\*Access to this website requires registration at the *Member Secured Services* portal on [bcbsm.com](http://bcbsm.com).

## State of Michigan contact information

---

### MI HR Service Center

P.O. Box 30002  
Lansing, Michigan 48909  
Local: 517-335-0529  
Toll free: 877-766-6447

### Office of Retirement Services

P.O. Box 30171  
Lansing, MI 48909-7671  
Local: 517-322-5103  
Toll free: 800-381-5111

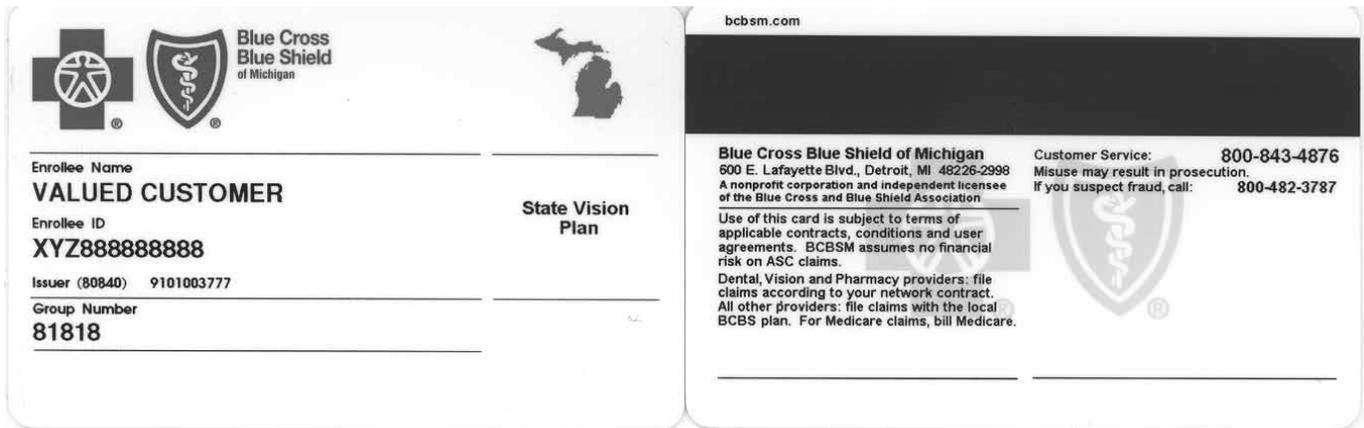
### Michigan Civil Service Commission

Employee Benefits Division  
P.O. Box 30002  
Lansing, MI 48909  
Toll free: 800-505-5011

# Your Blue Cross Blue Shield of Michigan ID card

Your BCBSM 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.



- 1<sup>st</sup> 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.
- 2<sup>nd</sup> 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.
- 3<sup>rd</sup> line:** **Issuer** identifies you as a BCBSM member. The number 80840 identifies our industry as an insurance carrier.
- 4<sup>th</sup> line:** **Group Number** tells us you are a BCBSM group member.

On the back of your ID card, you will find:

- A magnetic strip which will help providers process your claims. It includes information from the front of the card and the enrollee's date of birth. It does not include any benefit or health information.
- BCBSM'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 **bcbasm.com** and request one, or call the BCBSM State of Michigan Customer Service Center for assistance.
- Call the BCBSM State of Michigan Customer Service Center 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.

# Explanation of benefit payment

---

You will receive an *Explanation of Benefit Payments* (EOBP) form each time we process a claim under your contract number. The EOBP is not a bill. It is a statement that helps you understand how your benefits were paid. It tells you:

- The family member who received services
- Who provided the service, the payments made and any amount saved by using a participating provider
- Helpful Information about BCBSM programs
- Service dates, charges, payments and any balance you may owe

You may access your EOBP forms online by visiting **bcbsm.com** and signing in at the Members Secured Services site. You may also receive your EOBP by mail.

Please check your EOBP's carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the BCBSM State of Michigan Customer Service Center.

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

# Eligibility guidelines

---

## Employees

You are eligible to enroll in the State Vision Plan on the first day of the bi-weekly payroll period following your first day of employment. You must contact MI HR Service Center to enroll in the State Vision Plan. You are eligible to enroll in the State Vision Plan if:

- You are a State employee
- You have an appointment of at least 720 hours

You are not eligible to enroll if you have a non-career appointment.

## Retirees

### The State Employees Defined Benefit (DB) Plan

The State Employees Defined Benefit Plan covers most State employees hired before March 31, 1997. This includes Civil Service employees, appointed officials in the executive branch, and employees of the legislature and judiciary branch, as well as certain employees of non-central agencies.

If you retire under the State's DB plan, you can continue coverage without interruption if you receive an immediate retirement benefit under the State Employees Retirement Act (SERA) or the State Police Retirement Act (SPRA).

- **SERA retirees** can find additional information at:  
[http://www.michigan.gov/orsstatedb/0,1607,7-208-30607\\_48436---,00.html](http://www.michigan.gov/orsstatedb/0,1607,7-208-30607_48436---,00.html)
- **SPRA retirees** can find additional information at:  
[http://www.michigan.gov/ormspr/0,1607,7-224-40611\\_41901---,00.html](http://www.michigan.gov/ormspr/0,1607,7-224-40611_41901---,00.html)

If you need information on applying, changing or canceling coverage as well as the effects of other group coverage, visit: [http://www.michigan.gov/orsstatedb/0,1607,7-208-30607\\_48436\\_48437---,00.html#EnrChng](http://www.michigan.gov/orsstatedb/0,1607,7-208-30607_48436_48437---,00.html#EnrChng)

### State Employees Defined Contribution (DC) Plan

Most State employees hired on or after March 31, 1997 are in the 401(k) (DC) Plan, where the State contributes an amount equal to four percent of gross salary. In addition, the State matches any contributions you make to the account, up to another three percent. The retirement benefit is based on the amount of contributions and the performance of the investments you select for those contributions.

- **DC retirees** can obtain information on premium rates and plans at:  
[http://www.michigan.gov/documents/orsstatedc/R0749G-InsRatesDC\\_332231\\_7.pdf](http://www.michigan.gov/documents/orsstatedc/R0749G-InsRatesDC_332231_7.pdf)
- If you have questions about your 401(k) and 457 plans, or questions about eligibility including vesting, disability, death and insurance benefits, visit:  
[https://stateofmi.ingplans.com/einfo/pdfs/messages/client/benefitguide\\_20090731\\_134101.pdf](https://stateofmi.ingplans.com/einfo/pdfs/messages/client/benefitguide_20090731_134101.pdf)

Your insurance eligibility as a retiree begins on your retirement effective date, the first day of the month after you terminate employment. Since your coverage as an active employee continues through the end of the month in which you terminate employment, there should be no break in coverage as you go from active to retired status.

You can continue your vision coverage without interruption if:

- You terminated employment and have the equivalent of at least 10 years of full time State service. You must be age 60 or meet the DC age and service requirements.
- You receive an immediate defined benefit pension under one of the following:
  - State Employees' Retirement Act
  - State Police Retirement Act

## Applying for coverage

### Employees

You may enroll for vision coverage when you meet the State Vision Plan requirements for eligibility. You may enroll yourself and your eligible dependents within the first 31 days of your hire date. You must enroll by contacting the MI HR Service Center.

**Note:** Employees who work for an agency that does not participate with the MI HR Service Center must contact their respective agency's human resource office.

### Retirees

To apply for the State Vision Plan coverage or to ensure uninterrupted coverage, go to [www.michigan.gov/orsmiaccount](http://www.michigan.gov/orsmiaccount). You can also download an *Insurance Enrollment Change/Request form (R0452G)* available on the ORS Web site at [http://www.michigan.gov/documents/orsstatedb/R0452GH\\_244205\\_7.pdf](http://www.michigan.gov/documents/orsstatedb/R0452GH_244205_7.pdf).

Your insurance begins on your retirement effective date. Since your coverage as an active employee continues through the end of the month in which you terminate employment, there should be no gap in coverage as you go from active to retired status. However, if you file your application after the month in which you terminate employment, or if you waive coverage when you are first eligible, there could be a six-month delay in your coverage.

If you have a qualifying event, the six-month waiting period can be waived, and coverage can begin the first day of the second month after ORS receives your materials. The following are considered qualifying events for the purpose of adding or deleting a dependent. ORS must receive your application and the supporting documentation for a qualifying event by mail within 30 days of the qualifying event to waive the six-month waiting period. Photocopies are acceptable.

- **Adoption:** Acceptable proof is adoption papers, a sworn statement with the date of placement, or a court order verifying placement. In a legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption.
- **Birth:** Acceptable proof is a birth certificate.
- **Death:** Acceptable proof is original death certificate.
- **Divorce:** Acceptable proof is divorce papers.
- **Marriage:** Acceptable proof is a marriage certificate.
- **Involuntary loss of coverage in another group plan:** Provide a statement on letterhead from the terminating group insurance plan explaining who was covered, why coverage is ending, and the date coverage ends.

ORS can waive the six-month waiting period if you complete your insurance change request through **miAccount** and we receive, by mail, your confirmation page and required proofs, or an [Insurance Enrollment/Change Request \(R0452G\)](#) and required proofs within 30 days of the qualifying event. Coverage can begin the first of the month following the month in which we receive your completed application and required proofs.

## Dual eligibility

If you and your spouse are both covered by the State Vision Plan (retiree or active), you may:

- Maintain separate coverage through your individual plans, or
- Enroll in one plan, with one of you as a dependent

If you choose to maintain separate coverage, your child or children can only be covered by one of the parent's plans, not both. This applies even if you are divorced.

If you or your spouse separate from State service, take a leave of absence, or are laid off, the departing employee may be enrolled as a dependent on the remaining employee's State Vision Plan coverage, providing the remaining employee:

- Continues to meet eligibility requirements;
- Was covered as a dependent of the departing employee or was enrolled separately as an employee; and
- Notifies MI HR Service Center of his or her intent to transfer enrollment prior to the departure of the spouse from State service.

Once you return to work, you must wait until the State's next open enrollment period before you may transfer your coverage back into your own name.

# Making coverage changes

---

## Employees

You can make mid-year enrollment changes to your coverage based on a family status change. These changes occur if you or your dependents lose or need coverage because:

- You get married or divorced
  - You may enroll a new spouse within 31 days of your marriage; the effective date of the insurance will be the first day of the next pay period after notification to MI HR.
  - You may enroll in the State Vision Plan if you recently lost insurance coverage because of a divorce.  
**Note:** A former spouse's eligibility for State-sponsored insurance coverage will end on the date of your divorce.
- Your spouse begins or ends employment.
- Your spouse changes from part-time to full-time (or vice versa) or takes an unpaid leave of absence resulting in a significant change in your coverage.
- There is a significant change in your or your spouse's coverage through your spouse's non-State of Michigan employer plan.
- An eligible child is born, adopted, or you obtain legal guardianship. The effective date will be the date of birth, adoption, or legal guardianship.
- Your dependent 19- to 25-year-old child has returned to school, or stopped attending school.
- New dependents who are not enrolled within 31 days of the qualifying life event can be enrolled during the next open enrollment period.

For employees, the effective date for any other family status change will be the first day of the payroll period following the family status change or after enrollment, whichever is later.

## Retirees

As a retiree, you can change your insurance enrollments at any time during the year. Your enrollment will be subject to a six-month waiting period in any of the following situations:

- You do not notify us within 30 days of a qualifying event such as marriage, death, divorce, or involuntary loss of coverage in another group plan.
- You currently are not enrolled in any insurance plan.

For example, if we receive your enrollment or change request with the necessary proofs of eligibility on February 10, your coverage would begin August 1.

The six-month waiting period does not apply if you notify us within 30 days of a qualifying event such as marriage, death, divorce, or involuntary loss of coverage in another group plan. Coverage in the new plan will begin the first day of the second month after ORS receives your materials.

## Address changes

If you change your address, or if your address is incorrect in our records, please notify MI HR if you are an employee, or if you are a retiree use [www.michigan.gov/orsmiaccount](http://www.michigan.gov/orsmiaccount). This will ensure you will continue to receive any notices BCBSM sends to you.

## Terminating coverage

### Employees

The cancellation effective date will be the last day of the last payroll period of eligibility or when the entire group contract is discontinued.

### Retirees

You can voluntarily cancel your State Vision Plan coverage or your dependent's coverage at any time by logging into [www.michigan.gov/orsmiaccount](http://www.michigan.gov/orsmiaccount) or completing the ORS *Insurance Enrollment/Change Request (R0452G)*. The cancellation effective date will be the last day of the month in which a premium is paid.

## Dependent coverage

Eligible dependents include your spouse and any of your unmarried children until the day before they turn 19. In addition to being unmarried, children must meet the following conditions to be considered eligible. They must be:

- Your children by birth, legal adoption or legal guardianship who are in your custody and dependent on you for support. You will need to provide proof of dependency.
- Your children by birth, legal adoption or legal guardianship who do not reside with you, but are your legal responsibility for the provision of medical care (for example, children of divorced parents).
- In a legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.
- Step children for whom you have physical custody (i.e. step children living with you at least 50 percent of the time as stated in a current divorce decree) and for whom you provide 50 percent of their support.

## Dependent exclusions

You cannot claim a dependent on your coverage if he or she is:

- In the armed forces  
No person will be considered a dependent while in the armed forces of any country. Individuals who are called to active military duty are eligible for coverage under TRICARE, effective with the date of active duty orders.
- Already covered on another State Vision Plan  
No person can be covered by more than one State Vision Plan.

## Terminating dependent coverage

### Employees

Your dependent's coverage will automatically terminate:

- When your dependent no longer meets the definition of an eligible dependent  
**Note:** You must immediately notify MI HR Service Center if you divorce or if a child becomes ineligible.  
**Ex-spouses are not eligible for coverage as of the date of divorce.**
- When your dependent becomes eligible for coverage as an employee of State of Michigan
- When the entire group or the group dependent contract is discontinued
- When your coverage terminates

If you notify us more than 31 days after the date of the event, the change to your contract will be delayed, which may cause errors when your claims are processed. **If you fail to give timely notice, you may be held responsible for any payments made by State of Michigan and BCBSM on behalf of your ineligible dependent after the date of the event.** Please remember to report promptly any membership changes to MI HR Service Center so these changes can be reflected on your records.

### Retirees

Your dependent's coverage will automatically terminate on the last day of the last month for which you made any required dependent premium contribution and:

- When your dependent no longer meets the definition of an eligible dependent  
**Note:** You must immediately notify ORS if you divorce. **Ex-spouses are not eligible for coverage effective the date of divorce.**
- When your coverage terminates

## Continuing coverage for dependent children

Under certain circumstances, you can continue coverage for dependent children past the age of 19. If your coverage is still active but your dependent child no longer meets the eligibility criteria outlined in the section entitled "Dependent coverage," your dependent child can remain on your coverage if he or she is:

- Unmarried and between the ages of 19 and 25, and
- Regularly attending an accredited school and dependent on the employee for 50 percent or more of financial support.

This coverage will continue until the day before the child turns 25 if he or she remains eligible. (Coverage for these dependents will be the same as yours.)

## Continuing coverage for incapacitated children

Incapacitated children are those who are unable to earn a living because of a mental retardation or physical disability and must depend on their parents for support and maintenance. If your enrolled dependent is deemed an incapacitated child, the coverage for this child will continue beyond age 19 as long as:

- He or she became incapacitated before age 19,
- Documentation verifying the child's condition was provided to the insurance carrier prior to the child becoming 19,
- The child continues to be incapacitated, and
- Your coverage does not terminate for any other reason.

To ensure uninterrupted coverage for your incapacitated child, you must apply for continuation coverage before the end of the month in which the child turns 19. To apply for continuation coverage, contact MI HR Service Center, ORS, or the State of Michigan Customer Service Center for a BCBSM State Health Plan Disabled Dependent Application form. The Disabled Dependent Application form is also available on the State of Michigan's Web site at [www.michigan.gov/documents/mdcs/BCBSM\\_Disabled\\_Dependent\\_Application.pdf\\_270240\\_7.pdf](http://www.michigan.gov/documents/mdcs/BCBSM_Disabled_Dependent_Application.pdf_270240_7.pdf). Print a copy of this form. Make a copy of the completed form for your files.

Mail the completed form to:

Blue Cross Blue Shield of Michigan  
600 E. Lafayette Blvd.  
Mail Code 517J  
Detroit, MI 48226  
Attn: Senior Medical Analyst

For more information on dependent eligibility, refer to [http://www.michigan.gov/documents/mdcs/Dependent\\_Eligibility\\_Guidelines\\_325895\\_7.pdf](http://www.michigan.gov/documents/mdcs/Dependent_Eligibility_Guidelines_325895_7.pdf)

## **Continuing coverage while on a leave of absence or layoff**

If you are on a leave of absence, you can continue State Vision Plan coverage for you and your dependents by paying the full monthly premium.

Your human resource office will send you an Application for Continuation of Insurance Benefits. You must submit this completed application to the Employee Benefits Division within 60 days of the qualifying event or the date the coverage ends, whichever is later.

If you are on layoff, you can also continue State Vision Plan coverage for up to 18 months by paying the full monthly premium.

Your human resource office will send you an Application for Continuation of Insurance Benefits. This completed application must be sent to the Michigan Civil Service Commission, Employee Benefits Division within 60 days of the date your coverage ends.

When you return to work, you may want to contact MI HR Service Center to verify that your active coverage has been reinstated.

## **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 BCBSM.

**Blue vision participating providers** have signed agreements with us to accept our approved amount, minus your copayment, as payment in full for covered services. Participating providers also file claims for you and receive payment directly from us.

To locate a Blue participating vision provider, visit [bcbsm.com](http://bcbsm.com) or call the State of Michigan Customer Service Center.

**Nonparticipating vision care providers** have not signed agreements with us and can choose not to accept our approved amount as payment in full. This means you are responsible for any difference between our approved amount and the provider's charges. This amount is in addition to your copayments. You may also have to file your own claim to receive reimbursement.

## Out-of-state providers

Out-of-state vision providers may or may not participate with their local Blue Cross and Blue Shield Plan. Participating vision providers will accept the approved amount of their local Plan. Nonparticipating providers may not accept neither our nor the local Plan's approved amount as payment in full. This means you may be responsible for the difference between the approved amount and the provider's charges. This amount is in addition to your copayments. You may have to pay the full amount at the time of service and file your own claim to receive reimbursement.

## Copayments and out-of-pocket costs

When you receive vision care from a **participating 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:

- Seventy-five percent of the BCBSM-approved amount for vision examinations. You are responsible for your \$5 copayment and any additional charges.
- 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 pages 15 and 17 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

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 71mm. The provider may charge you for the difference in cost between standard and oversize lenses

We will cover the fee to insert new lenses into your current frames if you choose not to receive new frames.

- **Frames.** Once every 24 consecutive months or once in every 12 months if prescription changes. Standard frames must be able to hold prescribed lenses and can be made out of:
  - Plastic
  - Wire
  - Metal
- **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
- **Dispensing fee.** The full cost of the usual dispensing fees for measuring and verifying lenses, as well as for selecting, fitting and adjusting frames *if* obtained lenses or frames are from a participating provider.

## What is not covered

Your vision care benefit does not cover:

- Charges for designer frames and lens tinting darker than Rose tint #2
- Sunglasses, photosensitive or anti-reflective lenses that cost more than the benefit for regular lenses. Benefits are payable only up to the amount approved for standard 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
- Contact lens suitability exams are not covered if contact lenses are purchased
- 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 for Employees

Service	Participating providers	Nonparticipating providers
<b>Vision testing examination</b>		
Routine eye exam	100% of BCBSM-approved amount minus \$5 copay	75% of BCBSM-approved amount minus \$5 copay
	Once every 12 months	
<b>Eyeglass lenses (glass, plastic or prism up to 71 mm); Members may obtain either eyeglasses or contact lenses, but not both.</b>		
Single vision	100% of BCBSM-approved amount minus \$7.50 copay*	No copay; maximum of: <ul style="list-style-type: none"> <li>\$13 per pair for glass</li> <li>\$16 per pair for plastic</li> <li>\$15 per pair for prism</li> </ul>
	Once every 24 months, or once every 12 months if prescription has changed	
Bifocal (includes blended)	100% of BCBSM-approved amount minus \$7.50 copay*	No copay; maximum of: <ul style="list-style-type: none"> <li>\$20 per pair for glass</li> <li>\$23 per pair for plastic</li> <li>\$22 per pair for prism</li> </ul>
	Once every 24 months, or once every 12 months if prescription has changed	
Trifocal	100% of BCBSM-approved amount minus \$7.50 copay*	No copay; maximum of: <ul style="list-style-type: none"> <li>\$24 per pair for glass</li> <li>\$27 per pair for plastic</li> <li>\$26 per pair for prism</li> </ul>
	Once every 24 months, or once every 12 months if prescription has changed	
Special lenses	100% of BCBSM-approved amount minus \$7.50 copay*	50% or 75% of BCBSM-approved amount for comparable lenses, whichever is less
	Once every 24 months, or once every 12 months if prescription has changed	
Rose tints # 1 and 2	100% of BCBSM-approved amount	Maximum of \$3 per pair

# State of Michigan Vision Plan

## Summary of Benefits for Employees

Service	Participating providers	Nonparticipating providers
<b>Frames</b>		
Eyeglass frames	Frame allowance** minus \$7.50 copay*	Maximum of \$14.75** No copay
	Once every 24 months, or once every 12 months if prescription has changed	
<b>Contact lenses - Members may obtain either eyeglasses or contact lenses, but not both.</b>		
Medically necessary	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$96 per pair No copay
	Once every 24 months, or once every 12 months if prescription has changed	
Cosmetic, not medically necessary	Maximum of \$90 per pair No copay	Maximum of \$40 per pair No copay
	Once every 24 months, or once every 12 months if prescription has changed	

\*If member has already made a copay for lenses, no further copay is required.

\*\*See your union contract for actual frame allowance.

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 BCBSM-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.

# State of Michigan Vision Plan

## Summary of Benefits for Retirees

Service	Participating providers	Nonparticipating providers
<b>Vision testing examination</b>		
Routine eye exam	100% of BCBSM-approved amount minus \$5 copay	75% of BCBSM-approved amount minus \$5 copay
	Once every 12 months	
<b>Eyeglass lenses (glass, plastic or prism up to 71 mm); Members may obtain either eyeglasses or contact lenses, but not both.</b>		
Single vision	100% of BCBSM-approved amount minus \$7.50 copay*	No copay; maximum of: <ul style="list-style-type: none"> <li>\$13 per pair for glass</li> <li>\$16 per pair for plastic</li> <li>\$15 per pair for prism</li> </ul>
	Once every 24 months, or once every 12 months if prescription has changed	
Bifocal (includes blended)	100% of BCBSM-approved amount minus \$7.50 copay*	No copay; maximum of: <ul style="list-style-type: none"> <li>\$20 per pair for glass</li> <li>\$23 per pair for plastic</li> <li>\$22 per pair for prism</li> </ul>
	Once every 24 months, or once every 12 months if prescription has changed	
Trifocal	100% of BCBSM-approved amount minus \$7.50 copay*	No copay; maximum of: <ul style="list-style-type: none"> <li>\$24 per pair for glass</li> <li>\$27 per pair for plastic</li> <li>\$26 per pair for prism</li> </ul>
	Once every 24 months, or once every 12 months if prescription has changed	
Special lenses	100% of BCBSM-approved amount minus \$7.50 copay*	50% or 75% of BCBSM-approved amount for comparable lenses, whichever is less
	Once every 24 months, or once every 12 months if prescription has changed	
Rose tints # 1 and 2	100% of BCBSM-approved amount	Maximum of \$3 per pair

# State of Michigan Vision Plan

## Summary of Benefits for Retirees

Service	Participating providers	Nonparticipating providers
<b>Frames</b>		
Eyeglass frames	Frame allowance** minus \$7.50 copay*	Maximum of \$14 No copay
	Once every 24 months, or once every 12 months if prescription has changed	
<b>Contact lenses - Members may obtain either eyeglasses or contact lenses, but not both.</b>		
Medically necessary	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$96 per pair No copay
	Once every 24 months, or once every 12 months if prescription has changed	
Cosmetic, not medically necessary	Maximum of \$90 per pair No copay	Maximum of \$40 per pair No copay
	Once every 24 months, or once every 12 months if prescription has changed	

\*If member has already made a copay for lenses, no further copay is required.

\*\*Contact the BCBSM State of Michigan Customer Service Center for the current fee.

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 BCBSM-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. You will also need to complete a *Member Application For Payment Consideration* form. To obtain a form, call the BCBSM State of Michigan Customer Service Center.
3. Mail the claim form and itemized statement to the State of Michigan Customer Service Center at this address:

State of Michigan Customer Service Center  
Blue Cross Blue Shield of Michigan  
232 S. Capitol Avenue, Mail Code LO4A  
Lansing, MI 48933-1504

Please file claims promptly.

You will receive payment directly from BCBSM. The check will be in the enrollee's name, not the patient's name.

# Coordination of benefits

---

Coordination of benefits (COB) 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.

COB ensures the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

## How COB works

If you are covered by more than one group vision plan, COB 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. The secondary plan provides payments toward the remaining balance of covered services – up to the allowable amount determined by the carriers.

## 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).
- **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 BCBSM for reimbursement of the balance, please follow these steps:

1. Obtain an EOBP 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. If the provider is in Michigan, include the provider's Blue Cross Blue Shield of Michigan identification number (PIN). If the provider is located outside of Michigan, include the provider's federal tax ID number.
5. Send these items to:

Blue Cross Blue Shield of Michigan  
COB Membership, Mail Code 0526  
600 E. Lafayette  
Detroit, MI 48226-9942

Please make copies of all forms and receipts for your own files because BCBSM 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.

For your convenience, you can update your coordination of benefits information online at [bcbsm.com/cob](https://www.bcbsm.com/cob). If neither you nor your covered dependents have any additional vision coverage, simply call our automated response number at 866-611-7474 to update your information.

## Subrogation

In certain cases, another person, insurance carrier or organization may be legally obligated to pay for vision services that we have paid. When this happens:

- Your right to recover payment from them is transferred to BCBSM.
- You are required to do whatever is necessary to help BCBSM enforce their right of recovery.
- If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBSM. However, this does not apply if the funds you receive are from additional coverage you purchased in your name from another insurance company.

# 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

### A. Standard internal grievance procedure

Under the standard internal grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time you are permitted to take to file your grievance and for a period of up to 10 days if we have not received information we have requested from a health care provider (such as your doctor or hospital). The standard internal grievance procedure is as follows:

1. You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.

Mail your written grievance to the address found in the top right-hand corner of the first page of your EOB statement or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.

We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.

2. If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing.

Mail your request to:

Conference Coordination Unit  
Blue Cross Blue Shield of Michigan  
P.O. Box 2459  
Detroit, MI 48231-2459

You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit or at a local customer service center. Our written proposed resolution will be our final determination regarding your grievance.

In addition to the information found above, you should also know:

- a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal grievance procedure.
- b. Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
- c. You may obtain copies of information relating to our denial, reduction or termination of coverage for a vision care service for a reasonable copying charge.

## B. Expedited internal grievance procedure

If a physician substantiates orally or in writing that adhering to the time frame for the standard internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. **You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated or reduced coverage for a vision care service prior to your having received that vision care service or if you believe we have failed to respond timely to a request for benefits or payment.** The procedure is:

1. You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.

Call the expedited grievance hot line: 313-225-6800.

We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

In addition to the information found above, you should also know:

- a. You may authorize in writing another person, including, but not limited to, a physician to act on your behalf at any stage in the expedited internal grievance procedure.
- b. If our decision is communicated to you orally, we must provide you with written confirmation within two business days.

## 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 a 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 BCBSM, you may appeal a denial by BCBSM 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 BCBSM 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](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 BCBSM 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. BCBSM 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 portion 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 BCBSM membership records.

**Nonparticipating providers** – Providers that have not signed participation agreements with BCBSM agreeing to accept the BCBSM 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 BCBSM to accept the BCBSM-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 BCBSM.

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



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