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.

Effective October 1, 2013, BCBSM has partnered with Vision Service Plan® (VSP) to administer your vision benefits. 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 VSP at 1-855-356-4362. Our 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

Blue Cross Blue Shield of Michigan Contact information ................................................................. 1

Calling .................................................................................................................................................. 1

Special servicing numbers .................................................................................................................. 1

Writing .................................................................................................................................................. 1

Visiting .................................................................................................................................................. 2

Internet access ..................................................................................................................................... 2

State of Michigan contact information .............................................................................................. 2

Your Blue Cross Blue Shield of Michigan ID card ............................................................................. 3

VSP Savings Statement ....................................................................................................................... 4

Eligibility guidelines ............................................................................................................................ 5

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

Making coverage changes .................................................................................................................. 8

Employees ............................................................................................................................................ 8

Retirees ................................................................................................................................................ 8

Address changes ............................................................................................................................... 9

Terminating coverage ....................................................................................................................... 9

   Employees ....................................................................................................................................... 9

   Retirees ........................................................................................................................................... 9

Dependent exclusions ........................................................................................................................ 9

Terminating dependent coverage ...................................................................................................... 10

Employees .......................................................................................................................................... 10

Retirees ............................................................................................................................................... 10

Continuing coverage for dependent children .................................................................................. 10
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 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**

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 Michigan.........................................................................................................................................................855-356-4362

**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:

**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
**Internet access**

BCBSM’s home page................................................................................................................................................. bcbsm.com

BCBSM’s website for State of Michigan employees and retirees............................................................................ bcbsm.com/som

Healthy Blue Xtras* ................................................................ healthybluextras.com/  Network provider locator bcbsm.com

VSP’s home page ...................................................................................................................................................... vsp.com

*Access to this website requires registration at the Member Secured Services portal on bcbsm.com.

---

**State of Michigan contact information**

<table>
<thead>
<tr>
<th>MI HR Service Center</th>
<th>Office of Retirement Services</th>
<th>Michigan Civil Service Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 30002</td>
<td>P.O. Box 30171</td>
<td>Employee Benefits Division</td>
</tr>
<tr>
<td>Lansing, Michigan 48909</td>
<td>Lansing, MI 48909-7671</td>
<td>P.O. Box 30002</td>
</tr>
<tr>
<td>Local: 517-335-0529</td>
<td>Local: 517-322-5103</td>
<td>Lansing, MI 48909</td>
</tr>
<tr>
<td>Toll free: 877-766-6447</td>
<td>Toll free: 800-381-5111</td>
<td>Toll free: 800-505-5011</td>
</tr>
</tbody>
</table>
Your Blue Cross Blue Shield 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.

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:

- 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.
- 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. This statement replaces your Explanation of Benefits Payments (EOBP). Your Personalized Savings Statement is not a bill. It is a statement that helps you understand 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 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
- **SPRA retirees** can find additional information at: http://www.michigan.gov/orsmsp/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

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
- 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/msgs/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.

Your insurance can begin 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, ORS must have your enrollment request and required proofs by the 15th of the month prior to your retirement effective date. Enrollment requests received after the 15th of the month will be processed with an effective date for the 1st of the 2nd month after receipt of the request. 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 may not apply, and coverage could begin the first of the month following receipt of completed enrollment request and required proofs. ORS must receive your application and the supporting documentation for a qualifying event by mail within 30 days of the qualifying event or the standard six-month waiting period will apply. Photocopies are acceptable. The following are considered qualifying events for the purpose of adding or deleting a dependent.

- **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, the type of coverage, why coverage is ending, and the date coverage ends.

The six-month waiting period will not apply if you complete your insurance change request through miAccount and we receive 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 the MI HR Service Center.
  - 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 the MI HR Service Center if you are an employee, or if you are a retiree use www.michigan.gov/orsmiaccount. This will ensure you will continue to receive any notices BCBSM or VSP 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 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 the MI HR Service Center 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/VSP 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. 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


**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.
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 bcbsm.com or call VSP at 855-356-4362. 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.

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:
- Seventy-five percent of the VSP-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
  - 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 ungraded 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 VSP 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
- 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

<table>
<thead>
<tr>
<th>Service</th>
<th>VSP Providers</th>
<th>Nonparticipating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision testing examination</td>
<td>100% of VSP-approved amount minus $5 copay</td>
<td>75% of VSP-approved amount minus $5 copay</td>
</tr>
<tr>
<td>Routine eye exam</td>
<td></td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Eyeglass lenses (glass, plastic or prism up to 71 mm); <strong>Members may obtain either eyeglasses or contact lenses, but not both.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>No copay; maximum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $13 per pair for glass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $16 per pair for plastic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $15 per pair for prism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Bifocal (includes blended)</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>No copay; maximum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $20 per pair for glass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $23 per pair for plastic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $22 per pair for prism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Trifocal</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>No copay; maximum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $24 per pair for glass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $27 per pair for plastic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $26 per pair for prism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Special lenses</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>50% or 75% of VSP-approved amount for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>comparable lenses, whichever is less</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Rose tints # 1 and 2</td>
<td>100% of VSP-approved amount</td>
<td>Maximum of $3 per pair</td>
</tr>
</tbody>
</table>

*Copay for VSP Providers includes a $5 fee for VSP members and a $7.50 fee for non-VSP members.*
## State of Michigan Vision Plan
### Summary of Benefits for Employees

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

*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 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.
<table>
<thead>
<tr>
<th>Service</th>
<th>VSP Providers</th>
<th>Nonparticipating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision testing examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine eye exam</td>
<td>100% of VSP-approved amount minus $5 copay</td>
<td>75% of VSP-approved amount minus $5 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Eyeglass lenses (glass, plastic or prism up to 71 mm); Members may obtain either eyeglasses or contact lenses, but not both.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>No copay; maximum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $13 per pair for glass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $16 per pair for plastic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $15 per pair for prism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months, or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Bifocal (includes blended)</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>No copay; maximum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $20 per pair for glass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $23 per pair for plastic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $22 per pair for prism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months, or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Trifocal</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>No copay; maximum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $24 per pair for glass</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $27 per pair for plastic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $26 per pair for prism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months, or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Special lenses</td>
<td>100% of VSP-approved amount minus $7.50 copay*</td>
<td>50% or 75% of VSP-approved amount for comparable lenses, whichever is less</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 24 months, or once every 12 months if prescription has changed</td>
</tr>
<tr>
<td>Rose tints # 1 and 2</td>
<td>100% of VSP-approved amount</td>
<td>Maximum of $3 per pair</td>
</tr>
</tbody>
</table>
## State of Michigan Vision Plan
### Summary of Benefits for Retirees

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

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

**Contact the VSP 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 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
   3333 Quality Drive MS 321   Rancho
   Cordova, CA 95670-7985

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 (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.

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.

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 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.
5. Send these items to:

   Vision Service Plan
   
   P.O. Box 997105
   Sacramento, CA 95899-7105
   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 ammended 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](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. 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/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 BCBSM.

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

**VSP** – Vision Service Plan