



Blue Vision Benefits at-a-Glance

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. To find a VSP doctor, call 1-800-877-7195 or visit VSP's Web site at www.vsp.com.

	VSP Network Doctor	Non-VSP Provider
Eye Exam		
Covers a complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – \$5 copay	Reimbursement up to \$35 less a \$5 copay
	Once every 12 consecutive months	
Frames		
Covers standard eyeglass frames (not exceeding 60 mm in diameter). A wide selection of frames is available at each VSP network doctor location.	Covered – \$10 copay (one copay applies to both lenses and frames)	Reimbursement up to \$45, less a \$10 copay
	One frame every 12 consecutive months	
Lenses		
Covers standard lenses prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. Note: Additional pairs of prescription glasses and non-covered lens options are discounted when obtained from a VSP doctor.	Covered – \$10 copay (one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay
	One pair every 12 consecutive months	
Contact Lenses: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.		
Covers medically necessary contact lenses (that meet medically necessary criteria)	Covered – \$10 copay	Reimbursement up to \$210 after a \$10 copay (member responsible for difference)
	Once every 12 consecutive months	
Covers elective contact lenses that improve vision (prescribed, but do not meet medically necessary criteria)	Covered – \$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	
	Once every 12 consecutive months	
Copays		
• Eye exam	\$5 copay	\$5 copay applies to charge
• Frames and/or lenses or medically necessary contact lenses	A combined \$10 copay	Member responsible for difference between approved amount and provider's charge, less a \$10 copay

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