Blue Cross Blue Shield of Michigan

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

Blue Vision

Benefits-at-a-Glance

MEP Services

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 1,100 VSP provider locations in Michigan and 24,000 locations nationwide. To find a VSP provider, call 1-800-877-7195 or visit VSP's Web site at www.vsp.com.

	VSP Provider	Out-of-Network Provider
Eye exams		
Covers a complete eye exam by an ophthalmologist or optometrists. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered - 100%	Covered - reimbursement up to $35
	once every 12 consecutive months	
Eyeglass Frames		
Covers standard eyeglass frames. A wide selection of quality frames is fully covered by VSP up to the frame allowance. Members should ask their doctor which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered - $10 copayment	Covered - $45 copay
	once every 24 consecutive months	
Eyeglass Lenses		
Single vision, bifocal, trifocal or lenticular lenses in glass or plastic. Note: Additional pairs of prescription glasses and non-covered lens options are discounted when purchased from a VSP provider.	Covered - $10 copayment (one copay applies to both lenses and frames)	Covered - copay of: $25 single lenses, $40 bifocal lenses, $55 trifocal lenses $80 lenticular lenses
	once every 24 consecutive months	
Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both.		
Elective contact lenses (prescribed, but **not** medically necessary) may be chosen instead of spectacle lenses and a frame.	Covered - $10 copayment	Covered - $105 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 24 consecutive months	
Therapeutic contact lenses (medically necessary)	Covered - $10 copayment	Covered - reimbursement up to $210
	once every 24 consecutive months	
Copays/Coinsurance		
• Eye exam	Covered - 100%	reimbursement up to $35 applies to charge
• Frames and/or lenses or medically necessary contact lenses	Covered - $10 copayment	Member responsible for difference between approved amount and provider's charge, less a $45 copay

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.