



Blue Vision ChoiceSM 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 network doctor, call **800-877-7195** or log onto the VSP 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 – \$10 copay	Reimbursement up to \$35 less a \$10 copay
	One eye exam in any period of 12 consecutive months	

Lenses and Frames

Note: The full copay applies if you receive lenses and not frames.

Covers standard lenses (must not exceed 60 mm in diameter) 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: Discount on additional prescription glasses/sunglasses and savings on lens extras when obtained from a VSP doctor.	Covered – \$25 copay (one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay
	One pair of lenses, with or without frames, in any period of 12 consecutive months	
Covers standard frames Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered – \$25 copay (one copay applies to both lenses and frames)	Reimbursement up to \$45, less a \$25 copay
	One frame in any period of 24 consecutive months	

Contact Lenses

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Covers medically necessary contact lenses (require prior authorization approval from VSP and must meet criteria of medically necessary)	Covered – \$25 copay	Reimbursement up to \$210 after a \$25 copay (member responsible for difference)
	One pair of contact lenses in any period 12 consecutive months	
Covers elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Covered – \$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (no copay; member responsible for any cost exceeding the allowance)	Covered – \$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (no copay; member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period 12 consecutive months	

Copays

• Eye exam	\$10 copay	\$10 copay applies to charge
• Lenses and/or frames or medically necessary contact lenses	A combined \$25 copay	Member responsible for difference between approved amount and provider's charge, less a \$25 copay