



**Blue Cross
Blue Shield**
of Michigan

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

Michigan Catholic Conference

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Vision Coverage - Blue Choice VSP

Effective Date: 01/01/2018

Benefits-at-a-glance

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.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 3,000 VSP provider locations in Michigan and 53,000 locations nationwide. To find a VSP provider, call **1-800-877-7195** or visit VSP's Web site at www.vsp.com.

Member's responsibility (copayments)		
Benefits	VSP Provider	Out-of-Network Provider
Eye Exam	\$10 copay	Reimbursement up to \$45 less \$10 copay
Lenses and/or frames	\$10 copay combined with frames	Member responsible for difference between approved amount and provider's charge, less \$10 copay
Medically necessary contact lenses	\$10 copay	Member responsible for difference between approved amount and provider's charge, less \$10 copay

Eye exams		
Benefits	VSP Provider	Out-of-Network Provider
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	Covered - reimbursement up to \$45 less \$10 copay
		Once every 12 months

Lenses and frames		
Benefits	VSP Provider	Out-of-Network Provider
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 copay combined with frames	Covered - reimbursement up to \$30 for single vision lens; \$50 for bifocal lens; \$65 for trifocal lens; \$100 for lenticular lens less \$10 copay
		Once every 12 months

Benefits	VSP Provider	Out-of-Network Provider
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 - reimbursement up to \$150 less \$10 copay combined with lenses Once every 24 months	Covered - reimbursement up to \$70 less \$10 copay

Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both

Benefits	VSP Provider	Out-of-Network Provider
Elective contact lenses (prescribed, but not medically necessary) may be chosen instead of spectacle lenses and a frame.	Covered - \$150 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 months	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)
Therapeutic contact lenses (medically necessary)	Covered - \$10 copay Once every 12 months	Covered - reimbursement up to \$210 less \$10 copay