



**Blue Cross
Blue Shield**
of Michigan

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

MACOMB COUNTY EMPLOYEES

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Vision Coverage

Effective Date: On or after January 2021

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

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

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance **plus** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None (member responsible for difference between approved amount and provider's charge)
Medically necessary contact lenses	None	None (member responsible for difference between approved amount and provider's charge)
Contact lens suitability examination (fitting and evaluation)	Up to \$60 copay	None (member responsible for difference between approved amount and provider's charge)
Note: No copay is required for prescribed contact lenses that are not medically necessary.		

Eye exam		
Benefits	VSP network doctor	Non-VSP provider
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.	100% of approved amount	Reimbursement up to \$58 less \$5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

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Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
<p>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.</p> <ul style="list-style-type: none"> Progressive Lenses - Covered when rendered by a VSP network doctor 	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
Standard frames	\$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less	Reimbursement up to \$65 less \$10 copay (member responsible for any difference)
<p>Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.</p>	One pair of lenses, with or without frames, in any period of 12 consecutive months	One frame in any period of 12 consecutive months

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to \$210 (member responsible for any difference)
Contact lens suitability examination (fitting and evaluation)	\$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)		
	Contact lenses up to the allowance in any period of 12 consecutive months	Contact lenses up to the allowance in any period of 12 consecutive months

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