Blue Cross Blue Shield of Michigan

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

Blue Vision℠ Voluntary SG, VSP Choice Network 12/12/24 $10/$25 Copay Vision Coverage
Benefits-at-a-glance
Effective for groups on their plan year

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 or any other plan documents your group uses, if your group is self-funded. 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: Vision benefits are only available to covered members (subscribers, spouses and dependent children) age 19 and older. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $25 copay	Member responsible for difference between approved amount and provider's charge, after $25 copay
Medically necessary contact lenses	$25 copay	Member responsible for difference between approved amount and provider's charge, after $25 copay

Eye exam

Benefits	In-network	Out-of-network
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.	$10 copay	Reimbursement up to $34 less $10 copay (member responsible for any difference)
	One eye exam every calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
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:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$25 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $25 copay (member responsible for any difference)
	One pair of lenses, with or without frames, every calendar year	

Benefits	In-network	Out-of-network
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $25 copay (one copay applies to **both** lenses and frames)	Reimbursement up to $38.25 less $25 copay (member responsible for any difference)
	One frame every 2 calendar years	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$25 copay	Reimbursement up to $210 less $25 copay (member responsible for any difference)
	One pair of contact lenses every calendar year	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance every calendar year	

Blue Cross Blue Shield Blue Care Network of Michigan

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Note: To be eligible for coverage, the following services require your provider to obtain approval before they are provided - select radiology services, in patient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analysis.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSMID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Customized Benefit Summary for :	

These rates do not include upcoming federal taxes that will be added to your bill when they become effective.

Final rates will be determined by Underwriting based on actual enrollment. BCBSM/BCN has the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect. 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 and/or Blue Care Network certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan and/or Blue Care Network 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.

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