



**Blue Cross
Blue Shield
of Michigan**

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

SAGINAW VALLEY STATE UNIVERSITY

0070005360001 - 03J94

Effective Date: 01/01/2022

Vision Coverage

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

Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$10 copay	Member responsible for difference between approved amount and provider's charge, after \$10 copay
Medically necessary contact lenses	\$10 copay	Member responsible for difference between approved amount and provider's charge, after \$10 copay
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.	\$5 copay	Reimbursement up to \$50 less \$5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

Lenses and frames		
Benefits	VSP network doctor	Non-VSP provider
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.	\$10 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less \$10 copay (member responsible for any difference)
<ul style="list-style-type: none"> Progressive Lenses - Covered when rendered by a VSP network doctor 	One pair of lenses, with or without frames, in any period of 12 consecutive months	

ADM MOS816 VIS;BLUE VISION;BV-PL;BVFL

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Benefits	VSP network doctor	Non-VSP provider
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 \$10 copay (one copay applies to both frames and lenses)	Reimbursement up to \$70 less \$10 copay (member responsible for any difference)
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)	\$10 copay Contact lenses up to the allowance in any	Reimbursement up to \$210 less \$10 copay (member responsible for any difference)
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) Contact lenses up to the allowance in any	\$105 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 up to the allowance in any period of 12 consecutive months		