



**Blue Cross
Blue Shield
of Michigan**

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

DELTA COLLEGE

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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

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 \$45 less \$5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

155050%20%25%3K;ADM PLANYR JAN;ASCMOD 9441 MED;BLUE VISION;BV-FLA \$100;BVFL;BVPP CHOICE NET;CB ASC;CB-ET \$250 ASC;CB-MTC \$25 ASC;CB-OPMON 2K ASC;CB-OV \$25 ASC;CB-XC-IN ASC;CBC 20%-ON ASC;CBD \$500-IN ASC;CBD \$500-ON ASC;CBOLV 15 ASC;CBOPMIN\$6600ASC;DC 26-ME ASC;HC ASC;PDRX ASC

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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>	<p>\$10 copay (one copay applies to both lenses and frames)</p> <p>One pair of lenses, with or without frames, in any period of 12 consecutive months</p>	<p>Reimbursement up to approved amount based on lens type less \$10 copay (member responsible for any difference)</p>
<p>Standard frames</p> <p>Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.</p>	<p>\$100 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)</p> <p>One frame in any period of 12 consecutive months</p>	<p>Reimbursement up to \$70 less \$10 copay (member responsible for any difference)</p>

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
<p>Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)</p>	<p>\$10 copay</p> <p>Contact lenses up to the allowance in any period of 12 consecutive months</p>	<p>Reimbursement up to \$210 less \$10 copay (member responsible for any difference)</p>
<p>Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)</p>	<p>\$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p> <p>Contact lenses up to the allowance in any period of 12 consecutive months</p>	<p>\$85 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p>

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