



**Blue Cross
Blue Shield**
of Michigan

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

Birmingham Board of Education A0MY3 Vision Coverage Effective Date: On or after July 2016 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 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: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Benefits	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	\$7.50 copay	\$7.50 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined 7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay
Medically necessary contact lenses	\$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay
Note: No copay is required for prescribed contact lenses that are not medically necessary.		

Benefits	VSP network doctor	Non-VSP provider
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.	\$7.50 copay	Reimbursement up to \$34 less \$7.50 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

Benefits	VSP network doctor	Non-VSP provider
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>Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor</p>	<p>\$7.50 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 \$7.50 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)</p> <p>One frame in any period of 12 consecutive months</p>	<p>Reimbursement up to \$38.25 less \$7.50 copay (member responsible for any difference)</p>

Benefits	VSP network doctor	Non-VSP provider
Contact Lenses		
Benefits	VSP network doctor	Non-VSP provider
<ul style="list-style-type: none"> Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary) 	<p>\$7.50 copay</p> <p>One pair of contact lenses in any period of 12 consecutive months</p>	<p>Reimbursement up to \$210 less \$7.50 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>One pair of contact lenses in any period of 12 consecutive months</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>