



**Blue Cross  
Blue Shield  
of Michigan**

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

**MUSKEGON COMMUNITY COLLEGE  
A1MLU9  
0070045530004  
Vision Coverage  
Effective Date: On or after January 2024  
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 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

<b>Member's responsibility (copays)</b>		
<b>Benefits</b>	<b>VSP network doctor</b>	<b>Non-VSP provider</b>
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	<b>Combined</b> \$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
<b>Note:</b> No copay is required for prescribed contact lenses that are not medically necessary.		

<b>Eye exam</b>		
<b>Benefits</b>	<b>VSP network doctor</b>	<b>Non-VSP provider</b>
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 <b>consecutive</b> months		

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 10324MED;ASCMOD 7825 DEN;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ECMP-ASC;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HC (A) ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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## Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
<p><b>Standard</b> 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"> <li>Progressive Lenses - Covered when rendered by a VSP network doctor</li> </ul>	<p>\$10 copay (one copay applies to <b>both</b> lenses and frames)</p> <p>One pair of lenses, with or without frames, in any period of 12 <b>consecutive</b> 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><b>Note:</b> All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.</p>	<p>\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$10 copay (one copay applies to <b>both</b> frames and lenses)</p> <p>One frame in any period of 12 <b>consecutive</b> 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 <b>consecutive</b> months</p>	<p>Reimbursement up to \$210 less \$10 copay (member responsible for any difference)</p>
<p>Elective contact lenses that <b>improve</b> vision (prescribed, but do not meet criteria of medically necessary)</p>	<p>\$130 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 <b>consecutive</b> months</p>	<p>\$105 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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