Blue Cross Blue Shield of Michigan

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

Usui International Corporation
Group Number: 71505

Vision Coverage - Blue Vision
Effective Date: 01/01/2019
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. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 3,000 VSP provider locations in Michigan and 53,000 locations nationwide. To find a VSP provider, call **1-800-877-7195** or visit VSP's Web site at **www.vsp.com**.

Member's responsibility (copayments)

Benefits	VSP Provider	Out-of-Network Provider
Eye Exam	100%	100%
Frames and/or lenses or medically necessary contact lenses	No copay	Member responsible for difference between approved amount and provider's charge, after no copay
Benefit Maximum Maximum benefit for all eligible expenses	$400 per member	

Eye exams

Benefits	VSP Provider	Out-of-Network Provider
Covers a 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.	Covered - 100% Once every 12 months	Covered - 100%

Lenses and frames

Benefits	VSP Provider	Out-of-Network Provider
Covers standard eyeglass frames. A wide selection of quality frames is fully covered by VSP up to the frame allowance. Members should ask their doctor which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered - 100% Once every 12 months	Covered - 100%
Single vision, bifocal, trifocal or lenticular lenses in glass or plastic. **Note:** Additional pairs of prescription glasses and non-covered lens options are discounted when purchased from a VSP provider.	Covered - 100% (one copay applies to both lenses and frames) Once every 12 months	Covered - 100%

Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both

Benefits	VSP Provider	Out-of-Network Provider
Elective contact lenses (prescribed, but not medically necessary) may be chosen instead of spectacle lenses and a frame.	Once every 12 months	
Therapeutic contact lenses (medically necessary)	Covered - no copay	
	Once every 12 months	

Safety Eye Care Benefit:
Safety eye wear are prescription lenses and frames used for the purpose of safety glasses. Safety eye wear provides prescription glasses certified according to the requirements of the American National Standards Institute (ANSI).
This benefit is in addition to regular frames/lenses.
This coverage is provided for prescription coverage safety lenses and frames that are obtained from an in-network provider. Safety lenses/frames are NOT payable if provided by an out-of-network provider.
The maximum allowance for the frames is limited to $65, and there is no maximum allowance for the lenses.
The frequency/copayment for the safety glasses remains the same as the regular prescription lenses and frames.
This benefit is ONLY available for the SUBSCRIBER, not any dependents listed on the contract, including the spouse.