Blue Cross Blue Shield of Michigan

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Michigan Catholic Conference
Group Number: 71755 Package Code(s): 040
Division Code(s): 3000
Vision Coverage - Blue Choice VSP
Effective Date: 01/01/2027
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.

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	$10 copay	Reimbursement up to $45 less $10 copay
Lenses and/or frames	$10 copay combined with frames	Member responsible for difference between approved amount and provider's charge, less $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, less $10 copay

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 - $10 copay	Covered - reimbursement up to $45 less $10 copay
	Once every 12 months	

Lenses and frames

Benefits	VSP Provider	Out-of-Network Provider
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 - $10 copay combined with frames	Covered - reimbursement up to $30 for single vision lens; $50 for bifocal lens; $65 for trifocal lens; $100 for lenticular lens less $10 copay
	Once every 12 months	
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 - reimbursement up to $200 less $10 copay combined with lenses	Covered - reimbursement up to $70 less $10 copay
	Once every 12 months	

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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.	Covered - $200 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered - $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 Lens Suitability Exam	Covered - up to $40 copay	Not Covered
	Once every 12 months	
Therapeutic contact lenses (medically necessary)	Covered - $10 copay	Covered - reimbursement up to $210 less $10 copay
	Once every 12 months	

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