CITY OF JACKSON

Blue Vision℠ 12/12/12
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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

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.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay applies to $35 charge
Prescription glasses (lenses and/or frames)	A **combined** $10 copay	Member responsible for difference between approved amount and provider's charge, less a $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, less a $10 copay
Eye exam		
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 – $5 copay	Reimbursement up to $35, less a $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	
Lenses and frames		
Standard lenses (must not exceed 61 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. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	Covered – $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered – $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $45, less a $10 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

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Contact lenses	VSP network doctor	Non-VSP provider
Therapeutic/Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Covered - Reimbursement up to $210 maximum (member responsible for any difference) One pair of contact lenses in any period of 12 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	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) One pair of contact lenses in any period of 12 **consecutive** months	