



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

## ONE STOP PROPERTY MAINTENANCE

AOA-0000300082

### Vision Coverage

Effective Date: On or after January 2026

### 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. 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: Vision benefits are only available to covered members (subscribers, spouses and dependent children) age 19 and older.** Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

#### Member's responsibility (copays)

Benefits	In-network	Out-of-network
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

#### Eye exam

Benefits	In-network	Out-of-network
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 \$34 less \$5 copay (member responsible for any difference)
One eye exam every calendar year		

#### Lenses and Frames

Benefits	In-network	Out-of-network
<b>Standard lenses</b> (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. <b>Note:</b> Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	\$10 copay (one copay applies to <b>both</b> lenses and frames)	Reimbursement up to approved amount based on lens type less \$10 copay (member responsible for any difference)
One pair of lenses, with or without frames, every calendar year		

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Benefits	In-network	Out-of-network
Standard frames	\$200 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$10 copay (one copay applies to <b>both</b> lenses and frames)	Reimbursement up to \$38.25 less \$10 copay (member responsible for any difference)
One frame every 2 calendar years		

Contact Lenses		
Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	\$10 copay	Reimbursement up to \$210 less \$10 copay (member responsible for any difference)
One pair of contact lenses every calendar year		
Elective contact lenses that <b>improve</b> vision (prescribed, but does not meet criteria of medically necessary)	\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Contact lenses are covered up to allowance every calendar year		

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