



Monroe County Community College 37102-001 Vision Care (A80) Coverage 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.

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	Participating provider	Nonparticipating provider
Member's responsibility (copays)		
Eye exam	\$5 copay	\$5 copay
Prescription glasses (lenses and/or frames)	A combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge
Medically necessary contact lenses	\$7.50 copay	Member responsible for difference between approved amount and provider's charge
Eye exam		
Eye exam by a physician or optometrist	Covered – \$5 copay	Covered – 75% after \$5 copay
	One eye exam in any period of 24 consecutive months	
Lenses and frames		
Standard lenses, not to exceed 65 mm in diameter, when prescribed or dispensed by a physician, optometrist or optician	Covered – \$7.50 copay (one copay applies to both lenses and frames)	Covered – up to predetermined amount
	One pair of lenses, with or without frames, in any period of 24 consecutive months	
Standard frames	Covered – \$7.50 copay (one copay applies to both frames and lenses)	Covered – up to predetermined amount
	One frame in any period of 24 consecutive months	
Contact lenses		
Medically necessary contact lenses (must meet criteria of medically necessary)	Covered – \$7.50 copay	Covered – up to predetermined amount
	One pair of contact lenses in any period of 24 consecutive months	
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Covered – up to a maximum payment of \$35 per pair (member responsible for difference)	Covered – up to a maximum payment of \$35 per pair (member responsible for difference)
	One pair of contact lenses in any period of 24 consecutive months	

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