

State Health Plan PPO Vision Care Coverage

	Participating Provider	Nonparticipating Provider
Vision testing examination		
Eye exam	100% of BCBSM-approved amount minus \$5 copay	75% of BCBSM-approved amount minus \$5 copay
	Once every 12 months	
Frames – Members may obtain either eyeglasses or contact lenses, but not both		
Frames	Maximum varies based on bargaining unit minus \$7.50 copay*	Maximum of \$14.75 for 81823; \$14.00 for all other groups
	Once every 24 months, or once in every 12 months if prescription has changed	
Eyeglasses lenses (glass, plastic or prism)		
Single vision	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$13 per pair for glass; \$16 per pair for plastic, and \$15 per pair for prism; no copay
	Once every 24 months, or once in every 12 months if prescription has changed	
Bifocal (includes blended)	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$20 per pair for glass, \$23 per pair for plastic, and \$22 per pair for prism; no copay
	Once every 24 months, or once in every 12 months if prescription has changed	
Trifocal	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$24 per pair for glass, \$27 per pair for plastic, and \$26 per pair for prism; no copay
	Once every 24 months, or once in every 12 months if prescription has changed	
Special lenses	100% of BCBSM-approved amount minus \$7.50 copay*	50% or 75% of BCBSM-approved amount for comparable lenses, whichever is less
	Once every 24 months, or once in every 12 months if prescription has changed	
Rose tints # 1 and # 2	100% of BCBSM-approved amount	Maximum of \$3
	One every 24 months	
Contact Lenses – Members may obtain either eyeglasses or contact lenses, but not both		
Therapeutic contact lenses, medically necessary	100% of BCBSM-approved amount minus \$7.50 copay	Maximum of \$96; no copay
	One every 24 months	
Cosmetic contact lenses, not medically necessary	Maximum of \$90; no copay	Maximum of \$35 for 81826; \$40 for all other groups
	One every 24 months	
Copays		
• Eye exam	\$5 copay	\$5 copay
• Frames and/or lenses or therapeutic contact lenses	A combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge

*If member has already made a copay for lenses, no further copay is required.

Questions?

**Contact BCBSM's State of Michigan
Customer Service toll-free at 1-800-843-4876**

This benefit chart is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail. Payment amounts are based on the BCBSM-approved amount, less any applicable deductible and/or copay amount required by the SHP PPO. This coverage is provided pursuant to a contract entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan.