Vision care
Applies to:

Blue Cross Blue Shield of Michigan

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

☒ Medicare Plus Blue℠ PPO ☐ Medicare Plus Blue℠ Group PPO ☐ Both

Vision care

Vision care is designed to cover a member's preventive and routine visual needs, such as glaucoma testing for those at high risk, routine eye exams for both preventive and diagnostic purposes, and eyewear for corrective purposes.

Original Medicare

Original Medicare covers glaucoma tests once every 12 months for people who are at high risk. The beneficiary is at high risk if they have diabetes, a family history of glaucoma, are African–American and 50 years of age or older, or are Hispanic and age 65 or older. An eye doctor who is legally authorized by the state must perform the test.

Original Medicare also covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.

Original Medicare does not cover routine eye exams.

Medicare Plus Blue PPO Enhanced Benefit

Medicare Plus Blue is a Medicare Advantage Plan, which provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for additional, routine vision care benefits is provided to members under select individual Medicare Plus Blue PPO plans. Since Original Medicare does not cover routine vision care, the scope of the benefit, reimbursement methodology, maximum allowed payment amounts and member cost sharing are determined by Blue Cross.

Eye Exams

A routine eye exam is a complete assessment by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing, and other tests necessary to determine overall visual health. One routine eye exam is covered per any period of 12 consecutive months.

- $0 copay for up to one in-network routine eye exam
- $10 copay for up to one out-of-network (OON) routine eye exam

Eyewear

Eyewear must be prescribed and dispensed by an ophthalmologist or optometrist based on the findings of the most recent eye examination.

- One pair of lenses in any period of 24 consecutive months. Lenses (must not exceed 60 mm in diameter). Lenses may be molded or ground, glass or plastic. Slab–off prism and special base curve lenses are also covered when medically necessary.
  - — Single vision lenses
  - — Bifocal lenses

  - — Trifocal lenses
  - — Lenticular lenses
- One eyeglass frame in any period of 24 consecutive months
- Elective* contact lenses in lieu of lenses and frame, or medically necessary contact lenses, renewed in any period of 24 consecutive months
- Medically necessary** contact lenses in lieu of lenses and frame, or elective contact lenses, renewed in any period of 24 consecutive months

*Elective — prescribed by an ophthalmologist or optometrist, but does not meet the criteria of 'medically necessary'

** Medically necessary – requires approval from VSP and must meet the criteria of 'medically necessary'

Member Allowances:

Item	In-network	Out-of-network
Single vision lenses	N/A	$17.00
Bifocal lenses	N/A	$30.00
Trifocal lenses	N/A	$43.00
Lenticular lenses	N/A	$64.00
Frames	$100.00	$100.00
Elective contact lenses	$100.00	$100.00
Medically necessary contact lenses	N/A	$100.00

N/A Not applicable

Note: Members are responsible for all charges that exceed the allowances for the items listed above that are ordered and delivered by either in-network or OON providers.

Conditions for payment

In-network benefits are provided by Vision Service Plan (VSP) providers. Members can find a VSP provider by calling 1–800–877–7195. TTY users call 1–800–428–4833. Hours are 8 a.m. to 6 p.m., Monday through Friday. VSP network providers can also be located on-line by visiting the VSP website at: **https://www.vsp.com***.

Members do not require approval to utilize an OON provider. Should a member choose to receive services from an OON provider, the member is responsible to pay for all services out–of–pocket and to seek reimbursement from VSP for covered services, minus the member's cost–share and co–payments. Information on filing a claim for reimbursement of covered services is available on the VSP website **https://www.vsp.com***.

Reimbursement

Provider reimbursement is handled directly through VSP. The provider will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost–share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost–sharing

- Medicare Plus Blue PPO providers should collect the applicable cost-sharing from the member at the time of the service when possible. Cost–sharing refers to a flat–dollar copayment a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue PPO cost–sharing amounts from the member.
- If the member elects to receive a non–covered service, he or she is responsible for the entire charge associated with the non–covered service.

To verify benefits and cost–share, providers may utilize web–DENIS or call 1–866–309–1719.

Billing instructions for providers

Providers should contact VSP directly for billing instructions. The VSP website is **https://www.vsp.com***.

Revision History

Policy Number: MAPPO 1025

Revised: 8/2/2015, 2012

8/2/2015: Updated formatting, added revision history and policy number, revised Original Medicare coverage description, expanded definition of enhanced benefit coverage including in and out of network allowances, clarified that member reimbursement for out of network services is available through VSP, removed reference to CAREN for verification of member benefits.

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