

## 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<sup>SM</sup> PPO    Medicare Plus Blue<sup>SM</sup> 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<sup>SM</sup> PPO enhanced benefit

Medicare Plus Blue<sup>SM</sup> PPO 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 routine vision care is provided to members under all individual Medicare Plus Blue PPO plans. Additional coverage for supplemental eyewear is provided to members under select individual Medicare Plus Blue PPO plans. Since Original Medicare doesn't cover routine vision care and supplemental eyewear, 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 – \$10 copayment for up to one in-network routine eye exam, depending on the plan
- \$10 – \$20 copay for up to one out-of-network routine eye exam, depending on the plan
- \$34 member allowance for out-of-network routine eye exams

#### 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.

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- 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 doesn't 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	\$210.00
Routine eye exams	N/A	\$34.00

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 out-of-network providers.

Eye wear benefit provides a combined in- and out-of-network maximum benefit with 50% of allowed amounts up to \$100 every 12 months and may be used for either (a) elective contact lenses, or (b) one frame. Standard eyeglass lenses are reimbursed up to 50% of the allowed amount.

## Vision buy-up – optional supplemental

This plan offers some extra benefits that aren't covered by Original Medicare and not included in the enhanced benefits package. These extra benefits are called optional supplemental benefits. If a member chooses these optional supplemental benefits, they must sign up for them and may have to pay an additional premium. The optional supplemental benefits described are subject to the same appeals process as any other benefits.

Optional supplemental benefits are offered uniformly to all enrollees. Enrollees may choose to pay extra to receive coverage under the optional supplemental benefit. The optional supplemental benefit is paid for directly by the enrollee or on behalf of the enrollee through an additional premium and cost sharing.

### Optional supplemental vision

#### Essential, Vitality, Signature and Assure

##### In-Network

The optional eye wear benefit provides a \$250 (in addition to the enhanced vision benefit) combined in- and out-of-network maximum vision allowance every 12 months and may be used for either (a) elective contact lenses, or (b) frames.

##### Out-Of-Network

The optional eye wear benefit provides (in addition to the enhanced vision benefit) a combined in- and out-of-network maximum vision benefit with 50% coinsurance up to \$250 every 12 months and may be used for either (a) elective contact lenses, or (b) frames.

## Conditions for payment

In-network benefits are provided by Vision Service Plan 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 don't require approval to use an out-of-network provider. Should a member choose to receive services from out-of-network 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 sharing and copayments. 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 sharing. 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 that service.
- Cost sharing amounts incurred by the member under this benefit don't count toward the combined maximum out-of-pocket or to the deductible as listed in the Evidence of Coverage document.

To verify benefits and cost sharing, providers may use 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

Reviewed: 10/16/2020, 08/2018, 06/2016

Revised: 10/16/2020, 11/20/2019, 10/05/2018, 07/01/2016, 08/02/2015, 2012

10/16/2020: Updated the Out-of-Network section of the paper to reflect member cost share for optional supplemental coverage.

11/20/2019: Updated medically necessary contact lenses allowable amount from \$100 to \$210.

10/05/2018: Updated policy to add vision buy-up optional supplemental coverage.

07/01/2016: updated in-network copay from \$ 0 to \$0 to 10, depending on the plan; updated out-of-network copay from \$10 to \$10 to \$20, depending on the plan. Routine vision care applies to all individual plans. Supplemental eyewear applies only to select individual plans, added bullet indicating that cost sharing for these services do not apply to the plan's combined out-of-pocket maximum or deductible.

08/02/2015: 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 are available through VSP. Removed reference to CAREN for verification of member benefits.

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