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## EMERGING MARKETS

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

**Note:** Discounts up to 20% for additional prescription glasses and any amount over the allowance **plus** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

| Member's responsibility (copays)                                                                  |                              |                                                                                                     |
|---------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------|
| Benefits                                                                                          | VSP network doctor           | Non-VSP provider                                                                                    |
| Eye exam                                                                                          | \$5 copay                    | \$5 copay applies to charge                                                                         |
| Prescription glasses (lenses and/or frames)                                                       | <b>Combined</b> \$7.50 copay | Member responsible for difference between approved amount and provider's charge, after \$7.50 copay |
| Medically necessary contact lenses                                                                | \$7.50 copay                 | Member responsible for difference between approved amount and provider's charge, after \$7.50 copay |
| <b>Note:</b> No copay is required for prescribed contact lenses that are not medically necessary. |                              |                                                                                                     |

| Eye exam                                                                                                                                                                                |                    |                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------------------------|
| Benefits                                                                                                                                                                                | VSP network doctor | Non-VSP provider                                                                |
| 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 \$45 less \$5 copay (member responsible for any difference) |
| One eye exam in any period of 12 <b>consecutive</b> months                                                                                                                              |                    |                                                                                 |

ADM PLAN1R JAN;ADM SPA-HEQ-VIS;ASCMOD 11414VIS;BLUE VISION;BV-ARC;BV-PCL;BV-PL;BV-SGC;BV-UVC;BVC-\$7.50;BVFL;BVPP CHOICE NET;CDH  
FSADCFSA VC

## Lenses and frames

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | VSP network doctor                                                                                                                                                                                                                                        | Non-VSP provider                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <p><b>Standard</b> lenses 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.</p> <ul style="list-style-type: none"> <li>Progressive Lenses - Covered when rendered by a VSP network doctor</li> <li>Ultraviolet Coating - Covered when rendered by a VSP network doctor</li> <li>Scratch Guard Coating - Covered when rendered by a VSP network doctor</li> <li>Anti Reflective Coating - Covered when rendered by a VSP network doctor</li> <li>All tints - Covered when rendered by a VSP network doctor</li> </ul> | <p>\$7.50 copay (one copay applies to <b>both</b> lenses and frames)</p> <p>One pair of lenses, with or without frames, in any period of 12 <b>consecutive</b> months</p>                                                                                 | <p>Reimbursement up to approved amount based on lens type less \$7.50 copay (member responsible for any difference)</p> |
| <p>Standard frames</p> <p><b>Note:</b> All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>\$175 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less less \$7.50 copay (one copay applies to <b>both</b> frames and lenses)</p> <p>One frame in any period of 12 <b>consecutive</b> months</p> | <p>Reimbursement up to \$70 less \$7.50 copay (member responsible for any difference)</p>                               |

## Contact Lenses

| Benefits                                                                                                                                 | VSP network doctor                                                                                                                                                                                                                                               | Non-VSP provider                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)</p> | <p>\$7.50 copay</p> <p>Contact lenses up to the allowance in any period of 12 <b>consecutive</b> months</p>                                                                                                                                                      | <p>Reimbursement up to \$210 less \$7.50 copay (member responsible for any difference)</p>                                                                               |
| <p>Elective contact lenses that <b>improve</b> vision (prescribed, but do not meet criteria of medically necessary)</p>                  | <p>\$175 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p> <p>Contact lenses up to the allowance in any period of 12 <b>consecutive</b> months</p> | <p>\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p> |

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