



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

Accident Fund Holdings Inc

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Vision Coverage

Effective Date: On or after January 2027

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

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)	Combined \$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
Note: 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 \$50 less \$5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

ADM PLAN1R JAN;ADM SPA-HEQ-DEN;ADM SPA-HEQ-VIS;ASCMOD 11732MED;ASCMOD 11733DRG;ASCMOD 11734DEN;ASCMOD 11735VSH;BLUE DENTAL;BLUE VISION;BV-PL;BV-SGC;BV-UVC;BVC-\$7.50;BVFL;CDH FSADCFSA DC;CDH FSADCFSA VC;CDH-FSA-DC-FSA;DO-AO;DO-DI;DO-IN-C1-C0%;DO-IN-C2-C25%;DO-IN-C3-C50%;DO-IN-C4-C50%;DO-NP-C3-C50%;DO-NP-C4-C50%;DO-ON-C1-C0%;DO-ON-C2-C25%;DO-PC4X;DO-PPO;DO-RCR;dobm2600;doolm2400;HC (A) ASC;HEQ;L DORAF;PD-ESN ASC;PD-RX-CM ASC;PDRX ASC;PDTTC10/20/40 A;RX-VCP ASC;RXGLP-1 EXCLUS;SB ASC;SB-AMB ASC;SB-ECMP-ASC;SBD-IN\$500/\$1K;SBD-ON\$1K/\$2K A;SBOLV 20 ASC;SD ASC

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Lenses and frames		
Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) 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. - Progressive Lenses and Blended bi-focal lenses - Covered when rendered by a VSP network doctor - Ultraviolet Coating - Covered when rendered by a VSP network doctor - Scratch Guard Coating - Covered when rendered by a VSP network doctor	\$7.50 copay (one copay applies to both lenses and frames) One pair of lenses, with or without frames, in any period of 12 consecutive months	Reimbursement up to approved amount based on lens type less \$7.50 copay (member responsible for any difference)
Standard frames Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	\$150 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less less \$7.50 copay (one copay applies to both frames and lenses) One frame in any period of 12 consecutive months	Reimbursement up to \$70 less \$7.50 copay (member responsible for any difference)

Contact Lenses		
Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	\$7.50 copay Contact lenses up to the allowance in any period of 12 consecutive months	Reimbursement up to \$210 less \$7.50 copay (member responsible for any difference)
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$200 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance) Contact lenses up to the allowance in any period of 12 consecutive months	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

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Accident Fund Holdings Inc A1WWL2 0000000000002 Hearing Care Coverage Effective Date: On or after January 2027 Benefits-at-a-glance

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Member's responsibility (deductible and copay)

Note: Limited to a benefit maximum of \$2,707 for monaural hearing aids and binaural hearing aids every 36 months per member for participating providers.

Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

You **must** receive the following services from a **hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered
Hearing aid replacement - no limit during the 36 month benefit period, subject to review and approval	100% of approved amount	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office**

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visits.

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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