



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

Client: Bay Arenac Community High

Community BlueSM PPO Platinum \$250 Medical Coverage with Prescription Drugs Benefits-at-a-Glance - w/EA

Effective for groups on their plan year beginning on or after January 1, 2014

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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

In-network

Out-of-network *

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

	In-network	Out-of-network *
Deductibles	\$250 for one member \$500 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived for covered services performed in an in-network physician's office.	\$500 for one member \$1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	<ul style="list-style-type: none"> • \$20 copay for office visits and office consultations with a primary care provider • \$20 copay for office visits and office consultations with a specialist • \$20 copay for chiropractic services and osteopathic manipulative therapy • \$60 copay for urgent care visits • \$150 copay for emergency room visits 	\$150 copay for emergency room visits

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



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

In-network

Out-of-network *

Member's responsibility (deductibles, copays, coinsurance and dollar maximums), *continued*

<p>Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.</p>	<ul style="list-style-type: none"> • 50% of approved amount for bariatric surgery • 20% of approved amount for mental health care and substance abuse treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> • 50% of approved amount for bariatric surgery • 40% of approved amount for mental health care and substance abuse treatment • 40% of approved amount for most other covered services
<p>Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts</p>	<p>\$1,000 for one member \$2,000 for two or more members each calendar year</p>	<p>\$2,000 for one member \$4,000 for two or more members each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.</p>
<p>Lifetime dollar maximum</p>	<p>None</p>	

Preventive care services

<p>Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures</p>	<p>100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.</p>	<p>Not covered</p>
<p>Gynecological exam</p>	<p>100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.</p>	<p>Not covered</p>
<p>Pap smear screening – laboratory and pathology services</p>	<p>100% (no deductible or copay/coinsurance), one per member per calendar year</p>	<p>Not covered</p>
<p>Voluntary sterilizations for females</p>	<p>100% (no deductible or copay/coinsurance)</p>	<p>60% after out-of-network deductible</p>
<p>Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician</p>	<p>100% (no deductible or copay/coinsurance)</p>	<p>100% after out-of-network deductible</p>
<p>Contraceptive injections</p>	<p>100% (no deductible or copay/coinsurance)</p>	<p>60% after out-of-network deductible</p>
<p>Well-baby and child care visits</p>	<p>100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit </p>	<p>Not covered</p>
<p>Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act</p>	<p>100% (no deductible or copay/coinsurance)</p>	<p>Not covered</p>
<p>Fecal occult blood screening</p>	<p>100% (no deductible or copay/coinsurance), one per member per calendar year</p>	<p>Not covered</p>
<p>Flexible sigmoidoscopy exam</p>	<p>100% (no deductible or copay/coinsurance), one per member per calendar year</p>	<p>Not covered</p>
<p>Prostate specific antigen (PSA) screening</p>	<p>100% (no deductible or copay/coinsurance), one per member per calendar year</p>	<p>Not covered</p>

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



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

In-network

Out-of-network *

Preventive care services, *continued*

Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
One per member per calendar year		
Colonoscopy – routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
One per member per calendar year		

Physician office services

Office visits – must be medically necessary	<ul style="list-style-type: none"> \$20 copay for each office visit with a primary care provider \$20 copay for each office visit with a specialist 	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	<ul style="list-style-type: none"> \$20 copay for each office consultation with a primary care provider \$20 copay for each office consultation with a specialist 	60% after out-of-network deductible
Urgent care visits – must be medically necessary	\$60 copay per office visit	60% after out-of-network deductible

Emergency medical care

Hospital emergency room	\$150 copay per visit (copay waived if admitted or for an accidental injury)	\$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



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

In-network

Out-of-network *

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
Limited to a maximum of 120 days per member per calendar year		
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males Note: For voluntary sterilizations for females, see “ Preventive care services. ”	80% after in-network deductible	60% after out-of-network deductible
Elective abortions	80% after in-network deductible	60% after out-of-network deductible
Gender reassignment surgery	Not covered	Not covered
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
Limited to a lifetime maximum of one bariatric procedure per member		

Human organ transplants

Specified human organ transplants – must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities only
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a “low access area” by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider’s charge.

In-network

Out-of-network *

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will be responsible for your annual in-network deductible and you will be responsible for the member copay that applies to office visits. However, when these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Inpatient mental health care and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities only
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. ABA and AAEC services are not available outside of Michigan.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is limited to the same annual combined limit as for other diagnoses (limit combined for both rehabilitation and habilitative)	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	<ul style="list-style-type: none"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit	60% after out-of-network deductible
	Limited to a combined 30-visit maximum per member per calendar year (visits are combined with outpatient physical and occupational therapy)	

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



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

In-network

Out-of-network *

Other covered services, *continued*

Outpatient physical and occupational therapy – provided for rehabilitation/habilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a 30-visit maximum per member per calendar year Note: This 30-visit outpatient maximum is a <u>combined</u> maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.	
Outpatient speech therapy	80% after in-network deductible	60% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	Not covered	Not covered

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



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

Blue Preferred[®] Rx Prescription Drug Coverage Benefits-at-a-Glance

Specialty Pharmaceutical Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a “specialty pharmaceutical” whether or not the drug is obtained from a **90-Day Retail Network provider** or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member’s responsibility (copays)

Note: Your prescription drug copays, including mail order copays, are subject to the same annual out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 – Generic drugs	1 to 30-day period	\$10 copay	\$10 copay	\$10 copay	\$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	\$20 copay	No coverage	No coverage
	61 to 83-day period	No coverage	\$20 copay	No coverage	No coverage
	84 to 90-day period	\$20 copay	\$20 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	\$40 copay	\$40 copay	\$40 copay	\$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	\$80 copay	No coverage	No coverage
	61 to 83-day period	No coverage	\$110 copay	No coverage	No coverage
	84 to 90-day period	\$110 copay	\$110 copay	No coverage	No coverage
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	\$80 copay	\$80 copay	\$80 copay	\$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	\$160 copay	No coverage	No coverage
	61 to 83-day period	No coverage	\$230 copay	No coverage	No coverage
	84 to 90-day period	\$230 copay	\$230 copay	No coverage	No coverage

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin, or other covered injectable legend drugs Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

BCBSM Custom Select Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ Tier 1 (generic) – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ Tier 2 (preferred brand) – Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand-name drugs are also safe and effective, but require a higher copay. ▪ Tier 3 (nonpreferred brand) – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at bcbsm.com/pharmacy.</p>
Drug interchange and generic copay waiver	<p>BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>



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

Blue VisionSM (Pediatric Only) Benefits-at-a-Glance

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: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

	In-network	Out-of-network
Member's responsibility (copays)		
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None
Eye exam		
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.	100% of approved amount	Reimbursement up to \$34 (member responsible for any difference)
	One eye exam per calendar year	
Lenses and frames		
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. Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to \$38.25 (member responsible for any difference)
	One frame per calendar year	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to \$210 (member responsible for any difference)
	Covered – annual supply	
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary) If prescription contact lenses do not meet criteria for medically necessary, members may elect one of the following quantities of lenses as covered in full: <ul style="list-style-type: none"> Standard (one pair annually) – 1 contact lens per eye (total of 2 lenses) Monthly (six-month supply) – 6 contact lenses per eye (total of 12 lenses) Bi-weekly (six-month supply) – 12 contact lenses per eye (total of 24 lenses) Dailies (two-month supply) – 60 contact lenses per eye (total of 120 lenses) 	100% of approved amount	\$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	