State Employee Health Plan

Health Plan Comparison Chart

and other information

Don't forget to declare your tobacco status. You must do this every year!

For Active Employees

OPEN ENROLLMENT 2010

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Health Plan Comparison Chart

	Plan A		Plan B		Plan C – QHDHP with Health Savings Account	
	Blue Cross and Blue Shield Coventry Preferred Health Systems UMR, A UnitedHealthcare Company		Blue Cross and Blue Shield Coventry Preferred Health Systems UMR, A UnitedHealthcare Company		Coventry Preferred Health Systems UMR, A UnitedHealthcare Company	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers	Network Providers	Non Network Providers
Basic Provisions						
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status					
Annual Deductible: not included in Coinsurance maximums in Plans A & B	$150 single/$300 family	$500 single/$1,500 family	N/A	$500 single/$1,500 family	*Note: When selecting any level of dependent coverage, the entire family deductible must be met before claims are paid for any covered person.* $1,500 single/$3,000 family	$2,000 single/$4,000 family
Coinsurance *(for all eligible expenses, unless otherwise noted)*	20% Coinsurance	50% Coinsurance	30% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
Annual Coinsurance Maximum	$1,200 single/$2,400 family *(does not include Deductible and Copayments)*	$3,650 single/$7,300 family *(does not include Deductible and Copayments)*	$2,200 single/$4,400 family *(does not include Copayments)*	$3,650 single/$7,300 family *(does not include Deductible and Copayments)*	N/A	N/A
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A	$3,000 single/$6,000 family *(includes deductible and Coinsurance)*	$3,650 single/$7,300 family *(includes deductible and Coinsurance)*
Lifetime Benefit Maximum	No limit	No limit	No limit	No limit	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Member responsibility	Provider to write off	Member responsibility	Provider to write off	Member responsibility
Covered Services						
Inpatient Services	Deductible & 20% Coinsurance	$600 Copayment, Deductible & 50% Coinsurance	30% Coinsurance	$600 Copayment, Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physician Office Visits						
Primary Care Provider	$20 Copayment	Deductible & 50% Coinsurance	Adults: $20 Copayment/ Dependent children age 18 and under: $10 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Specialist	$40 Copayment	Deductible & 50% Coinsurance	Adults: $40 Copayment / Dependent children age 18 and under: $25 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance

Urgent care center	$20 Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	$20 Copayment & 30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Emergency Room Visits	$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	$200 Copayment (waived if admitted) then Deductible & 50% Coinsurance	$100 Copayment (waived if admitted) then 30% Coinsurance	$200 Copayment (waived if admitted) then Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	30% Coinsurance	Deductible & 30% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Major Diagnostic Tests	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Home Health Care *services must be pre-approved by health plan*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Hospice *services must be pre-approved by health plan; limited to six months*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physical Rehabilitation Services: *including chiropractic care (services limited to those medically necessary and appropriate: medical records must show continued improvement)*						
Inpatient facility	Deductible & 20% Coinsurance	$600 Copayment, Deductible & 50% Coinsurance	30% Coinsurance	$600 Copayment, Deductible & 50% Coinsurance	Deductible & 20% Coinsurance: limited to 20 days per calendar year	Deductible & 50% Coinsurance: limited to 20 days per calendar year
Outpatient facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance: • Both facility and office based Outpatient Rehab is limited to 20 visits per calendar year • Chiropractic is limited to 26 visits per calendar year	Deductible & 50% Coinsurance: • Both facility and office based Outpatient Rehab is limited to 20 visits per calendar year • Chiropractic is limited to 26 visits per calendar year
Office based	Deductible & 20% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year	30% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year		
Durable Medical Equipment	Deductible & 20% Coinsurance: limited to $5,000 per person per year	Deductible & 50% Coinsurance: limited to $5,000 per person per year	30% Coinsurance: limited to $5,000 per person per year	Deductible & 50% Coinsurance: limited to $5,000 per person per year	Deductible & 20% Coinsurance: limited to $1,000 per person per year	Deductible & 50% Coinsurance: limited to $1,000 per person per year
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Antigen Administration: *desensitization/treatment; allergy shots*	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Infertility Treatment: *limited to testing & three attempts at artificial insemination per year*	Office visit Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Office visit Copayment & 30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance; diagnosis & surgical treatment only; limited to $2,000 per year	Deductible & 50% Coinsurance; diagnosis & surgical treatment only; limited to $2,000 per year

Licensed Dietitian Consultation: *for medical management of a documented disease*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Mental Health						
Mental Illness & Drug or Alcohol Treatment	Same Coverage as Medical					
Preventive Care						
Age Appropriate Routine Physical Exam	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Well-Woman Care: *office visit, PAP smear test & STD testing*	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Well-Man Care: *office visit & PSA blood test*	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Mammogram	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Covered Immunizations	Covered in full	Dependent children up to age 6: Covered in full Adults: Deductible & 50% Coinsurance	Covered in full	Dependent children up to age 6: Covered in full Adults: Deductible & 50% Coinsurance	Covered in full	Dependent children up to age 6: Covered in full Adults: Deductible & 50% Coinsurance
Routine Hearing Exam	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Routine Vision Exam: *refraction exam for glasses; lenses & frames **not** covered*	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Age Appropriate Bone Density Screening	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Colonoscopy	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Non Covered Services						
TMJ/Orthognathic Treatment	Not covered under medical: see dental, limited					
Weight Loss Surgery	Not covered; see FSA					
Prescription Drugs						
Prescription Drug Services	Covered by separate contract with Caremark					
Dental						
Dental Services	Covered by separate contract with Delta Dental					

The comparison chart is NOT the governing document. Members need to refer to the Certificate of Coverage and Benefit Descriptions posted on ***http:www.khpa.ks.gov*** 2010 Open Enrollment Website.

Health Savings Account - Only Available with Plan C

Plan C - QHDHP HSA				
	Full-Time Employee		Part-Time Employee	
	Employee Only	Employee + Dependents	Employee Only	Employee + Dependents*
Employer Contribution		$56.25 ($1,350.00 per year)	$28.13 ($675.12 per year)	$42.19 ($1,012.56 per year)
Employee Contributions	$25.00 to $89.58	$25.00 to $200.00	$25.00 to $98.95	$25.00 to $214.06

**The HSA contribution maximums for Employee + Spouse, Employee + Children, or Employee + Family are the same.*

Note: All columns represent 24 semi-monthly payments. The HSA total State contribution for nine-month Regents employees are distributed evenly over 16 pay periods each year.

Banking Institutions for Plan C – Qualified High Deductible Health Plans with Health Savings Accounts - go to www.khpa.ks.gov for more information.

- **Coventry – UMB Bank**
- **Preferred Health Systems – Health Equity**
- **UMR, A UnitedHealthcare Company – American Chartered Bank**

Prescriptions Drug Benefits for Plan A and Plan B

Tier	Type of Prescription Medication	You Pay	Your Coinsurance Maximum
Tier 1	**Generic drugs**	20% Coinsurance	There is a combined Coinsurance maximum of $2,580 per person/year that applies to Tiers 1, 2 and 3.
Tier 2	**Preferred brand name drugs**	35% Coinsurance	
Tier 3	**Special Case Medications** (Very high-cost medications used to treat conditions that are generally life threatening)	$75 Copayment per standard fill or 30-day supply	
Tier 4	**Non preferred brand name drugs**	60% Coinsurance	N/A (unless an override has been granted by Caremark)
Tier 5	**Discount Tier medications**	100% of discounted price	N/A

Preferred drug list, specialty drug list and discount tier list available on the web at www2.caremark.com/kse

Prescription Drug Chronic Care Benefit for Plan A and Plan B

Prescription Drugs for:	Prescription Drug Product	Member Responsibility Per 30-Day Supply
Diabetes	Generic drug	10% to a maximum of $10
	Preferred brand name drug	20% to a maximum of $20
Asthma	Generic drug	10% to a maximum of $10
	Preferred brand name drug	20% to a maximum of $20

Prescription Drug Benefits for Plan C - QHDHP

	Network	Non Network
Generic	Deductible then $10 Copayment	Deductible then $20 Copayment
Preferred	Deductible then $30 Copayment	Deductible then $60 Copayment
Non Preferred	Deductible then $55 Copayment	Deductible then $110 Copayment

Prescription drugs covered by Plan C are subject to an annual Deductible then Copayments. Copay is per each 30 day supply. Plan includes generic incentive program.

Flexible Spending Account - Not Available with Plan C

	Health Care FSA		Dependent Care FSA	
	Minimum	Maximum	Minimum	Maximum
24 semi-monthly payroll deductions	$8.00	$208.33	$16.00	$208.33
16 semi-monthly payroll deductions	$12.00	$312.50	$24.00	$312.50

2010 Semi-Monthly Base Rates for State of Kansas Active Employees

Employee Category/ Annual Pay	Plan A				Plan B				HDHP			Delta Dental	Superior Vision Services – Basic	Superior Vision Services – Enhanced
	Blue Cross Blue Shield of Kansas	Coventry	Preferred Health Systems	UMR A United Healthcare Company	Blue Cross Blue Shield of Kansas	Coventry	Preferred Health Systems	UMR A United Healthcare Company	Coventry	Preferred Health Systems	UMR A United Healthcare Company			
Full-Time 1: Less than $28,000														
Employee Only	$24.63	$24.52	$24.96	$24.14	$24.40	$24.30	$24.71	$23.93	$22.25	$22.25	$22.25	$0.00	$2.18	$3.63
Employee + Spouse	$109.58	$107.49	$115.92	$100.10	$105.10	$103.11	$111.13	$96.10	$70.61	$70.61	$70.61	$6.76	$4.36	$7.26
Employee + Children	$92.14	$90.46	$97.25	$84.51	$88.53	$86.93	$93.38	$81.28	$60.49	$60.49	$60.49	$5.41	$3.93	$6.53
Employee + Family	$173.71	$170.12	$184.60	$157.48	$166.03	$162.62	$176.37	$150.61	$105.47	$105.47	$105.47	$12.17	$6.10	$10.16
Full-Time 2: $28,000 to $48,000														
Employee Only	$29.58	$29.36	$30.26	$28.57	$29.10	$28.89	$29.74	$28.14	$22.25	$22.25	$22.25	$0.00	$2.18	$3.63
Employee + Spouse	$119.49	$117.17	$126.54	$108.96	$114.51	$112.30	$121.20	$104.52	$70.61	$70.61	$70.61	$6.76	$4.36	$7.26
Employee + Children	$101.06	$99.17	$106.80	$92.48	$97.00	$95.20	$102.45	$88.86	$60.49	$60.49	$60.49	$5.41	$3.93	$6.53
Employee + Family	$187.56	$183.65	$199.43	$169.87	$179.18	$175.46	$190.45	$162.37	$105.47	$105.47	$105.47	$12.17	$6.10	$10.16
Full-Time 3: More than $48,000														
Employee Only	$34.54	$34.20	$35.57	$33.00	$33.81	$33.49	$34.79	$32.35	$22.25	$22.25	$22.25	$0.00	$2.18	$3.63
Employee + Spouse	$129.38	$126.83	$137.13	$117.81	$123.91	$121.48	$131.27	$112.92	$70.61	$70.61	$70.61	$6.76	$4.36	$7.26
Employee + Children	$109.96	$107.86	$116.33	$100.44	$105.46	$103.46	$111.51	$96.42	$60.49	$60.49	$60.49	$5.41	$3.93	$6.53
Employee + Family	$201.42	$197.18	$214.27	$182.26	$192.35	$188.33	$204.56	$174.15	$105.47	$105.47	$105.47	$12.17	$6.10	$10.16
All Part-Time														
Employee Only	$69.18	$68.03	$72.66	$63.98	$66.72	$65.63	$70.03	$61.78	$44.74	$44.74	$44.74	$3.76	$2.18	$3.63
Employee + Spouse	$182.56	$178.76	$194.07	$165.37	$174.43	$170.82	$185.37	$158.10	$106.47	$106.47	$106.47	$12.29	$4.36	$7.26
Employee + Children	$159.43	$156.17	$169.30	$144.68	$152.46	$149.37	$161.84	$138.45	$93.67	$93.67	$93.67	$10.59	$3.93	$6.53
Employee + Family	$269.43	$263.61	$287.09	$243.09	$256.96	$251.43	$273.74	$231.94	$152.02	$152.02	$152.02	$19.12	$6.10	$10.16
HealthyKIDS Participants														
Employee + Children	$40.68	$40.20	$42.14	$38.49	$39.64	$39.18	$41.03	$37.57	$28.98	$28.98	$28.98	$1.21	$3.93	$6.53
Employee + Family	$122.23	$119.84	$129.47	$111.43	$117.12	$114.85	$124.00	$106.86	$67.20	$67.20	$67.20	$7.96	$6.10	$10.16

2010 Semi-Monthly Non-Tobacco User Discount Rates for State of Kansas Active Employees

Employee Category/ Annual Pay	Plan A				Plan B				HDHP			Delta Dental	Superior Vision Services – Basic	Superior Vision Services – Enhanced
	Blue Cross Blue Shield of Kansas	Coventry	Preferred Health Systems	UMR A United Healthcare Company	Blue Cross Blue Shield of Kansas	Coventry	Preferred Health Systems	UMR A United Healthcare Company	Coventry	Preferred Health Systems	UMR A United Healthcare Company			
Full-Time 1: Less than $28,000														
Employee Only	$4.63	$4.52	$4.96	$4.14	$4.40	$4.30	$4.71	$3.93	$2.25	$2.25	$2.25	$0.00	$2.18	$3.63
Employee + Spouse	$89.58	$87.49	$95.92	$80.10	$85.10	$83.11	$91.13	$76.10	$50.61	$50.61	$50.61	$6.76	$4.36	$7.26
Employee + Children	$72.14	$70.46	$77.25	$64.51	$68.53	$66.93	$73.38	$61.28	$40.49	$40.49	$40.49	$5.41	$3.93	$6.53
Employee + Family	$153.71	$150.12	$164.60	$137.48	$146.03	$142.62	$156.37	$130.61	$85.47	$85.47	$85.47	$12.17	$6.10	$10.16
Full-Time 2: $28,000 to $48,000														
Employee Only	$9.58	$9.36	$10.26	$8.57	$9.10	$8.89	$9.74	$8.14	$2.25	$2.25	$2.25	$0.00	$2.18	$3.63
Employee + Spouse	$99.49	$97.17	$106.54	$88.96	$94.51	$92.30	$101.20	$84.52	$50.61	$50.61	$50.61	$6.76	$4.36	$7.26
Employee + Children	$81.06	$79.17	$86.80	$72.48	$77.00	$75.20	$82.45	$68.86	$40.49	$40.49	$40.49	$5.41	$3.93	$6.53
Employee + Family	$167.56	$163.65	$179.43	$149.87	$159.18	$155.46	$170.45	$142.37	$85.47	$85.47	$85.47	$12.17	$6.10	$10.16
Full-Time 3: More than $48,000														
Employee Only	$14.54	$14.20	$15.57	$13.00	$13.81	$13.49	$14.79	$12.35	$2.25	$2.25	$2.25	$0.00	$2.18	$3.63
Employee + Spouse	$109.38	$106.83	$117.13	$97.81	$103.91	$101.48	$111.27	$92.92	$50.61	$50.61	$50.61	$6.76	$4.36	$7.26
Employee + Children	$89.96	$87.86	$96.33	$80.44	$85.46	$83.46	$91.51	$76.42	$40.49	$40.49	$40.49	$5.41	$3.93	$6.53
Employee + Family	$181.42	$177.18	$194.27	$162.26	$172.35	$168.33	$184.56	$154.15	$85.47	$85.47	$85.47	$12.17	$6.10	$10.16
All Part-Time														
Employee Only	$49.18	$48.03	$52.66	$43.98	$46.72	$45.63	$50.03	$41.78	$24.74	$24.74	$24.74	$3.76	$2.18	$3.63
Employee + Spouse	$162.56	$158.76	$174.07	$145.37	$154.43	$150.82	$165.37	$138.10	$86.47	$86.47	$86.47	$12.29	$4.36	$7.26
Employee + Children	$139.43	$136.17	$149.30	$124.68	$132.46	$129.37	$141.84	$118.45	$73.67	$73.67	$73.67	$10.59	$3.93	$6.53
Employee + Family	$249.43	$243.61	$267.09	$223.09	$236.96	$231.43	$253.74	$211.94	$132.02	$132.02	$132.02	$19.12	$6.10	$10.16
HealthyKIDS Participants														
Employee + Children	$20.68	$20.20	$22.14	$18.49	$19.64	$19.18	$21.03	$17.57	$8.98	$8.98	$8.98	$1.21	$3.93	$6.53
Employee + Family	$102.23	$99.84	$109.47	$91.43	$97.12	$94.85	$104.00	$86.86	$47.20	$47.20	$47.20	$7.96	$6.10	$10.16

Delta Dental Benefits

	Delta Dental PPO Network Provider	Delta Dental Premier Network Provider	Non Network* Provider
Annual Benefit Maximum	$1,700 per member		
Lifetime Orthodontic Benefit Maximum	50% Coinsurance to a $1,000 per member		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	$50 per person per Plan year Not to exceed an annual family Deductible of $150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT Applies when you have NOT had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

**Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.*

Your Coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

Vision Benefits

Service or Item	Basic Plan: Network	Enhanced Plan: Network	Both Plans: Non Network
Eye Exams: Subject to $50 Copayment			
• Eye exam, M.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
• Eye exam, O.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
Eyeglasses: Subject to $25 materials Copayment			
• Frame	Up to $100 retail*	Up to $100 retail*	Up to $45
• Single vision lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $31
• Bifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $51
• Trifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $64
• Lenticular lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $80
• Progressive lenses, pair	Not covered	Covered up to $165*	Not covered
• High index lenses, pair**	Not covered	Covered up to $116*	Not covered
• Polycarbonate lenses, pair**	Not covered	Covered up to $116*	Not covered
• Scratch coat	Not covered	Covered in full	Not covered
• UV coat	Not covered	Covered in full	Not covered
Contact Lenses: Not subject to materials Copayment			
• When medically necessary	Covered in full	Covered in full	Up to $210 retail*
• Elective/cosmetic retail	Up to $150 retail*	Up to $150 retail*	Up to $105 retail*
Contact Lens Exam (fitting fee) ($35 Copayment)			
• Specialty contacts***	Not Covered	Up to $50*	Not Covered
• Standard Contacts****	Not Covered	Covered in full	Not Covered

**You are responsible for any charges above the allowance.*
*** You may only be covered for one pair of high index lenses or polycarbonate lenses under the Enhanced Plan (up to the allowance provided above).*
**** Specialty contacts are for new contact lens wearers or patients who wear toric, gas permeable or multi-focal lenses; includes two follow-up visits within three months of initial fitting.*
***** Standard contacts are for existing contact lens wearers of disposable, daily wear or extended lenses; includes two follow-up visits within three months of initial fitting.*

Notes:
- Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same plan year.
- For non network claims, Copayment amounts are deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.