State Employee Health Plan

Health Plan Comparison Chart

and other information

For Non State Employer Groups

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					
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.

STATE EMPLOYEE HEALTH PLAN (SEHP) ENROLLMENT FORM

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

For HR Use ONLY	
EMPLOYEE ID #	
STATE AGENCY #	
NON STATE GROUP #	
EFFECTIVE DATE	

EMPLOYEE INFORMATION (EMPLOYEE MUST COMPLETE) – (EMPLOYEES AND SPOUSES AGE 65 AND OVER MUST ALSO COMPLETE HEALTH CARE SELECTION FORM).

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	GENDER M F O O	Date of Birth (Mo/Day/Yr)	MAILING ADDRESS O Current Address O Change of Address
				STREET ADDRESS
				CITY, STATE ZIP COUNTY

EMPLOYEE INFORMATION – (EMPLOYER MUST COMPLETE)

Date currently employed in eligible position	Date employed in non-eligible position (if applicable)

NON STATE/REGENTS BENEFIT PROGRAM GROUP

Must check only one

O P1 O F1 O F2 O F3

TYPE OF ACTION – (EMPLOYER MUST COMPLETE)

O Open Enrollment
O New Address (See Above)

O New Employee

O Other (specify) ______________________

Date of Event ___/___/___

COVERAGE ELECTION - (EMPLOYEE MUST COMPLETE)

GENERAL INFORMATION (CHECK ONE)
How do you wish to pay for the cost of coverage?
O Before Tax O After-tax

TOBACCO USE - Do you use any form of tobacco? Please see Non Tobacco use information on back of this form.
O Yes* O No O Choose not to disclose
*If you answered yes, are you willing to enroll in the HealthQuest tobacco cessation program? O Yes O No

MEDICAL INSURANCE PROVIDER - (CHECK ONE)

Blue Cross and Blue Shield	Coventry Health Care of Kansas	Preferred Health Systems	UMR-A UnitedHealthCare Company
O Plan A	O Plan A	O Plan A	O Plan A
O Plan B	O Plan B	O Plan B	O Plan B
	O Plan C –attach HSA Form	O Plan C –attach HSA Form	O Plan C –attach HSA Form

MEDICAL AND PRESCRIPTION DRUG COVERAGE LEVEL (CHECK ONE)
O Waive Coverage
O 1 Member only
O 2 Member and Spouse
O 3 Member and Child(ren)
O 4 Member and Family

DENTAL COVERAGE LEVEL (CHECK ONE) – (4 - DEPENDENT DENTAL IS AVAILABLE ONLY IF DEPENDENT MEDICAL COVERAGE IS SELECTED – AND WILL BE AT THE SAME LEVEL AS MEDICAL)
O 1 Member only
O 4 Dependent Dental

VISION COVERAGE PLAN (CHECK ONE)
O Basic Plan O Enhanced Plan O Waive Vision Coverage

VISION COVERAGE LEVEL (CHECK ONE)
O 1 Member only
O 2 Member and Spouse
O 3 Member and Child(ren)
O 4 Member and Family

DEPENDENT INFORMATION (List spouse and/or unmarried dependent children to be covered – subject to definition and Relationship codes on reverse)

Relationship Code (See back of form)	Name (Last, First, MI)	Social Security Number (Required)	Gender M F	Date of Birth Month / Day / Year
			O O	
			O O	
			O O	
			O O	

DEPENDENT ADDRESS: O Same As Employee O Different – **PLEASE PROVIDE**: ______________________

MEDICARE (If you, your spouse and/or dependent is eligible for Medicare and are to be covered under the SEHP, please complete the following information and attach copies of all Medicare cards as they are REQUIRED.)

Name (Last, First, MI)	Hospital (Part A) (Mo/Day/Yr)	Medical (Part B) (Mo/Day/Yr)	Medicare Claim Number

EMPLOYEE AUTHORIZATION: By my signature below, I agree to the Terms and Conditions as listed on the reverse of this form. I also understand that I must provide supporting documentation regarding any change in family status along with this enrollment form in order for my form to be processed.

Signed: ______________________ Date: ________
EMPLOYEE SIGNATURE – DO NOT PRINT

PERSONNEL OFFICER AUTHORIZATION: By my signature below, I understand that incomplete forms and forms submitted without required supporting documentation will be returned to me and must be returned to KHPA within 31 days of the qualifying event.
Personnel Officer Printed Name: ______________________
Personnel Officer Signature: ______________________
Telephone Number (include ext.): ______________ Date: ________

Rev. 08/09

AUTHORIZATION: TERMS AND CONDITIONS

NON TOBACCO USER DISCOUNT

1. **I AM A TOBACCO USER**
   - **a.** I agree to allow the State of Kansas Health Care Commission and/or Kansas Health Policy Authority to enroll me in a cessation program that I will complete, to their satisfaction, prior to the end of the 2010 plan year as a condition to obtaining the discount.

     By making this election I affirmatively declare that I am a tobacco user. However, prior to the end of the 2010 plan year, I will complete the tobacco cessation program in which I shall be enrolled by the State of Kansas Health Care Commission and/or Kansas Health Policy Authority. As a direct result of my agreement to complete this cessation program, I will receive the non-tobacco user discount for the 2010 plan year.

   - **b.** I will not enroll in or complete a cessation program and understand that I will not get the discount.

     By making this election I affirmatively declare that I am a tobacco user and choose not to participate in the non-tobacco user discount for the 2010 plan year.

2. **I AM NOT A TOBACCO USER**
   - **a.** By making this election I affirmatively declare that I will not use tobacco, in any form, during the 2010 plan year. I understand that even a single instance of tobacco use may constitute a fraudulent misrepresentation on my part and may subject me to penalties which may include, but may not be limited to, elimination of employer contribution to my health insurance premium.

3. **I CHOOSE NOT TO DISCLOSE MY STATUS**
   - **a.** I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing not to participate in the non-tobacco user discount for the 2010 plan year. No negative inferences shall be made based on my decision not to disclose my status.

I acknowledge that if I do not make a Tobacco Use election and do not return this form, I will automatically be defaulted to the base rate and will not be able to participate in the non tobacco user discount for the 2010 plan year.

COVERAGE LEVEL CODES:
1 = Member Only
2 = Member and Spouse Only
3 = Member and Child(ren) Only
4 = Member and Family (Spouse AND Child(ren))

RELATIONSHIP CODES:
SP = spouse
D = daughter
P = stepson or stepdaughter
S = son
GC = grandson or granddaughter
L = legal custody dependent
XX = qualified medical child support order
H = handicapped child over age 23

• I have read and agree to the provisions in both the "State of Kansas Open Enrollment Booklet" and the "State of Kansas Benefits Guidebook" for the plan year in which I am enrolling.

• I am responsible for reviewing my benefit selections and the deductions for coverage on the State of Kansas Employee Service Center and my payroll statement. If there is an error on my payroll statement, I must contact my personnel officer within 14 working days in order to make any corrections. If I fail to take this action timely, I waive my right to correct my election for the remainder of the current plan year.

• If enrolling in SEHP coverage, I authorize the deduction from my earnings for the cost of coverage which I have selected. I understand that payment on a pretax basis means that my gross pay will be reduced by the cost of the coverage before federal, state, FICA and Medicare taxes are deducted.

• I verify the information on the Enrollment Form to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained on this Enrollment Form will be used to determine eligibility for coverage. I further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force.

• If waiving coverage in the SEHP at this time, I understand that enrollment at a later date is subject to late enrollment restrictions and may or may not be approved.

• I cannot start, change or stop any pretax election until the next open enrollment period unless I experience a qualifying event. **If I experience a qualifying event, I must complete an enrollment or Change Form within 31 calendar days of the event causing the change. I must provide appropriate supporting documentation of the event. KHPA must receive the completed form and appropriate supporting documentation within 10 days of completion.**

• If enrolling my dependent(s) for coverage, I certify that they meet the requirements for dependent coverage. Any attempt by me to enroll dependents which do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law. **I must provide appropriate proof of dependency for each dependent such as marriage license or birth certificate, along with the Enrollment or Change Form.**

• Any open enrollment change made in anticipation of a qualifying event such as a pending divorce will not be allowed. If I am in the midst of divorce proceedings, my covered spouse cannot be dropped from coverage until the granting of the final divorce decree.

• I agree to the following terms for myself and my dependents:
Unless otherwise prevented by law, we authorize health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance provider or its authorized representatives. Except as otherwise prevented by law, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances relating to health benefit coverage and care. This authorization shall be valid for the duration of coverage.

• I acknowledge that I have obtained a copy of this authorization.

• I agree that a reproduced copy of this authorization will be as valid as the original.

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	$37.50 ($900.00 per year)	$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.

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.