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of the Blue Cross and Blue Shield Association

CITY OF LINCOLN PARK - MUNICI A0IXF9 12678-000 Simply Blue HSA LG (with prescription drugs) Effective Date: On or after July 2015 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, copay and/or 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: A list of services that require approval **before** they are provided is available online at bcbsm.com/importantinfo. Select **Approving covered services**.

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 diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Benefits	In-Network	Out-of-Network
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.		
Benefits	In-Network	Out-of-Network
Deductibles	\$6,350 for a one-person contract or \$12,700 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	\$12,700 for a one-person contract or \$25,400 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage. Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update.	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update.
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays)	None	<ul style="list-style-type: none"> 20% of approved amount for most covered services
Note: Coinsurance amounts apply once the deductible has been met. Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	\$6,350 for a one-person contract or \$12,700 for a family contract (2 or more members) each calendar year	\$15,000 for a one-person contract or \$30,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Benefits	In-Network	Out-of-Network
Preventive care services		
Benefits	In-Network	Out-of-Network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	Not Covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	Not Covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 8 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 	Not Covered
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	100% (no deductible or copay/coinsurance)	Not Covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
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.	80% 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	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Benefits	In-Network	Out-of-Network
Physician office services		
Benefits	In-Network	Out-of-Network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Emergency medical care		
Benefits	In-Network	Out-of-Network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Benefits	In-Network	Out-of-Network
Diagnostic services		
Benefits	In-Network	Out-of-Network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Maternity services provided by a physician or certified nurse midwife		
Benefits	In-Network	Out-of-Network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Hospital care		
Benefits	In-Network	Out-of-Network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital		
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Alternatives to hospital care		
Benefits	In-Network	Out-of-Network
Skilled nursing care and related physician services - must be in a participating skilled nursing facility	100% after in-network deductible	100% after in-network deductible
Limited to a maximum of 90 days per member per calendar year		
Hospice care	100% after in-network deductible	100% after in-network deductible
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: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 	100% after in-network deductible	100% after in-network deductible
Infusion therapy: <ul style="list-style-type: none"> • 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 	100% after in-network deductible	100% after in-network deductible

Benefits	In-Network	Out-of-Network
Surgical services		
Benefits	In-Network	Out-of-Network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males	100% after in-network deductible	80% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Elective abortions	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Human organ transplants		
Benefits	In-Network	Out-of-Network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible - in participating facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Mental health care and substance abuse treatment		
Benefits	In-Network	Out-of-Network
Inpatient mental health care	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment must be preauthorized subject to medical criteria 	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	100% after in-network deductible	100% after in-network deductible - in participating facilities only
<ul style="list-style-type: none"> Physician's office 	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities only	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Benefits	In-Network	Out-of-Network
Autism spectrum disorders, diagnoses and treatment		
Benefits	In-Network	Out-of-Network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	100% after in-network deductible	100% after in-network deductible
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.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-Network	Out-of-Network
Other covered services		
Benefits	In-Network	Out-of-Network
Outpatient Diabetes Management Program (ODMP)	100% after in-network deductible	80% after out-of-network deductible
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.		
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible

Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
Limited to a combined 12-visit maximum per member per calendar year		
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Limited to a combined 30-visit maximum per member per calendar year		
Durable medical equipment	100% after in-network deductible	100% after in-network deductible
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.		
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible



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CITY OF LINCOLN PARK - MUNICI

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Simply BlueSM PPO HSA LG - Prescription Drug Coverage

Effective Date: On or after July 2015

Benefits-at-a-glance

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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. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many 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. Log in under "I am a Member." 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) once applicable deductible has been met.

Member's responsibility (copays)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, may be subject to the deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum:

- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug.
- The 20% member liability for covered drugs obtained from an out-of-network pharmacy.

Copays		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
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	1 to 30-day period	You pay deductible (no coinsurance)	You pay deductible (no coinsurance)	You pay deductible (no coinsurance)	You pay deductible then 20% of approved amount plus an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay deductible (no coinsurance)	No coverage	No coverage
	84 to 90-day period	You pay deductible (no coinsurance)	You pay deductible (no coinsurance)	No coverage	No coverage

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	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
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	FDA-approved drugs	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	Prescribed over-the-counter drugs – when covered by BCBSM	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug coinsurance
State-controlled drugs	State-controlled drugs	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	FDA-approved generic and select brand-name prescription preventive drugs, supplements, and vitamins (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	Other FDA-approved brand-name prescription preventive drugs, supplements, and vitamins (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs. Note: Needles and syringes have no copay.	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty		

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Note: An **in-network** pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) 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 .
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <i>plus</i> your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate 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.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.



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**CITY OF LINCOLN PARK - MUNICI
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Blue Vision Certification LG
Effective Date: On or after July 2015
Benefits-at-a-glance**

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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.

Benefits	VSP Network doctor	Non-VSP provider
Member's responsibility (copays)		
Benefits	VSP Network doctor	Non-VSP provider
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	Member responsible for difference between approved amount and provider's charge
Medically necessary contact lenses	None	Member responsible for difference between approved amount and provider's charge

Benefits	VSP Network doctor	Non-VSP provider
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.	100% of approved amount (no copay)	Reimbursement up to \$35 (member responsible for any difference)
Limited to one vision examination in any period of 12 consecutive months		

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Benefits	VSP Network doctor	Non-VSP provider
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.	None	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	Limited to one pair of eyeglass lenses with or without frames, in any period of 12 consecutive months	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames	\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	Reimbursement up to \$45 (member responsible for any difference)
Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.		

Benefits	VSP Network doctor	Non-VSP provider
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)	None	Reimbursement up to \$210 (member responsible for any difference)
	Limited to one pair of contact lenses in any period of 12 consecutive months	
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Limited to one pair of contact lenses in any period of 12 consecutive months	