Adult Vision Plan

PREMERA | BLUE CROSS

Washington plans for groups 1-50
Beginning January 1, 2016

Adult Vision Plan can be paired with any small group medical plan

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	ADULT VISION	
	IN-NETWORK	OUT-OF-NETWORK
Adult Vision		
Vision exam (1 PCY)	$25 Copay	$25 Copay
Eyewear ($150 PCY)	Covered In Full	Covered In Full

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.