Vision

[Benefit Overview]

Vision Benefit included at no premium charge for employee & dependents based on elected Medical Plan

$0.00

PREMERA BLUE CROSS

Deductible Type	In-Network	Out-of-Network
Routine Eye Exams (per calendar year)	$10 co-pay	No Coverage
Vision Hardware -Under 19- (per calendar year)	1 pair glasses/frames or contacts (covered at 100%)	No Coverage
Vision Hardware -Over 19-	100% coverage up to Max Allowance of $300 (per calendar year)	No Coverage

KAISER PERMANENTE®

Deductible Type	In-Network	Out-of-Network
Routine Eye Exams (every 12 months)	$15 co-pay	No Coverage
Vision Hardware -Under 19- (lenses, frames & contacts)	No Charge: 1 per year free	No Coverage
Vision Hardware -Over 19- (lenses, frames & contacts)	24-month Max Allowance of $250 (after allowance, member pays 100%)	No Coverage