

Highlights of your Health Care Coverage

Grant County

Group Number: 1037338

Effective Date: 01/01/2016

STANDALONE VISION PLAN		
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
VISION SERVICES		
Routine Vision Exam (1 PCY)	\$25 Copay	\$25 Copay
Vision Hardware (\$300 PCY)	Covered in Full	Covered in Full

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.