PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Vision Coverage

Bering Straits Native Corporation

Group Number: 4000231

Effective Date: 01/01/2017

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

VISION BENEFITS		
Routine Vision Exam (1 Per Calendar Year)	Covered In Full*	Covered In Full*
Vision Hardware ($200 Per Calendar Year)	Covered In Full*	Covered In Full*

*Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

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.