

WEA Select Vision Plan A



NOVEMBER 1, 2016–OCTOBER 31, 2017

All benefit-eligible employees, as defined by the bargaining unit or group, must participate in the plan.

This is a brief comparison of benefits. For details of benefit limitations and exclusions, please refer to the benefit book on the vision page available online at premera.com/wea.

Network	Plan A	
	PBC	Other
Copay amounts		
Exam	\$5	\$0
Materials	\$0	\$0
Exam		
Once every calendar year after copay	Paid in full	\$48
Eyeglass lenses (pair) Once every calendar year		
Single vision	Paid in full	\$45
Bifocal	Paid in full	\$74
Trifocal	Paid in full	\$87
Lenticular	Paid in full	\$122
Progressive lenses	\$125	\$125
Lens tinting and coating	N/C	N/C
Oversize lenses	N/C	N/C
Frames		
Once every 2 calendar years	\$80	\$45
Contact lenses (in lieu of frames and eyeglass lenses)		
Once every 2 calendar years	\$130	
Monthly composite rate	\$17.75	

N/C = Not covered

WEA Select Vision Plan A benefits and rates are underwritten and administered by Premera Blue Cross.

Benefits are subject to Premera Blue Cross allowable charges. Premera Blue Cross network providers agree not to bill for amounts over the allowable charge.

Vision rates

Each eligible employee pays the monthly composite rate, which covers the employee and all eligible dependents. An employee may be enrolled as a subscriber on the WEA Select Vision Plan through only one school district.

Enrollee pays:

- Copay amounts as noted
- All charges exceeding any allowed amounts or benefit maximums
- All charges for non-covered benefits

Premera Blue Cross WEA Select Customer Service

800-932-9221
800-842-5357 (TTY)

Go to premera.com/wea for:

Benefit books • Claim forms • Provider directory*

First time users will need their Premera ID number to create a new account.

*Select Vision in the Network section.

WEA Plan Consultant:



206-467-4646

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