Vision Plan Schedule of Benefits (Effective January 01, 2021)
JHH/JHHSC Non-Union and Union Employees and Eligible Dependents

Services & Supplies (In Alphabetical Order)		JH Routine Vision Care Network	Out of Network Provider
Contact Lenses	Medically necessary	$10 co-pay, then up to $170	$10 co-pay, then up to $170
	Elective	$10 co-pay, then up to $100	$10 co-pay, then up to $100
Materials	Single vision	$10 co-pay (one co-pay for all materials combined), then up to $75	$10 co-pay (one co-pay for all materials combined), then up to $70
	Bifocal	$10 co-pay (one co-pay for all materials combined), then up to $95	$10 co-pay (one co-pay for all materials combined), then up to $80
	Trifocal	$10 co-pay (one co-pay for all materials combined), then up to $120	$10 co-pay (one co-pay for all materials combined), then up to $110
	Lenticular	$10 co-pay (one co-pay for all materials combined), then up to $175	$10 co-pay (one co-pay for all materials combined), then up to $160
	Frames	$10 co-pay (one co-pay for all materials combined), then up to $120	$10 co-pay (one co-pay for all materials combined), then up to $120
Vision Exam	Vision Exam	$10 co-pay, then 100% (one routine exam or contact lens fitting fee every 12 months; contact lens fitting fee may be provided in lieu of eye exam, but not in the same benefit year)	Up to $35 (one routine exam or contact lens fitting fee every 12 months; contact lens fitting fee may be provided in lieu of eye exam, but not in the same benefit year)