

Vision Plan Schedule of Benefits (Effective January 01, 2020)
 Suburban Hospital 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)