## Vision Schedule of Benefits (Effective July 01, 2017 - June 30, 2018)
Johns Hopkins Student Health Program - Members Under Age 20 Only

### Services & Supplies (In Alphabetical Order)
- **Contact Lenses**
  - Medically necessary: Up to $600
  - Elective: Up to $150, plus 15% discount on charges above $150
- **Single vision**
  - 100% of allowed amount

#### Bifocal
- 100% of allowed amount
  - ($0 copay - ultraviolet protective coating, standard progressive lenses, plastic photosensitive lenses)
  - ($20 copay - blended segment lenses, photochromatic glass lenses)
  - ($30 copay - intermediate vision lenses, polycarbonate lenses)
  - ($35 copay - standard anti reflective coating)
  - ($48 copay - premium anti reflective coating)($55 copay - hi-index lenses)
  - ($60 copay - ultra anti reflective coating)
  - ($70 copay select progressive lenses)($75 copay - polarized lenses)
  - ($90 copay - premium progressive lenses)
  - ($195 ultra progressive lenses)

#### Trifocal
- 100% of allowed amount
  - ($0 copay - ultraviolet protective coating, standard progressive lenses, plastic photosensitive lenses)
  - ($20 copay - blended segment lenses, photochromatic glass lenses)
  - ($30 copay - intermediate vision lenses, polycarbonate lenses)
  - ($35 copay - standard anti reflective coating)
  - ($48 copay - premium anti reflective coating)($55 copay - hi-index lenses)
  - ($60 copay - ultra anti reflective coating)
  - ($70 copay select progressive lenses)($75 copay - polarized lenses)
  - ($90 copay - premium progressive lenses)
  - ($195 ultra progressive lenses)

#### Lenticular
- 100% of allowed amount
  - ($0 copay - ultraviolet protective coating, standard progressive lenses, plastic photosensitive lenses)
  - ($20 copay - blended segment lenses, photochromatic glass lenses)
  - ($30 copay - intermediate vision lenses, polycarbonate lenses)
  - ($35 copay - standard anti reflective coating)
  - ($48 copay - premium anti reflective coating)($55 copay - hi-index lenses)
  - ($60 copay - ultra anti reflective coating)
  - ($70 copay select progressive lenses)($75 copay - polarized lenses)
  - ($90 copay - premium progressive lenses)
  - ($195 ultra progressive lenses)

#### Materials
- Frames: Up to $150, plus 20% discount on charges above $150

#### Vision Exam
- Vision Exam
  - 100% of allowed amount
    - (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)

### Johns Hopkins Routine Vision Care Network Providers
- Up to $600

### Out Of Network Providers
- Up to $225
- Up to $75
- Up to $25
- Up to $35
- Up to $45
- Up to $45

Revised: 6/27/2017