Vision Plan and Rates 2017

Ohio Healthcare Plan
Central Division of OHI

Plan Option	
Network	VSP Network through Group Benefits Agency
Exam Copay	$10
Prescription Glasses Copay	$25
Medically Necessary Contacts	Covered in full
Exam	Every 12 months
Lenses	Every 12 months Single vision, lined bifocal, lined trifocal. Polycarbonate for dependent children.
Frames Or Contact Lenses	Every 24 months Up to $150; plus, 20% off any out-of-pocket costs over $150. Or Every 12 months Up to $150, with copay not to exceed $60 for exam.
Progressive Lens, Scratch Resistant, Anti Reflective Coatings, Additional Glasses or Sunglasses	20% off
Contact Lens Fitting and Evaluation	15% off
Laser Vision Correction	Discount
Monthly Premiums	
	Single **$ 8.16** **Family** **$21.87**