

M-NCPPC EYEMED BENEFIT SUMMARY

Vision Care Services	Copay/Allowance	Frequency
HIGH PLAN		
Exam (with dilation as necessary)	\$10 copay	Once every 12 months
Frames (Any available frame at provider location)	\$0 co-pay, \$250 allowance; 20% off balance over \$250	Once every 12 months
Standard Plastic Lenses Single vision Bifocal Trifocal Lenticular Standard Progressive Premium Progressive Tier 1 Premium Progressive Tier 2 Premium Progressive Tier 3 Premium Progressive Tier 4	 \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$20 copay \$30 copay \$45 copay \$0 copay; 20% off retail less \$120 allowance	Once every 12 months (in lieu of contact lenses)
Contact Lenses <i>(contact lens allowance includes materials only.)</i>		
Conventional Disposable Medically necessary	 \$0 co-pay, \$200 allowance; 15% off balance over \$200 \$0 co-pay, \$200 allowance, plus balance over \$200 \$0 co-pay, paid in full	Once every 12 months (in lieu of lenses)
MODERATE PLAN		
Exam (with dilation as necessary)	\$10 copay	Once every 12 months
Frames (Any available frame at provider location)	\$0 co-pay, \$150 allowance; 20% off balance over \$150	Once every 24 months
Standard Plastic Lenses Single vision Bifocal Trifocal Lenticular Standard Progressive Premium Progressive Tier 1 Premium Progressive Tier 2 Premium Progressive Tier 3 Premium Progressive Tier 4	 \$0 copay \$0 copay \$0 copay \$0 copay \$55 copay \$75 copay \$85 copay \$100 copay \$55 copay; 20% off retail less \$120 allowance	Once every 12 months (in lieu of contact lenses)
Contact Lenses <i>(contact lens allowance includes materials only.)</i>		
Conventional Disposable Medically necessary	 \$0 co-pay, \$130 allowance; 15% off balance over \$130 \$0 co-pay, \$130 allowance, plus balance over \$130 \$0 co-pay, paid in full	Once every 12 months (in lieu of lenses)
LOW PLAN		
Exam (with dilation as necessary)	\$10 copay	Once every 12 months
Frames (Any available frame at provider location)	\$0 co-pay, \$150 allowance; 20% off balance over \$150	Once every 24 months
Standard Plastic Lenses Single vision Bifocal Trifocal Lenticular Standard Progressive Premium Progressive Tier 1 Premium Progressive Tier 2 Premium Progressive Tier 3 Premium Progressive Tier 4	 \$0 copay \$0 copay \$0 copay \$0 copay \$55 copay \$75 copay \$85 copay \$100 copay \$55 copay; 20% off retail less \$120 allowance	Once every 24 months (in lieu of contact lenses)
Contact Lenses <i>(contact lens allowance includes materials only.)</i>		
Conventional Disposable Medically necessary	 \$0 co-pay, \$130 allowance; 15% off balance over \$130 \$0 co-pay, \$130 allowance, plus balance over \$130 \$0 co-pay, paid in full	Once every 24 months (in lieu of lenses)