MNCPPC
VISION 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		Once every 12 months (in lieu of contact lenses)
Single vision	$0 copay	
Bifocal	$0 copay	
Trifocal	$0 copay	
Lenticular	$0 copay	
Standard Progressive	$0 copay	
Premium Progressive Tier 1	$20 copay	
Premium Progressive Tier 2	$30 copay	
Premium Progressive Tier 3	$45 copay	
Premium Progressive Tier 4	$0 copay; 20% off retail less $120 allowance	
Contact Lenses *(contact lens allowance includes materials only.*		
Conventional	$0 co-pay, $200 allowance; 15% off balance over $200	Once every 12 months (in lieu of lenses)
Disposable	$0 co-pay, $200 allowance, plus balance over $200	
Medically necessary	$0 co-pay, paid in full	
	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		Once every 12 months (in lieu of contact lenses)
Single vision	$0 copay	
Bifocal	$0 copay	
Trifocal	$0 copay	
Lenticular	$0 copay	
Standard Progressive	$55 copay	
Premium Progressive Tier 1	$75 copay	
Premium Progressive Tier 2	$85 copay	
Premium Progressive Tier 3	$100 copay	
Premium Progressive Tier 4	$55 copay; 20% off retail less $120 allowance	
Contact Lenses *(contact lens allowance includes materials only.*		
Conventional	$0 co-pay, $130 allowance; 15% off balance over $130	Once every 12 months (in lieu of lenses)
Disposable	$0 co-pay, $130 allowance, plus balance over $130	
Medically necessary	$0 co-pay, paid in full	
	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		Once every 24 months (in lieu of contact lenses)
Single vision	$0 copay	
Bifocal	$0 copay	
Trifocal	$0 copay	
Lenticular	$0 copay	
Standard Progressive	$55 copay	
Premium Progressive Tier 1	$75 copay	
Premium Progressive Tier 2	$85 copay	
Premium Progressive Tier 3	$100 copay	
Premium Progressive Tier 4	$55 copay; 20% off retail less $120 allowance	
Contact Lenses *(contact lens allowance includes materials only.*		
Conventional	$0 co-pay, $130 allowance; 15% off balance over $130	Once every 24 months (in lieu of lenses)
Disposable	$0 co-pay, $130 allowance, plus balance over $130	
Medically necessary	$0 co-pay, paid in full	