INDIANA | KENTUCKY

Vision Care Plus Shelf Rates

(For effective dates of January 1, 2015 through December 1, 2015)
Vision Plan Options

The Dental Care Plus Group:

Corporate Office:
100 Crowne Point Place
Cincinnati, OH 45241
513-554-1100
800-367-9466

Kentucky Regional Office:
1552 Ormsby Station Court
Louisville, KY 40223
800-367-9466

Central Ohio Office:
6065 Frantz Road
Suite 103
Dublin, OH 43017
800-367-9466

Vision Care PLUS
The plus is service.

Insured benefits are underwritten by: Fidelity Security Life Insurance Company, Kansas City, MO. Policy #: VC-76, M-9059

Vision Care Plus

Brought to you by The Dental Care Plus Group in partnership with Avēsis Third Party Administrators, Inc.

Indiana | Kentucky
For Effective Dates of 1/1/2015 to 12/1/2015

	Enhanced Plan		Plus Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Frequency[1]				
Vision Exam	12 Months	12 Months	12 Months	12 Months
Standard Lenses	12 Months	12 Months	12 Months	12 Months
Frame	24 Months	24 Months	24 Months	24 Months
Contact Lenses	12 Months	12 Months	12 Months	12 Months
Eye Examination	Covered in full after co-pay	Up to $35	Covered in full after co-pay	Up to $35
Spectacle Lenses (pair)				
Standard Single Vision	Covered in full after co-pay	Up to $25	Covered in full after co-pay	Up to $25
Standard Bifocal	Covered in full after co-pay	Up to $40	Covered in full after co-pay	Up to $40
Standard Trifocal	Covered in full after co-pay	Up to $50	Covered in full after co-pay	Up to $50
Standard Lenticular	Covered in full after co-pay	Up to $80	Covered in full after co-pay	Up to $80
Progressives	20% off U&C, plus a $50 allowance	Up to $40	20% off U&C, plus a $50 allowance	Up to $40
Lens Options*	Preferred pricing (20% off retail)	N/A	Preferred pricing (20% off retail)	N/A
Frame	$35 wholesale allowance (approx. retail: $75-$100)[2] Walmart: $52 retail	Up to $45	$50 wholesale allowance (approx. retail: $100-$150)[2] Walmart: $68 retail	Up to $45
Contact Lenses*	After 20% discount, 10% for disposable		After 20% discount, 10% for disposable	
Elective	$110 allowance	Up to $110	$130 allowance	Up to $130
Medically Necessary	Covered in full	Up to $250	Covered in full	Up to $250
Funded LASIK	Discount plus a $100 one-time/lifetime allowance	$100 one-time/lifetime allowance	Discount plus a $150 one-time/lifetime allowance	$150 one-time/lifetime allowance

	Enhanced Plan		Plus Plan	
	Voluntary	Employer-Sponsored	Voluntary	Employer-Sponsored
Co-Pay[3] - Exam/Materials	$10/$10		$10/$10	
Employee-Only	$7.88	$6.23	$8.01	$6.90
Employee-Spouse	$13.80	$10.91	$14.01	$12.07
Employee-Child(ren)	$14.98	$11.84	$15.21	$13.10
Family	$20.85	$17.38	$24.96	$19.23
Co-Pay[3] - Exam/Materials	$10/$25		$10/$25	
Employee-Only	$6.66	$5.61	$7.70	$6.40
Employee-Spouse	$11.66	$9.82	$13.48	$11.19
Employee-Child(ren)	$12.66	$10.66	$14.63	$12.15
Family	$18.57	$15.30	$23.59	$17.84

[1] Avesis frequency is based on plan year, not service year. [2] Values provided may be more or less depending on the provider's retail pricing. [3] Avesis co-pays do not apply to any contact lens benefit, out-of-network benefit or Lasik Surgery Benefit.
*Additional discounts are not insured benefits.

Some provisions, benefits, exclusions or limitations listed herein may vary depending on your state of residence.

Limitations: This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Avesis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions: There are no benefits under the plan for professional services or materials connected with and arising from: 1) Orthoptics or vision training; 2) Subnormal vision aids and any supplemental testing; 3) Plano (non-prescription) lenses, sunglasses; 4) Two pairs of glasses in lieu of bifocal lenses; 5) Any medical or surgical treatment of eye or support structures; 6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services; 7) Any eye examination or corrective eyewear required by an employer as a condition of employment and safety eyewear; 8) Services or materials provided as a result of Workers' Compensation Law, or similar legislation, required by any governmental agency whether Federal, State or subdivision thereof.

Notes and Disclaimers: The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only, or both contact lenses and professional services (fitting fees). Laser vision correction is considered refractive surgery, an elective procedure, and may involve potential risks to patients. Avesis is not responsible for the outcome of any refractive surgery.

Termination Provisions: Coverage will end on the earliest of: the date the policy ends, the date the employee's employment ends, or the date the employee is no longer eligible.

Note: Groups that are current DCPG clients, that have terminated coverage or choose to terminate coverage with DCPG moving forward are not eligible for the New Sale Shelf Rates for two years from the date of termination. Please contact your DCPG sales representative for pricing during this two-year period.

Please contact your DCPG sales representative at 800-367-9466 or visit www.DentalCarePlus.com/Vision for more information.

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