

Vision Care Plus Indiana/Kentucky 2016

Good for effective dates of January 1, 2016 through December 1, 2016.

Brought to you by The Dental Care Plus Group (DCPG) in partnership with Avésis Third Party Administrators, Inc.

	Enhanced Plan		Plus Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Frequency¹				
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	N/A	After 20% discount, 10% for disposable	N/A
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-Pay³ – Exam/Materials	\$10/\$10	\$10/\$10	\$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-Pay³ – Exam/Materials	\$10/\$25	\$10/\$25	\$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

Groups that have terminated coverage with DCPG are not eligible for the New Sale Shelf Rates for two years from the date of termination. Please contact your DCPG sales representative or account manager at (800) 367-9466 or visit DentalCarePlus.com/Vision for more information.

1. Avésis 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. Avésis 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 eye wear. 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 Avésis 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 eye wear required by an employer as a condition of employment and safety eye wear; 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. Avésis 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.

Insured benefits are underwritten by: Fidelity Security Life Insurance Company, Kansas City, MO

Policy #: VC-76, M-9059

DCPG-IN-KY-PPO-SMGROUP-RATES-2016