

# Indiana/Kentucky/Tennessee Vision 2020

(2-200 Eligible Employees)



Brought to you by The Dental Care Plus Group (DCPG) in partnership with Avesis. Good for effective dates of January 1, 2020 through June 1, 2020. Additional plan designs are available for groups of all sizes.

|   | Enhanced Plan  |                                   | Plus Plan  |                                   |
|---|--|-----------------------------------|--|-----------------------------------|
|   | In-Network   | Out-of-Network                    | In-Network   | Out-of-Network                    |
| <b>Frequency<sup>1</sup></b>                                      |  |                                   |  |                                   |
| <b>Vision Exam</b>  | 12 Months  | 12 Months                         | 12 Months  | 12 Months                         |
| <b>Standard Lenses</b>  | 12 Months  | 12 Months                         | 12 Months  | 12 Months                         |
| <b>Frame</b>  | 24 Months  | 24 Months                         | 24 Months  | 24 Months                         |
| <b>Contact Lenses</b>   | 12 Months  | 12 Months                         | 12 Months  | 12 Months                         |
| <b>Eye Examination</b>  | Covered in full after co-pay   | Up to \$35                        | Covered in full after co-pay   | Up to \$35                        |
| <b>Contact Lens Fit and Follow-Up</b>                             |  |                                   |  |                                   |
| <b>Standard Fitting</b>   | Up to \$50 member out-of-pocket max  | N/A                               | Up to \$50 member out-of-pocket max  | N/A                               |
| <b>Custom Fitting</b>   | Up to \$75 member out-of-pocket max  | N/A                               | Up to \$75 member out-of-pocket max  | N/A                               |
| <b>Spectacle Lenses (pair)</b>                                    |  |                                   |  |                                   |
| <b>Standard Single Vision</b>                                     | Covered in full after co-pay   | Up to \$25                        | Covered in full after co-pay   | Up to \$25                        |
| <b>Standard Bifocal</b>   | Covered in full after co-pay   | Up to \$40                        | Covered in full after co-pay   | Up to \$40                        |
| <b>Standard Trifocal</b>  | Covered in full after co-pay   | Up to \$50                        | Covered in full after co-pay   | Up to \$50                        |
| <b>Standard Lenticular</b>  | Covered in full after co-pay   | Up to \$80                        | Covered in full after co-pay   | Up to \$80                        |
| <b>Progressives</b>   | Standard progressives = \$75<br>Premium progressives = \$110<br>All other progressives = \$50 allowance + 20% discount | Up to \$40                        | Standard progressives = \$75<br>Premium progressives = \$110<br>All other progressives = \$50 allowance + 20% discount | Up to \$40                        |
| <b>Lens Options*</b>  | Preferred pricing  | N/A                               | Preferred pricing  | N/A                               |
| <b>Frame<sup>2</sup></b>  | \$100 retail allowance (up to 20% discount above allowance)<br>Walmart/Sam's: \$52.00<br>Costco: \$54.99               | Up to \$45                        | \$130 retail allowance (up to 20% discount above allowance)<br>Walmart/Sam's: \$68.00<br>Costco: \$74.99               | Up to \$45                        |
| <b>Contact Lenses*</b><br>(In lieu of frame and spectacle lenses) |  |                                   |  |                                   |
| <b>Elective</b>   | \$100 retail allowance (up to 10% discount above allowance)  | Up to \$85                        | \$130 retail allowance (up to 10% discount above allowance)  | Up to \$110                       |
| <b>Medically Necessary</b>  | Covered in full  | Up to \$250                       | Covered in full  | Up to \$250                       |
| <b>Funded LASIK</b>   | Discount plus a \$150 one-time/lifetime allowance  | \$150 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                |
| <b>Co-Pay<sup>3</sup> - Exam/Materials</b>                        | <b>\$10/\$10</b>   | <b>\$10/\$10</b>                  | <b>\$10/\$10</b>   | <b>\$10/\$10</b>                  |
| <b>Employee-Only</b>  | \$8.35   | \$6.60                            | \$8.49   | \$7.31                            |
| <b>Employee-Spouse</b>  | \$14.63  | \$11.56                           | \$14.85  | \$12.79                           |
| <b>Employee-Child(ren)</b>  | \$15.88  | \$12.55                           | \$16.12  | \$13.89                           |
| <b>Family</b>   | \$22.10  | \$18.42                           | \$26.46  | \$20.38                           |
| <b>Co-Pay<sup>3</sup> - Exam/Materials</b>                        | <b>\$10/\$25</b>   | <b>\$10/\$25</b>                  | <b>\$10/\$25</b>   | <b>\$10/\$25</b>                  |
| <b>Employee-Only</b>  | \$7.06   | \$5.95                            | \$8.16   | \$6.78                            |
| <b>Employee-Spouse</b>  | \$12.36  | \$10.41                           | \$14.29  | \$11.86                           |
| <b>Employee-Child(ren)</b>  | \$13.42  | \$11.30                           | \$15.51  | \$12.88                           |
| <b>Family</b>   | \$19.68  | \$16.22                           | \$25.01  | \$18.91                           |

Rates listed above include 10 percent commission and are guaranteed for two years.

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](http://DentalCarePlus.com/Vision) for more information.

1. Avesis frequency is based on plan year, not service year. 2. Approximate retail value after materials co-pay is met. 3. Avesis materials 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 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 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. 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. Insured benefits are underwritten by: Fidelity Security Life Insurance Company, Kansas City, MO. Policy #: VC-76, M-9059