VISION GROUP 2022

OHIO

2-200 ELIGIBLE EMPLOYEES

The Dental Care PLUS GROUP
A DentaQuest Company

Brought to you by The Dental Care Plus Group (DCPG) in partnership with Avesis. Good for effective dates of January 1, 2022 through December 1, 2022. Additional plan designs are available for groups of all sizes.

	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
CONTACT LENS FIT AND FOLLOW-UP				
Standard Fitting	Up to $50 member out-of-pocket max	N/A	Up to $50 member out-of-pocket max	N/A
Custom Fitting	Up to $75 member out-of-pocket max	N/A	Up to $75 member out-of-pocket max	N/A
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	Standard progressives = $75 Premium progressives = $110 All other progressives = $50 allowance + 20% discount	Up to $40	Standard progressives = $75 Premium progressives = $110 All other progressives = $50 allowance + 20% discount	Up to $40
Lens Options*	Preferred pricing	N/A	Preferred pricing	N/A
Frame[2]	$100 retail allowance (up to 20% discount above allowance) Walmart / Sam's: $52.00 Costco: $54.99	Up to $45	$130 retail allowance (up to 20% discount above allowance) Walmart / Sam's: $68.00 Costco: $74.99	Up to $45
Contact Lenses* (In lieu of frame and spectacle lenses)				
Elective	$100 retail allowance (up to 10% discount above allowance)	Up to $85	$130 retail allowance (up to 10% discount above allowance)	Up to $110
Medically Necessary	Covered in full	Up to $250	Covered in full	Up to $250
Funded LASIK	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
Co-Pay[3] **– Exam/Materials**	**$10/$10**	**$10/$10**	**$10/$10**	**$10/$10**
Employee-Only	$7.78	$6.16	$7.90	$6.81
Employee-Spouse	$13.62	$10.76	$13.83	$11.91
Employee-Child(ren)	$14.79	$11.69	$15.03	$12.93
Family	$20.46	$17.50	$25.14	$19.36
Co-Pay[3] **– Exam/Materials**	**$10/$25**	**$10/$25**	**$10/$25**	**$10/$25**
Employee-Only	$6.57	$5.54	$7.60	$6.32
Employee-Spouse	$11.51	$9.70	$13.30	$11.05
Employee-Child(ren)	$12.83	$10.53	$14.45	$11.66
Family	$18.34	$15.11	$23.42	$18.03

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 for details or visit **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