

# DeltaVision®

## Vision benefits proposal

### Dynamic Select Plus 150 plan

<b>Employer group</b>	South Carolina Bankers Employee Benefit Trust	<b>Effective date</b>	January 1, 2022
<b>Quote date</b>	August 16, 2021		

<b>Frequency</b>			
Exam	Once every calendar year	Lenses	Once every calendar year
Frame	Once every calendar year	Contacts	Once every calendar year

Plan allows member to receive either frame and lens services, or frame and contacts in the same year

Vision care services	In-network member cost	Out-of-network member reimbursement
<b>Exam services</b>		
Exam with dilation as necessary	\$10 copay	Up to \$40
Retinal imaging	Up to \$39	Not covered
<b>Contact lens fit and follow-up</b>		
Fit and Follow-up Standard	\$40 allowance	Not covered
Fit and Follow-up Premium	10% off retail price less \$40 allowance	Not covered
<b>Frames</b>		
Frame	\$0 copay; 20% off balance over \$150 allowance	Up to \$60
<b>Lenses</b>		
Single vision	\$25 copay	Up to \$20
Bifocal	\$25 copay	Up to \$40
Trifocal	\$25 copay	Up to \$60
Lenticular	\$25 copay	Up to \$100
Progressive - Standard	\$75 copay	Up to \$40
Progressive - Premium tier 1/2/3	\$110/\$120/\$135 copay	Up to \$40
Progressive - Premium tier 4	\$90 copay; 20% off retail price less \$120 allowance	Up to \$40
<b>Lens options</b>		
Photochromic - Non-glass	\$60 copay	Not covered
Polycarbonate - Std - Children under 20	\$0 copay	Not covered
Polycarbonate - Standard	\$40	Not covered
Anti reflective coating - Standard	\$45	Not covered
Anti reflective coating - Premium tier 1/2/3	\$57/\$68/80% of charge	Not covered
Scratch coating - Standard plastic	\$15	Not covered
Tint - Solid or gradient	\$15	Not covered
UV treatment	\$15	Not covered
All other lens options	20% off retail price	Not covered
<b>Contact lenses</b>		
Contacts - Conventional	\$25 copay; 15% off balance over \$150 allowance	Up to \$90
Contacts - Disposable	\$25 copay; plus balance over \$150 allowance	Up to \$90
Contacts - Medically necessary	\$25 copay; \$250 allowance	Up to \$250
<b>Other</b>		
Hearing Care from Amplifon NetworkCare	Discounts on hearing aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

### Rates - 24 Month rate guarantee

Monthly premiums	Voluntary
Single	\$6.95
Employee & spouse	\$13.86
Employee & child(ren)	\$14.85
Family	\$23.73

Rates quoted are based on dependent coverage up to age 26

Where allowances are shown member is responsible for all charges in excess of the allowance in addition to the applicable copay. Allowances are paid only once during the benefit period. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits for Medically Necessary Contact Lenses are limited to conditions of aphakia, keratoconus or severe anisometropia. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. The percentage discounts and flat dollar fixed pricing for certain lens options and retinal imaging are discount features, not insured benefits, and may be subject to change. Member is responsible for paying the cost of such items directly to the provider.

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