



A Medical Mutual® Company

Superior Vision Ohio—2024

Superior Dental Care (SDC) offers exclusive fully-funded Superior Vision plans as part of a bundled benefits package with any SDC dental plan. Superior Vision plans offer expanded coverage and discounts through a broad provider network of MDs, ODs and optical retail chains. **Bundling a Superior Vision plan with your SDC dental plan** gives you the convenience of one-source enrollment, installation and billing for both dental and vision. Employer groups with 500-1,000 enrolled employees or more may be eligible for custom underwritten plans/rates based on the group's specifications. Groups with 1,001 or more enrolled employees will receive custom underwritten plans/rates.

To be eligible for one of the Superior Vision plans, your group must first select an SDC dental plan.

Once your group is enrolled in an active SDC dental plan, simply add a Superior Vision plan to complete your Superior Wellness dental and vision bundle! It's just that easy to bundle with SDC!

Rate Assumptions:

- Your group must be enrolled in an active SDC dental plan in order to be eligible for the Superior Vision plans and rates.
- Rate guarantee: Follows the rate guarantee offered on the dental quote/rate sheet.

Eligibility Requirements:

- Your group must be enrolled in an active SDC dental plan before electing a Superior Vision plan.**
- Minimum 2 enrolled employees up to 1,000 enrolled employees.
- Tied to Dental Option: Vision enrollment is tied to the dental enrollment. Vision enrollment mirrors dental enrollment exactly.
- Employer Paid Option: The employer pays any portion of the employee premium and 0% of the dependent premium. Employees may enroll in dental only, vision only, or both.
- Voluntary Option: The employer pays 0% of the employee premium and 0% of the dependent premium. Employees may enroll in dental only, vision only, or both.

Groups must select one vision plan—dual option is not available.

The proposed rates are based on meeting the criteria above. These rates are subject to change if the above criteria is not met as described.

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements.

All allowances are at a retail value; the insured is responsible for any charges in excess of this retail allowance.

Ohio Superior Vision Plans—2024

	SV111		SV112	
	In Network	Out of Network	In Network	Out of Network
Exam Ophthalmologist (MD)	Covered in Full	Up to \$34	Covered in Full	Up to \$34
Exam Optometrist (OD)	Covered in Full	Up to \$26	Covered in Full	Up to \$26
Frames	\$130 Retail Allowance	Up to \$60	\$100 Retail Allowance	Up to \$46
Standard Contact Lens Fitting ¹	Covered in Full	Not Covered	Covered in Full	Not Covered
Specialty Contact Lens Fitting ¹	\$50 Retail Allowance	Not Covered	\$50 Retail Allowance	Not Covered
Standard Lenses Per Pair:				
Single Vision	Covered in Full	Up to \$28	Covered in Full	Up to \$28
Bifocal	Covered in Full	Up to \$41	Covered in Full	Up to \$41
Trifocal	Covered in Full	Up to \$53	Covered in Full	Up to \$53
Progressive	Covered at Lined Trifocal Level	Up to \$53	Covered at Lined Trifocal Level	Up to \$53
Lenticular	Covered in Full	Up to \$84	Covered in Full	Up to \$84
Contact Lenses ²	\$130 Retail Allowance	Up to \$100	\$100 Retail Allowance	Up to \$80
Medically Necessary	Covered in Full	Up to \$210	Covered in Full	Up to \$210
Co-Payment				
Exam	\$10	\$10	\$20	\$20
Materials ³	\$25	\$25	\$25	\$25
Contact Lens Fitting Exam	\$30	\$30	\$30	\$30
Frequency: Exam/Lens/Frame	12 Months / 12 Months / 24 Months		24 Months / 24 Months / 24 Months	

Rates

Monthly Rates	Tied to Dental	Employer Paid	Voluntary	Tied to Dental	Employer Paid	Voluntary
2-Tier						
Employee	\$4.19	\$4.69	\$5.69	\$2.65	\$2.96	\$3.59
Employee + Family	\$11.30	\$12.65	\$15.32	\$7.06	\$7.90	\$9.56
3-Tier						
Employee	\$4.19	\$4.69	\$5.69	\$2.65	\$2.96	\$3.59
Employee + One Dependent	\$8.12	\$9.08	\$11.01	\$5.11	\$5.72	\$6.93
Employee + Family	\$14.03	\$15.69	\$19.01	\$8.73	\$9.76	\$11.83
4-Tier						
Employee	\$4.19	\$4.69	\$5.69	\$2.65	\$2.96	\$3.59
Employee + Spouse	\$8.38	\$9.37	\$11.36	\$5.29	\$5.92	\$7.17
Employee + Child(ren)	\$9.48	\$10.61	\$12.86	\$5.88	\$6.58	\$7.98
Employee + Family	\$14.67	\$16.40	\$19.88	\$9.13	\$10.21	\$12.37

SIGN UP IS EASY!

Contact SDC's Account Services Team at
AccountServices@SuperiorDental.com | 1-800-762-3159
SuperiorDental.com

¹ Standard Contact Lens Fitting applies to a current contact lens user who wears disposable, daily wear or extended wear lenses only. Specialty Contact Lens Fitting applies to new contact wearers and/or a member who wears toric, gas permeable or multi-focal lenses.
² Contact lenses are in lieu of eyeglass lenses and frames benefits.
³ Materials co-pay applies to lenses and frames only, not contact lenses.

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