STATE OF DELAWARE: HIGH PLAN

Summary of benefits

40% OFF

additional complete pair of prescription eyeglasses*

20% OFF

non-covered items, including non-prescription sunglasses*

Find an eye doctor

(Insight Network)

- 855-259-0490
- **eyemed.com/member**
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up

You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

Vision Care Services	In-Network Member Cost at PLUS PROVIDERS	In-Network Member Cost	Out-of-Network Member Reimbursement
EXAM SERVICES			
Exam	$0 copay	$5 copay	Up to $30
Retinal Imaging	$0 copay	$0 copay	Up to $20
CONTACT LENS FIT AND FOLLOW-UP			
Fit and Follow-up – Standard	Up to $40	Up to $40	Not covered
Fit and Follow-up – Premium	10% off retail price	10% off retail price	Not covered
FRAME			
Frame	$0 copay; 20% off balance over $260 allowance	$0 copay; 20% off balance over $210 allowance	Up to $105
STANDARD PLASTIC LENSES			
Single Vision	$10 copay	$10 copay	Up to $25
Bifocal	$10 copay	$10 copay	Up to $40
Trifocal	$10 copay	$10 copay	Up to $55
Lenticular	$10 copay	$10 copay	Up to $55
Progressive – Standard	$10 copay	$10 copay	Up to $40
Progressive – Premium Tier I, II or III	$95, $105, $120 copay	$95, $105, $120 copay	Up to $40
Progressive – Premium Tier IV	$225 copay	$225 copay	Up to $40

STATE OF DELAWARE: HIGH PLAN

Summary of benefits

Vision Care Services	In-Network Member Cost at PLUS PROVIDERS	In-Network Member Cost	Out-of-Network Member Reimbursement
LENS OPTIONS			
Anti Reflective Coating – Standard	$0 copay	$0 copay	Up to $5
Anti Reflective Coating – Premium Tier I, II or III	$57, $68 or $100 copay	$57, $68 or $100 copay	Up to $5
Photochromic – Non-Glass	$75	$75	Not covered
Polycarbonate – Standard	$0 copay	$0 copay	Up to $5
Scratch Coating – Standard Plastic	$0 copay	$0 copay	Up to $5
Tint – Solid and Gradient	$0 copay	$0 copay	Up to $5
UV Treatment	$0 copay	$0 copay	Up to $5
All Other Lens Options	20% off retail	20% off retail	No coverage
CONTACT LENSES			
Contacts - Conventional	$0 copay; 15% off balance over $260 allowance	$0 copay; 15% off balance over $210 allowance	Up to $170
Contacts - Disposable	$0 copay; 100% of balance over $260 allowance	$0 copay; 100% of balance over $210 allowance	Up to $170
Contacts – Medically Necessary	$0 copay; paid in full	$0 copay; paid in full	Up to $200
OTHER			
Hearing Care from Amplifon Network[1]	Up to 66% off hearing aids; call 1.877.203.0675	Up to 66% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network[1]	15% off retail or 5% off promo price; call 1.800.988.4221	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

STATE OF DELAWARE: HIGH PLAN

Summary of benefits

Vision Care Services

FREQUENCY	Allowed Frequency - Adults	Allowed Frequency - Kids
Exam	Once every plan year	Once every plan year
Frame	Once every plan year	Once every plan year
Lenses	Once every plan year	Once every plan year
Contact Lenses	Once every plan year	Once every plan year

(Plan allows member to receive either contacts and frame, or frames and lens services).

*Additional discounts above the plan coverage are not available with all providers.

[1]Discounts are not an insured benefit.

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.