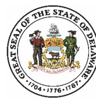

State of Delaware Vision Plan Comparison Chart for State Employees
(Effective July 1, 2026)

***Please note:** The specific premiums (rates) referenced in this document apply to State of Delaware employees. If you are a school district or charter school employee, your benefits may be different from what is presented here as some schools offer their own local school plans for vision insurance. Flex credits offered to school district or charter school employees to reduce their employee premiums for vision benefits are not reflected in this information. Please visit your school website or contact your organization's Human Resource/Benefits Office for information regarding your benefits, premiums (rates), and flex credits.*

Plan Options	EyeMed Low Vision Plan		EyeMed High Vision Plan	
Network	Insight		Insight	
Coverage Options/ Premiums (Rates)	**Total Monthly Premium (Rate)**	**Bi-Weekly Premium (Rate)**	**Total Monthly Premium (Rate)**	**Bi-Weekly Premium (Rate)**
Individual	$5.84	$2.92	$12.94	$6.47
Individual & Spouse	$9.20	$4.60	$20.42	$10.21
Individual & Child(ren)	$9.36	$4.68	$20.82	$10.41
Family	$15.16	$7.58	$33.60	$16.80
Plan Feature	**In-Network Member Copay**	**Out-of-Network Reimbursement (“Up to” amount noted)**	**In-Network Member Copay**	**Out-of-Network Reimbursement (“Up to” amount noted)**
Exam	$10 or $0 at PLUS Provider	$30	$5 or $0 at PLUS Provider	$30
Retinal Imaging	$0	$20	$0	$20
Frame	$0 copay; Allowance: $160 or $210 at PLUS Provider; Receive 20% off balance over allowance	$80	$0 copay; Allowance: $210 or $260 at PLUS Provider; Receive 20% off balance over allowance	$105
Standard Plastic Lenses - Single Vision or Bifocal or Trifocal	$20	$25 Single $40 Bifocal $55 Trifocal	$10	$25 Single $40 Bifocal $55 Trifocal
Standard Progressive Lenses	$85	$40	$10	$40
Premium Progressive - Tier 1, 2, 3 or 4	T1 $105, T2 $115, T3 $130, T4 $235	$40	T1 $95, T2 $105, T3 $120, T4 $225	$40
Lens Option - Standard Polycarbonate - Kids under 19	$0	$5	$0	$5
Contact Lenses *(Disposable)*	$0 copay; Allowance: $160 or $210 at PLUS Provider; Pay 100% of balance over allowance	$105	$0 copay; Allowance: $210 or $260 at PLUS Provider; Pay 100% of balance over allowance	$170

	Frequency	Frequency
Exam	Once per plan year	Once per plan year
Frame	Once per plan year	Once per plan year
Lenses or Contact Lenses	Once per plan year	Once per plan year
Medical Follow-Up Exam for Diabetic Vision Care	Once every 6 months	Once every 6 months

Important Note: For detailed information about all the benefits offered through the State's vision plan, including the plan limitations, exclusions and diabetic care services, visit the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits.