



The following is a summary of the vision benefits for State of Delaware. This document is not the Summary Plan Description document.

The Policy and Certificate (“Policy”) is the contract between State of Delaware and Fidelity Security Life Insurance Company which provides the coverage for the vision care benefits. Any discrepancy between this Summary and the Policy will be resolved in favor of the Policy.

Plan Information

State of Delaware has selected EyeMed Vision Care as your vision wellness program. The plan, underwritten by Fidelity Security Life Insurance Company, allows you to improve your vision health through a routine eye exam, while saving you money on your eye care purchases. The plan is available through thousands of provider locations participating on the EyeMed **Access Network**.

The EyeMed Network

EyeMed Vision Care’s network of providers includes private practitioners, as well as the nation’s premier optical retailers, LensCrafters®, Sears Optical, Target Optical, JC Penney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemedvisioncare.com and choose the **Access Network**. You may also call EyeMed’s Customer Care Center at **1-855-259-0490**. EyeMed’s Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

Using In-Network Providers

When making an appointment with an in-network provider of your choice, identify yourself as an EyeMed member; provide your name and the name of your organization or plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the **Access Network**. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to verify your eligibility.

When you receive services at an in-network EyeMed Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses.

Using Out-of-Network Providers

If you receive services from an out-of-network provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Covered Vision Care Services. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, an EyeMed out-of-network claim form is available at www.eyemedvisioncare.com or by calling EyeMed’s Customer Care Center at **1-855-259-0490**.

Summary of Vision Care Services

| | Member In-Network Cost | Out-of-Network Reimbursement* |
|---|---|---|
| Exam Dilation as necessary Refraction | \$10 co-pay \$0 \$0 | Up to \$35 |
| Diabetic Services (Available for Type 1 and 2 Diabetics) Medical Follow Up Exam Retinal Imaging Extended Ophthalmoscopy Gonioscopy Scanning Laser | \$0 co-pay \$0 co-pay \$0 co-pay \$0 co-pay \$0 co-pay | \$77 \$50 \$15 \$15 \$33 |
| Vision Therapy Services Vision Therapy Evaluation Vision Therapy | \$0 co-pay 25% co-pay for up to 10 therapy sessions per benefit year | \$46 25% co-pay for up to 10 therapy sessions per benefit year |
| Exam Options – Contact Lenses Standard Fit and Follow-Up Premium Fit and Follow-Up | Up to \$55 10% off retail price | N/A N/A |
| Frames** | \$0 copay, 20% off balance over \$160 | Up to \$45 |
| Standard Plastic Lenses Single Vision Bifocal Trifocal Lenticular Standard Progressive Premium Progressive (scheduled)*** Premium Progressive (other) | \$20 copay \$20 copay \$20 copay \$20 copay \$85 \$111 - \$123 \$85 plus (80% of charge less \$120 allowance) | Up to \$25 Up to \$40 Up to \$55 Up to \$55 Up to \$40 Up to \$40 Up to \$40 |
| Standard Lens Options UV coating Tint (solid and gradient) Standard scratch resistance Standard polycarbonate - Adults Standard polycarbonate – Kids Under 19 Standard anti-reflective coating Premium Anti-reflective coating (scheduled)*** Premium Anti-reflective coating (other) Photochromic/Transitions Plastic Polarized Other add-ons and services | \$15 \$15 \$0 \$40 \$0 \$45 \$57 - \$68 20% off retail price \$75 20% off retail price 20% off retail price | N/A N/A \$5 N/A \$5 N/A N/A N/A N/A N/A N/A |

| <u>Continued from page 2</u> | Member In-Network Cost | Out-of-Network Reimbursement* |
|---|--|--------------------------------------|
| Contact Lenses**** | | |
| Conventional | \$0 copay, 15% off balance over \$160 | Up to \$105 |
| Disposable | \$0 copay, 100% of balance over \$160 | Up to \$105 |
| Medically necessary | \$0 (paid in full by plan) | Up to \$200 |
| Lasik or PRK from US Laser Network | 15% off retail price 5% off promotional price | N/A |
| Frequency - based on <i>Date of Last Service</i> | | |
| Exam | Once every 12 months | Once every 12 months |
| Diabetic Services | Once every 6 months | Once every 6 months |
| Vision Therapy Evaluation | Once every 12 months | Once every 12 months |
| Vision Therapy | Up to 10 visits every 12 months | Up to 10 visits every 12 months |
| Lenses <u>or</u> Contact Lenses | Once every 12 months | Once every 12 months |
| Frames | Once every 12 months | Once every 12 months |

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim form for reimbursement. You will be reimbursed up to the amount shown on the chart.

** Frame allowance provides no remaining balance for future use within the same Benefit Frequency.

***Fixed pricing schedule for Premium Progressives and Premium Anti-Reflective available at www.eyemedvisioncare.com.

**** For prescription contact lenses for only one eye, the Vision Care plan will pay one-half of the amount payable for contact lenses for both eyes. Contact Lens allowance is a declining balance. Any remaining balance may be used within the same benefit frequency. Where the Insured Person previously used an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously used an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider.

Additional Discounts

In addition to the vision care services outlined in the Summary of Vision Care Services, EyeMed Vision Care provides a discount on products at an in-network provider once your insurance benefits have been used. The discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the plan at network providers.

Discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, contact lenses or certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Diabetic Eye Care Benefit

Members of the plan who have Type 1 or Type 2 diabetes are eligible to receive supplemental coverage for additional services from their vision Provider. Services are available up to two times per benefit year.

Diabetes Mellitus or Diabetes is a metabolic disease in which a person has high blood sugar, either because the body does not produce enough insulin or because cells do not respond to the insulin that is produced. Diabetic Retinopathy is damage to the retina caused by complications of Diabetes Mellitus.

Definitions of covered services are:

- **Office Visit (Medical Follow-up Eye Exam):** A vision examination for diabetic vision care.
- **Gonioscopy:** An eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.
- **Extended Ophthalmoscopy:** Procedure to examine the interior of the eye, focusing on the posterior segment of the eye, including the lens, retina and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report. *(Not covered if Retinal Imaging was provided in previous 6 months).*
- **Retinal Imaging:** The recording of portions, or the complete, retinal surface and structures. *(Not covered if Extended Ophthalmoscopy was provided in previous 6 months).*
- **Scanning Laser:** Computerized ophthalmic diagnostic imaging of the back two-thirds ("posterior segment") of the eye; includes interpretation and report, unilateral.

Availability of diagnostic equipment and services varies by location. Members are encouraged to call their provider to confirm availability of services.

Vision Therapy Benefit

Members of the plan are eligible for the Vision Therapy Services benefit, a therapeutic program that provides treatment for a variety of visual dysfunctions.

Vision Therapy involves patient participation in a sequence of non-surgical therapeutic procedures designed to modify visual function and is effective in treating accommodative disorders, amblyopia, non-strabismic binocular disorders, and strabismus. Conditions excluded from this benefit include nystagmus, traumatic brain injury, learning disabilities, dyslexia, and all other non-stated conditions.

- **Accommodative Disorders or Accommodative Dysfunctions:** A non-aging, non-refractive, neuromuscular abnormality of the visual system characterized by the eyes inability to maintain accurate or prolonged focus.
- **Amblyopia:** A visual developmental condition that is characterized by poor or indistinct vision in an eye that is otherwise physically normal due to visual stimulation failing to transmit or being poorly transmitted through the optic nerve to the brain for a continuous period of time.
- **Dyslexia:** A neurologically-based learning disability that alters how the brain processes written information.
- **Learning Disability:** A classification of several disorders in which a person has difficulty learning in a typical manner. A Learning Disability affects the brain's ability to receive and process information.
- **Nonstrabismic Binocular Disorders:** A visual defect in which the two eyes fail to work together. Nonstrabismic Binocular Disorders causes a person to exert an undue amount of effort in sustaining continuous singular binocular vision.
- **Nystagmus:** A disorder characterized by rapid, involuntary, back-and-forth oscillations of the eye, usually affecting both eyes. Nystagmus may be congenital or acquired.
- **Orthoptics:** The treatment of visual habits, binocular vision disorders and muscle imbalance by reeducation of visual habits, exercise and vision training.
- **Pleoptic:** A system of treating Amblyopia by retraining visual habits using guided exercises.
- **Strabismus:** A condition in which the visual axis of the eyes is not parallel, preventing the eyes from focusing on the same point in space at the same time.
- **Traumatic Brain Injury:** A condition that occurs when an external force traumatically injures the brain.
- **Vision Therapy Evaluation:** A sensorimotor evaluation of ocular derivation with interpretation and report.
- **Vision Therapy:** Orthoptic and/or Pleoptic training with continual medical direction aimed at correcting and improving binocular, oculomotor, visual processing and perceptual disorders. Vision Therapy must be under the direct supervision of the Provider. Vision Therapy does not include practice sessions at home, school or other venue.

The therapy sessions are administered during office visits under direct supervision of the Provider, with techniques taught to the patient for continued therapy at home. Duration of treatment varies depending on the severity of the condition and the presence of complicating factors. Without the supervision of the Provider, other applications (school or home) are considered practice sessions and are not considered insured benefits.

Based on the outcome of the Vision Therapy evaluation, the vision Provider will schedule, conduct, or refer out for therapy sessions.

Not all locations offer Vision Therapy Services. Members are encouraged to call their Provider to confirm availability of services.

Discounts on Laser Vision Correction

EyeMed Vision Care, in conjunction with LCA Vision, offers discounts to members interested in Lasik and PRK from the U.S. Laser Network. EyeMed members receive a discount (15% off retail or 5% off promotional price) when using a network provider in the U.S. Laser Network, owned and operated by LCA Vision. The US Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call **1-877-5LASER6**.

After you have located a U.S. Laser Network provider, you should contact the provider and identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at **1-877-5LASER6** to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to U.S. Laser Network. Upon receipt of the deposit, U.S. Laser Network will issue an authorization number to the member and to the provider prior to treatment. Once you receive treatment, the deposit will be applied to the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the balance of the fee. Should you decide against the treatment, the deposit will be refunded.

After treatment, you should follow all post-operative instructions carefully. It is your responsibility to schedule any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

Discount Mail Order Contact Lens Replacement Program

After initial contact lens fitting and purchase, you may obtain replacement contact lenses via the Internet and they will be mailed directly to you. For more information, log on to www.eyemedvisioncontacts.com. The contact lens benefit allowance is not applicable to this service.

Plan limitations and exclusions

Benefits are not provided for services or materials arising from:

Subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;

Medical, pathological and/or surgical treatment of the eye, eyes or supporting structures;

Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;

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;

Plano (non-prescription) lenses;

Non-prescription sunglasses;

Two pair of glasses in lieu of bifocals;

Services or materials provided by any other group benefit plan providing vision care;

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:

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available;

Services, supplies, prescription medication or treatment for diabetes, except as specifically included under the Diabetic Eye Care Benefit; and

Any Vision Therapy provided for Nystagmus, Traumatic Brain Injury, Learning Disability, Dyslexia or any other condition not specifically included under the Vision Therapy Benefit.

Discount benefits may not be combined with any discount, promotional offering, or other group benefit plans.

Certain brand name vision materials in which the manufacturer imposes a no-discount practice.

Sample Savings

The following examples illustrate how your benefit would be applied to the services received at any in-network provider's office or location:

If a member chooses to receive:

| | |
|--|-------------------------|
| A comprehensive vision care examination: | you pay \$ 10.00 |
| A frame up to a value of \$160: | you pay \$ 0.00 |
| One pair of bifocal lenses: | you pay \$ 20.00 |
| Ultraviolet coating: | you pay \$ 15.00 |
| The total cost to the member is: | \$45.00 |

If a member chooses to receive:

| | |
|--|-------------------------|
| A comprehensive vision care examination: | you pay \$ 10.00 |
| A frame up to a value of \$200: | you pay \$ 32.00 |
| A pair of single vision lenses: | you pay \$ 20.00 |
| Standard anti-reflective coating: | you pay \$ 45.00 |
| The total cost to the member is: | \$107.00 |

The EyeMed **Access Network** is always growing, and provider locations are subject to change. Therefore, we recommend using the Provider Locator service through EyeMed's web site www.eyemedvisioncare.com (choose the **Access Network**) or calling EyeMed's Customer Care Center at 1-855-259-0490 or to locate the EyeMed Provider closest to you.

Member Complaint Procedure

If you are dissatisfied with the services provided by an EyeMed Vision Care provider, you may write to EyeMed at the address shown below or call the EyeMed Vision Care Member Services toll free telephone number at **1-855-259-0490**. If you write, the address is:

EyeMed Vision Care, L.L.C.
Attention: Quality Assurance
4000 Luxottica Place
Mason, Ohio 45040

If you call, the EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution. If a resolution cannot be reached during the telephone call, or you are not satisfied with the resolution, you may file a written complaint to the address listed above. All written complaints will be acknowledged within three business days and resolved within 30 calendar days.

Appealing Claims

As part of the claims administration process, EyeMed Vision Care (via First American Administrators, Inc., a wholly-owned subsidiary of EyeMed) will pay claims for benefits due under the Plan, provide written explanations of the reasons for denied claims, and handle requests for reviews of denied claims. If your claim is denied in whole or in part, you have the right to have the claim reviewed and reconsidered.

Please send a written request to review the claim within 180 days of the denial to:

EyeMed Vision Care, L.L.C.
Attention: Claim Appeals
4000 Luxottica Place
Mason, Ohio 45040

Your written letter of appeal should include:

- The applicable claim number or Explanation of Benefits, if applicable;
- The item of your coverage that you feel was misinterpreted or inaccurately applied; and
- Any additional information that you believe will help EyeMed Vision Care complete its review of your appeal, such as documents, records or comments.

EyeMed Vision Care will review your appeal for benefits and notify you in writing of its decision, as well as the reasons for the decision, within 30 calendar days of receipt of the appeal.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

Note: The Insured benefits are underwritten by Fidelity Security Life Insurance Company. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care.