City of Coral Gables

RFP # 2019-021

Group Vision Insurance

Appendix A

Benefit Review

City of Coral Gables
RFP 2019-021
Group Vision Insurance
Requested Benefits

	Requested Benefits		Avesis (A Guardian Life Company)	
	Benefits		Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	Covered in full after $10 copay	Up to $35
Retinal Imaging	$39 Allowance	Not Covered	Not Covered	Not Covered
Lenses				
Single	$25 Copay	$25 Allowance	$25 Copay	Up to $25
Bifocal	$25 Copay	$40 Allowance	$25 Copay	Up to $40
Trifocal	$25 Copay	$60 Allowance	$25 Copay	Up to $50
Lenticular	$25 Copay	$100 Allowance	$25 Copay	Up to $80
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$100 Allowance and 20% off balance	Up to $45
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$100 Allowance and 10% off balance	Up to $85
Medically Necessary	100%	$200 Allowance	Covered in full	Up to $250
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	Optional rider is available	Optional rider is available
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months

City of Coral Gables
RFP 2019-021
Group Vision Insurance
Requested Benefits

	Requested Benefits		Florida Blue	
	Benefits		Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $30
Retinal Imaging	$39 Allowance	Not Covered	Not Covered	Not Covered
Lenses				
Single	$25 Copay	$25 Allowance	$25 Copay	Up to $25
Bifocal	$25 Copay	$40 Allowance	$25 Copay	Up to $40
Trifocal	$25 Copay	$60 Allowance	$25 Copay	Up to $60
Lenticular	$25 Copay	$100 Allowance	$25 Copay	Up to $100
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$100 Allowance and 20% discount on any overage	Up to $50
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$100 Allowance and 15% discount on any overage	Up to $80
Medically Necessary	100%	$200 Allowance	Covered in full	Up to $200
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	Not covered	Not covered
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months

City of Coral Gables
RFP 2019-021
Group Vision Insurance
Requested Benefits

	Requested Benefits		Humana	
	Benefits		Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $30
Retinal Imaging	$39 Allowance	Not Covered	Upt to $39	Not Covered
Lenses				
Single	$25 Copay	$25 Allowance	$15 Copay	Up to $25
Bifocal	$25 Copay	$40 Allowance	$15 Coapy	Up to $40
Trifocal	$25 Copay	$60 Allowance	$15 Coapy	Up to $60
Lenticular	$25 Copay	$100 Allowance	$15 Coapy	Up to $100
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$130 Allowance and 20% off balance	Up to $65
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$130 Allowance and 15% off balance	Up to $104
Medically Necessary	100%	$200 Allowance	Covered in full	Up to $200
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	Up to 2 additional services per benefit year for each service	Allowances by procedure
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months

City of Coral Gables
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Group Vision Insurance
Requested Benefits

	Requested Benefits		MetLife	
	Benefits		Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $45
Retinal Imaging	$39 Allowance	Not Covered	Upt to $39	Applied to the exam allowance
Lenses				
Single	$25 Copay	$25 Allowance	$25 Copay	Up to $30
Bifocal	$25 Copay	$40 Allowance	$25 Copay	Up to $50
Trifocal	$25 Copay	$60 Allowance	$25 Copay	Up to $65
Lenticular	$25 Copay	$100 Allowance	$25 Copay	Up to $100
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$100 Allowance	Up to $55
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$100 Allowance	Up to $80
Medically Necessary	100%	$200 Allowance	Covered in full after eyewear copay	Up to $210
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	No additional coverage	No additional coverage
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months

City of Coral Gables
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Group Vision Insurance
Requested Benefits

	Requested Benefits		Superior Vision	
	Benefits		Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $33 (MD) Up to $28 (OD)
Retinal Imaging	$39 Allowance	Not Covered	Covered	Not Covered
Lenses				
Single	$25 Copay	$25 Allowance	Covered In Full	Up to $28
Bifocal	$25 Copay	$40 Allowance	Covered In Full	Up to $40
Trifocal	$25 Copay	$60 Allowance	Covered In Full	Up to $53
Lenticular	$25 Copay	$100 Allowance	Covered In Full	Up to $84
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$100 Retail Allowance	Up to $56
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$100 Retail Allowance	Up to $80
Medically Necessary	100%	$200 Allowance	Covered in full	Up to $210
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	Not Covered Benefit	Not Covered Benefit
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months

City of Coral Gables
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Group Vision Insurance
Requested Benefits

	Requested Benefits		VSP	
	Benefits		Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $45
Retinal Imaging	$39 Allowance	Not Covered	Up to $39	Not Covered
Lenses				
Single	$25 Copay	$25 Allowance	$25 Copay	Up to $30
Bifocal	$25 Copay	$40 Allowance	$25 Copay	Up to $50
Trifocal	$25 Copay	$60 Allowance	$25 Copay	Up to $65
Lenticular	$25 Copay	$100 Allowance	$25 Copay	Up to $100
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$130 Allowance and 20% off balance	Up to $70
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$130 Allowance	Up to $105
Medically Necessary	100%	$200 Allowance	100%	Up to $210
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	Supplemental Eye Care Available	No additional coverage
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months

City of Coral Gables
RFP 2019-021
Group Vision Insurance
Alternate Benefits

	Requested Benefits		MetLife	
	Benefits		Alternate Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $45
Retinal Imaging	$39 Allowance	Not Covered	Up to $39	Applied to the exam allowance
Lenses				
Single	$25 Coapy	$25 Allowance	$25 Coapy	Up to $30
Bifocal	$25 Copay	$40 Allowance	$25 Copay	Up to $50
Trifocal	$25 Copay	$60 Allowance	$25 Copay	Up to $65
Lenticular	$25 Copay	$100 Allowance	$25 Copay	Up to $100
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$100 Allowance	Up to $55
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$100 Allowance	Up to $80
Medically Necessary	100%	$200 Allowance	Covered in full after eyewear copay	Up to $200
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	No additional coverage	No additional coverage
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months
			Supplemental Rider second pair of glassess or contacts	Same OON benefit as primary plan

City of Coral Gables
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Group Vision Insurance
Alternate Benefits

	Requested Benefits		Superior Vision	
	Benefits		Alternate Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $33 (MD) Up to $28 (OD)
Retinal Imaging	$39 Allowance	Not Covered	Covered	Not Covered
Lenses				
Single	$25 Coapy	$25 Allowance	Covered In Full	Up to $28
Bifocal	$25 Copay	$40 Allowance	Covered In Full	Up to $40
Trifocal	$25 Copay	$60 Allowance	Covered In Full	Up to $53
Lenticular	$25 Copay	$100 Allowance	Covered In Full	Up to $84
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$100 Retail Allowance	Up to $56
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$100 Retail Allowance	Up to $80
Medically Necessary	100%	$200 Allowance	Covered in Full	Up to $210
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	Not Covered Benefit	Not Covered Benefit
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 12 months	Once every 12 months

City of Coral Gables
RFP 2019-021
Group Vision Insurance
Alternate Benefits

	Requested Benefits		VSP	
	Benefits		Alternate Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				Reimbursement
Eye Exam				
Routine	100% after $10 Copay	$30 Allowance	$10 copay	Up to $45
Retinal Imaging	$39 Allowance	Not Covered	Up to $39	Not Covered
Lenses				
Single	$25 Coapy	$25 Allowance	$25 Copay	Up to $30
Bifocal	$25 Copay	$40 Allowance	$25 Copay	Up to $50
Trifocal	$25 Copay	$60 Allowance	$25 Copay	Up to $65
Lenticular	$25 Copay	$100 Allowance	$25 Copay	Up to $100
Frames	$100 Allowance and 20% off balance	$50 Retail Allowance	$100 Allowance and 20% off balance	Up to $70
Contact Lenses				
Conventional	$100 Allowance and 15% off balance	$80 Allowance	$100 Allowance	Up to $105
Medically Necessary	100%	$200 Allowance	100%	Up to $210
Diabetic Eye Care				
Exam, Retinal imaging, Extended ophthalmoscopy,Gonio-scopy, Scanning laser	Up to 2 additional services per benefit year for each service	Allowances by procedure	Supplemental Eye Care Available	No additional coverage
Frequency				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contacts	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 12 months	Once every 12 months