City of Marshall, MN
Vision Comparison
8/31/2020 for effective date 01/01/2021

	OPTION A Current			OPTION B Proposed		OPTION C		OPTION D		OPTION E	
	Ameritas			Eyemed		Eyemed		Avesis Plan		VSP	
	Full Plan Network	Full Plan Out of Network	Materials Only In/Out of Network	Full Plan Network	Full Plan Out of Network	Materials Only Network	Materials Only Out of Network	Full Plan Network	Full Plan Out of Network	Full Plan Network	Full Plan Out of Network
Annual Eye Exam for Full Plan	12 months			12 months				12 months		12 months	
Copay/Deductible	$10 Deductible	$10 Deductible then up to $43	N/A	$10 Copay	Up to $40	N/A	N/A	$10 Copay	$35 reimbursement	$10 Copay	$45 reimbursement
Lenses - Standard	12 months		12 months	12 months		12 months		12 months		12 months	
Basic Single Vision	$25 Deductible	$25 Deductible then Up to $26	$10 Deductible then Up to $40	$25 Copay	Up to $30	$25 Copay	Up to $30	Covered in full	Up to $25	$25 Copay	$30 reimbursement
Lined Bifocal	$25 Deductible	$25 Deductible then Up to $43	$10 Deductible then Up to $60	$25 Copay	Up to $50	$25 Copay	Up to $50	Covered in full	Up to $40	$25 Copay	$50 reimbursement
Lined Trifocal	$25 Deductible	$25 Deductible then Up to $60	$10 Deductible then Up to $75	$25 Copay	Up to $70	$25 Copay	Up to $70	Covered in full	Up to $50	$25 Copay	$65 reimbursement
Lenticular	$25 Deductible	$25 Deductible then Up to $91	$10 Deductible then Up to $80	$25 Copay	Up to $70	$25 Copay	Up to $70	Covered in full	Up to $80	$25 Copay	$100 reimbursement
Contact Lenses	12 months		12 months	12 months		12 months		12 months		12 months	
Contacts - Necessary	100%	Up to $210	Up to $140	100%	Up to $210	100%	Up to $210	Covered in full	$250 reimbursement	$25 Copay	$210 reimbursement
Contacts - Conventional	Up to $105	Up to $100	Up to $140	$0 Copay $130 allowance additional 15% off balance over allowance	Up to $91	$0 Copay $130 allowance additional 15% off balance over allowance	Up to $91	$130 allowance	$110.50 reimbursement	$130 allowance	$105 reimbursement
Frames	24 months		24 months	24 months		24 months		24 months		24 months	
	$25 Deductible then $120 Allowance	$25 Deductible then up to $40	$10 Deductible then $100	$0 Copay $130 allowance additional 20% off balance over allowance	Up to $91	$0 Copay $130 allowance additional 20% off balance over allowance	Up to $91	$25 Copay $130 allowance	Up to $45	$25 Copay $130 allowance	$70 reimbursement
Plan Costs-Monthly Rates											
	Voluntary		Voluntary	Voluntary		Voluntary		Voluntary		Voluntary	
	Exam and Materials		Materials Only	Exam and Materials		Materials Only		Exam and Materials		Exam and Materials	
Employee Only	$12.42		$6.85	$7.24		$5.32		Employee Only $8.76		$9.18	
Employee Plus 1	$21.62		$12.51	$13.76		$10.11		Employee Plus Spouse $16.54		$13.31	
Family	$29.53		$17.85	$20.20		$14.84		Employee Plus Children $18.02		$23.86	
Plus Family								Employee Plus Family $23.20			
Rate Guarantee											
	1 year			4 years		4 years		4 years		4 years	
Participation Requirements											
								Requires a minimum of 5 employees enrolled.		Rates based on enrollment of 10-50 employees	
Changes											
										Only Exam and Materials plans are available for this size group.	