City of Delray Beach
Voluntary Vision BAFO Evaluation
Effective Date: October 1, 2021

GEHRING GROUP
EMPLOYEE BENEFITS | RISK MANAGEMENT

		CURRENT		RENEWAL (EYEMED INITIAL)			RENEWAL (EYEMED BAFO)		
Vision		**EyeMed**		**EyeMed**			**EyeMed**		
Frequency of Services									
Examination		12 Months		12 Months			12 Months		
Lenses or Contact Lenses		12 Months		12 Months			12 Months		
Frames		24 Months		24 Months			24 Months		
		In Network	**Out of Network**	**In Network**	**Out of Network**		**In Network**	**Out of Network**	
Eye Exam		$10 Copay	Up to $40 Reimbursement	$10 Copay **$0 at PLUS Providers**	Up to $40 Reimbursement		$10 Copay **$0 at PLUS Providers**	Up to $40 Reimbursement	
Lenses									
Single Vision		No Charge after $15 Copay	Up to $30 Reimbursement	No Charge after $15 Copay	Up to $30 Reimbursement		No Charge after $15 Copay	Up to $30 Reimbursement	
Bifocal			Up to $50 Reimbursement		Up to $50 Reimbursement			Up to $50 Reimbursement	
Trifocal			Up to $70 Reimbursement		Up to $70 Reimbursement			Up to $70 Reimbursement	
Frames									
Retail		Up to $130 Allowance; 20% Discount over $130	Up to $98 Reimbursement	Up to $130/**$180 at PLUS providers**; 20% Discount over $180	Up to $98 Reimbursement		Up to $130/**$180 at PLUS providers**; 20% Discount over $180	Up to $98 Reimbursement	
Contact Lenses (In lieu of eyeglasses)									
Non-elective (Medically Necessary)		No Charge	Up to $210 Reimbursement	No Charge	Up to $210 Reimbursement		No Charge	Up to $210 Reimbursement	
Conventional		Up to $130 Allowance; 15% Discount over $130	Up to $110 Reimbursement	Up to $130 Allowance; 15% Discount over $130	Up to $110 Reimbursement		Up to $130 Allowance; 15% Discount over $130	Up to $110 Reimbursement	
Disposable		Up to $130 Allowance	Up to $110 Reimbursement	Up to $130 Allowance	Up to $110 Reimbursement		Up to $130 Allowance	Up to $110 Reimbursement	
Participation Requirement		n/a		Minimum 10 enrolled			Minimum 10 enrolled		
Rate Guarantee		**Expires 9/30/2021**		**4 Years**			**4 Years**		
Monthly Premium Rates		**Per Month**	**Per Pay**	**Per Month**	**Per Pay**	**Per Pay $ Incr.**	**Per Month**	**Per Pay**	**Per Pay $ Incr.**
EE Only	293	$4.98	$2.30	$5.42	$2.50	$0.20	$5.12	$2.36	$0.06
EE + 1	145	$9.71	$4.48	$10.57	$4.88	$0.40	$9.99	$4.61	$0.13
EE + 2 or more	173	$13.93	$6.43	$15.16	$7.00	$0.57	$14.33	$6.61	$0.18
Monthly Premium	**611**	**$5,276.98**		**$5,743.39**			**$5,427.80**		
Annual Premium		**$63,323.76**		**$68,920.68**			**$65,133.60**		
$ Increase		**n/a**		**$5,596.92**			**$1,809.84**		
% Increase		**n/a**		**8.8%**			**2.9%**		