

**SUMTER COUNTY BOARD OF COMMISSIONERS  
EXECUTIVE SUMMARY**

**SUBJECT:** Humana, Inc. Voluntary Vision Plan (Staff Recommends Option 1).  
**REQUESTED ACTION:** Approve Humana Vision plan Option 1 effective October 1, 2012.

Work Session (Report Only)    **DATE OF MEETING:** 08/14/2012  
 Regular Meeting                       Special Meeting

**CONTRACT:**     N/A    Vendor/Entity: Humana, Inc.  
Effective Date: 10/01/2012    Termination Date: 09/30/2014  
Managing Division / Dept:                      Support Services

**BUDGET IMPACT:**                      Voluntary Benefit – no budget impact  
 Annual                      **FUNDING SOURCE:** \_\_\_\_\_  
 Capital                      **EXPENDITURE ACCOUNT:** \_\_\_\_\_  
 N/A

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**HISTORY/FACTS/ISSUES:**  
Staff is recommending approval of a voluntary vision plan with Humana, Inc. Many employees have expressed interest in having a vision plan; the Sumter County Sheriff currently has a vision plan with Humana.

The Willis Group, the County insurance broker was tasked with providing proposals from several vision carriers (attached). With input from Willis Group and analysis by County staff of the benefits and available in-network providers, the list was reduced to three carriers: Davis Vision, EyeMed and Humana. Staff determined that there are no significant differences between the carriers. As the Sheriff currently uses Humana and has expressed that their employees are happy with the carrier, it is recommended that the contract be awarded to Humana. Humana is providing a 2 year rate guarantee.

There are two options with Humana:

- Option 1: 12/12/12 – Examination, lenses and frames every 12 months
- Option 2: 12/24/12 – Examination and lenses every 12 months; frames every 24 months.

As the difference in cost between the two options is only \$1.23 per month and Option 1 provides lenses each year, staff is recommending approval of Option 1.

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ADVANTICA								
PLAN HIGHLIGHTS	SELECT PLUS 125 PLAN OPTION 1 (12/12/12)		SELECT PLUS 125 PLAN OPTION 2 (12/24/12)		SELECT PLUS 150 PLAN OPTION 1 (12/12/12)		SELECT PLUS 150 PLAN OPTION 2 (12/24/12)	
General Plan Information	In Network	Out of Network						
Examination Copay	\$10	Reimbursed up to \$40						
Materials Copay	\$25	Varies, see below						
<b>Benefit Frequency</b>								
Examinations	Once every 12 months							
Lenses	Once every 12 months							
Frames	Once every 12 months		Once every 24 months		Once every 12 months		Once every 24 months	
Contacts (in lieu of Lenses and Frames)	Once every 12 months							
<b>Plan Provisions</b>		<b>After Copay</b>		<b>After Copay</b>		<b>After Copay</b>		<b>After Copay</b>
Single Vision Lens	Covered in full after copay	Reimbursed up to \$20	Covered in full after copay	Reimbursed up to \$20	Covered in full after copay	Reimbursed up to \$20	Covered in full after copay	Reimbursed up to \$20
Bifocal Lens	Covered in full after copay	Reimbursed up to \$40	Covered in full after copay	Reimbursed up to \$40	Covered in full after copay	Reimbursed up to \$40	Covered in full after copay	Reimbursed up to \$40
Trifocal Lens	Covered in full after copay	Reimbursed up to \$60	Covered in full after copay	Reimbursed up to \$60	Covered in full after copay	Reimbursed up to \$60	Covered in full after copay	Reimbursed up to \$60
Frames	\$125 allowance after \$25 copay	Reimbursed up to \$40	\$125 allowance after \$25 copay	Reimbursed up to \$40	\$150 allowance after \$25 copay	Reimbursed up to \$40	\$150 allowance after \$25 copay	Reimbursed up to \$40
<b>Contacts</b>	<i>In lieu of lenses and frames</i>							
Medically Necessary	\$250 allowance after \$25 copay	Reimbursed up to \$250	\$250 allowance after \$25 copay	Reimbursed up to \$250	\$250 allowance after \$25 copay	Reimbursed up to \$250	\$250 allowance after \$25 copay	Reimbursed up to \$250
Elective (fitting follow up & lenses)	\$125 allowance after \$25 copay	Reimbursed up to \$60	\$125 allowance after \$25 copay	Reimbursed up to \$60	\$150 allowance after \$25 copay	Reimbursed up to \$80	\$150 allowance after \$25 copay	Reimbursed up to \$80
Contact Fitting Fee	\$30 allowance	Not covered	\$30 allowance	Not covered	\$40 allowance	Not covered	\$40 allowance	Not covered
<b>Lens Options</b>								
Standard Progressive	\$50	Not covered						
UV Coating	\$16	Not covered						
Tint (Solid & Gradient)	\$16	Not covered						
Scratch Resistance	\$16	Not covered						
Basic Polycarbonate	Children - no cost under age 19 Adults - \$30	Not covered	Children - no cost under age 19 Adults - \$30	Not covered	Children - no cost under age 19 Adults - \$30	Not covered	Children - no cost under age 19 Adults - \$30	Not covered
Standard Anti-Reflective	\$45	Not covered						
<b>Other Services</b>								
Corrective Vision Services (e.g. Laser Surgery)	Discount through QualSight	Not covered						
<b>Network</b>								
Independent Practitioners	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A
Retail Chain Stores	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A

ADVANTICA				
PLAN HIGHLIGHTS	SELECT PLUS 125 PLAN OPTION 1 (12/12/12)	SELECT PLUS 125 PLAN OPTION 2 (12/24/12)	SELECT PLUS 150 PLAN OPTION 1 (12/12/12)	SELECT PLUS 150 PLAN OPTION 2 (12/24/12)
PREMIUM ANALYSIS	Proposed	Proposed	Proposed	Proposed
Employee	\$6.68	\$5.44	\$7.78	\$6.38
Employee + Spouse	\$13.38	\$10.92	\$15.58	\$12.78
Employee + Child	\$14.20	\$11.56	\$16.52	\$13.56
Family	<u>\$22.36</u>	<u>\$18.22</u>	<u>\$26.02</u>	<u>\$21.36</u>
Monthly Premium	\$6,584.92	\$5,365.04	\$7,664.68	\$6,289.60
Annual Premium	\$79,019.04	\$64,380.48	\$91,976.16	\$75,475.20
Rate Guarantee	2 years			
Contribution Requirement	Voluntary			
Participation Requirement	Minimum 10 eligible enrolled			
Notes/Comments				

Actual rates will be based on final enrollment.

THIS BENEFIT SUMMARY IS FOR ILLUSTRATION PURPOSES ONLY.

This insurance proposal is not to be construed as an exact or complete analysis of the policies nor as legal evidence of insurance. The provisions of the actual policies will prevail.

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Assumptions - Based on medical participation

EE	254
E + S	60
E + C	83
E + Family	130
Total	<u>527</u>

BOARD OF COUNTY COMMISSIONERS, SUMTER COUNTY, FLORIDA

10/1/2012 Vision Marketing

AETNA				
PLAN HIGHLIGHTS	OPTION 1 (12/12/12)		OPTION 2 (12/24/12)	
General Plan Information	In Network	Out of Network	In Network	Out of Network
Examination Copay	\$10	Reimbursed up to \$25	\$10	Reimbursed up to \$25
Materials Copay	\$25	Varies, see below	\$25	Varies, see below
<b>Benefit Frequency</b>				
Examinations	Once every 12 months		Once every 12 months	
Lenses	Once every 12 months		Once every 12 months	
Frames	Once every 12 months		Once every 24 months	
Contacts (in lieu of Lenses and Frames)	Once every 12 months		Once every 12 months	
<b>Plan Provisions</b>		<b>After Copay</b>		<b>After Copay</b>
Single Vision Lens	Covered in full after copay	Reimbursed up to \$10	Covered in full after copay	Reimbursed up to \$10
Bifocal Lens	Covered in full after copay	Reimbursed up to \$25	Covered in full after copay	Reimbursed up to \$25
Trifocal Lens	Covered in full after copay	Reimbursed up to \$55	Covered in full after copay	Reimbursed up to \$55
Frames	Conventional: \$130 allowance; plus 20% off balance Disposable: \$130 allowance; no discount on balance	Reimbursed up to \$65	Conventional: \$130 allowance; plus 20% off balance Disposable: \$130 allowance; no discount on balance	Reimbursed up to \$65
<b>Contacts</b>	<i>In lieu of lenses and frames</i>		<i>In lieu of lenses and frames</i>	
Medically Necessary	Covered in full	Reimbursed up to \$200	Covered in full	Reimbursed up to \$200
Elective (fitting follow up & lenses)	\$130 allowance; plus 15% off balance	Reimbursed up to \$90	\$130 allowance; plus 15% off balance	Reimbursed up to \$90
Contact Fitting Fee	\$40 copay	Not Covered	\$40 copay	Not Covered
<b>Lens Options</b>				
Standard Progressive	\$90	Reimbursed up to \$25	\$90	Reimbursed up to \$25
UV Coating	\$15	Not Covered	\$15	Not Covered
Tint (Solid & Gradient)	\$15	Not Covered	\$15	Not Covered
Scratch Resistance	Covered in full	Reimbursed up to \$15	Covered in full	Reimbursed up to \$15
Basic Polycarbonate	Children under 19: Covered in full Adults - \$40	Reimbursed up to \$35 (not covered for adults)	Children under 19: Covered in full Adults - \$40	Reimbursed up to \$35 (not covered for adults)
Standard Anti-Reflective	\$45	Not Covered	\$45	Not Covered
<b>Other Services</b>				
Corrective Vision Services (e.g. Laser Surgery)	15% discount on retail or 5% discount on promotional pricing	Not Covered	15% discount or 5% discount on promotional pricing	Not Covered
<b>Network</b>				
Independent Practitioners	Yes	N/A	Yes	N/A
Retail Chain Stores	Yes	N/a	Yes	N/a

BOARD OF COUNTY COMMISSIONERS, SUMTER COUNTY, FLORIDA

10/1/2012 Vision Marketing

AETNA		
PLAN HIGHLIGHTS	OPTION 1 (12/12/12)	OPTION 2 (12/24/12)
PREMIUM ANALYSIS	Proposed	Proposed
Employee	\$8.22	\$7.16
Employee + Spouse	\$15.62	\$13.61
Employee + Child	\$16.44	\$14.32
Family	\$24.17	\$21.06
Monthly Premium	\$7,531.70	\$6,561.60
Annual Premium	\$90,380.40	\$78,739.20
Rate Guarantee	2 years	
Contribution Requirement	Voluntary	
Participation Requirement	25%	
Notes/Comments	EyeMed Vision Care Network	

*Actual rates will be based on final enrollment.*

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Assumptions - Based on medical participation

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E + Family	130
Total	527

PLAN HIGHLIGHTS	DAVIS VISION				EYEMED			
	OPTION 1 (12/12/12)		OPTION 2 (12/24/12)		OPTION 1 (12/12/12)		OPTION 2 (12/24/12)	
General Plan Information	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Examination Copay	\$10	Reimbursed up to \$40	\$10	Reimbursed up to \$40	\$10	\$30 allowance	\$10	\$30 allowance
Materials Copay	\$25	Varies, see below	\$25	Varies, see below	\$25	Varies, see below	\$25	Varies, see below
Benefit Frequency								
Examinations	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Lenses	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Frames	Once every 12 months		Once every 24 months		Once every 12 months		Once every 24 months	
Contacts (in lieu of Lenses and Frames)	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Plan Provisions		After Copay		After Copay		No Copay		No Copay
Single Vision Lens	Covered in full after copay	Reimbursed up to \$40	Covered in full after copay	Reimbursed up to \$40	Covered in full after copay	\$25 allowance	Covered in full after copay	\$25 allowance
Bifocal Lens	Covered in full after copay	Reimbursed up to \$60	Covered in full after copay	Reimbursed up to \$60	Covered in full after copay	\$40 allowance	Covered in full after copay	\$40 allowance
Trifocal Lens	Covered in full after copay	Reimbursed up to \$80	Covered in full after copay	Reimbursed up to \$80	Covered in full after copay	\$60 allowance	Covered in full after copay	\$60 allowance
Frames	Collection: Up to \$25 copay Non-collection: \$130 allowance, plus 20% off balance	Reimbursed up to \$50	Collection: Up to \$25 copay Non-collection: \$130 allowance, plus 20% off balance	Reimbursed up to \$50	\$130 allowance, plus 20% off balance	\$65 allowance	\$130 allowance, plus 20% off balance	\$65 allowance
Contacts	In lieu of lenses and frames		In lieu of lenses and frames		In lieu of lenses only		In lieu of lenses only	
Medically Necessary	Covered in full	Reimbursed up to \$225	Covered in full	Reimbursed up to \$225	Covered in full	\$200 allowance	Covered in full	\$200 allowance
Elective (fitting follow up & lenses)	\$130 allowance, plus 15% off balance	Reimbursed up to \$105	\$130 allowance, plus 15% off balance	Reimbursed up to \$105	Conventional: \$130 allowance; plus 15% off balance Disposable: \$130 allowance; no discount on balance (Lenses only, fit/follow-up is a separate benefit)	\$104 allowance	Conventional: \$130 allowance; plus 15% off balance Disposable: \$130 allowance; no discount on balance (Lenses only, fit/follow-up is a separate benefit)	\$104 allowance
Contact Fitting Fee	Standard lenses - Included Specialty lenses - \$60 allowance, plus 15% off balance	Included in above	Standard lenses - Included Specialty lenses - \$60 allowance, plus 15% off balance	Included in above	Standard Contacts - Up to \$40 Premium Contacts - 10% off retail	Not Covered	Standard Contacts - Up to \$40 Premium Contacts - 10% off retail	Not Covered
Lens Options								
Standard Progressive	\$50	Reimbursed up to \$60	\$50	Reimbursed up to \$60	\$90	\$40 allowance	\$90	\$40 allowance
UV Coating	\$12	Not Covered	\$12	Not Covered	Covered in full	\$8 allowance	Covered in full	\$8 allowance
Tint (Solid & Gradient)	Covered in full	Not Covered	Covered in full	Not Covered	\$15	Not Covered	\$15	Not Covered
Scratch Resistance	Covered in full	Not Covered	Covered in full	Not Covered	Covered in full	\$8 allowance	Covered in full	\$8 allowance
Basic Polycarbonate	Children - Covered in full Adults - \$30	Not Covered	Children - Covered in full Adults - \$30	Not Covered	\$40	Not Covered	\$40	Not Covered
Standard Anti-Reflective	\$35	Not Covered	\$35	Not Covered	\$45	Not Covered	\$45	Not Covered
Other Services								
Corrective Vision Services (e.g. Laser Surgery)	Up to 25% off provider's fee or 5% off promotional price	Not Covered	Up to 25% off provider's fee or 5% off promotional price	Not Covered	15% off retail price or 5% off promotional price	Not Covered	15% off retail price or 5% off promotional price	Not Covered
Network								
Independent Practitioners	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A
Retail Chain Stores	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A

PLAN HIGHLIGHTS	DAVIS VISION		EYEMED	
	OPTION 1 (12/12/12)	OPTION 2 (12/24/12)	OPTION 1 (12/12/12)	OPTION 2 (12/24/12)
<b>PREMIUM ANALYSIS</b>	<b>Proposed</b>	<b>Proposed</b>	<b>Proposed</b>	<b>Proposed</b>
Employee	\$6.66	\$5.46	\$5.71	\$4.95
Employee + Spouse	\$11.98	\$9.83	\$10.85	\$9.40
Employee + Child	\$12.65	\$10.38	\$11.42	\$9.90
Family	\$19.97	\$16.38	\$16.79	\$14.55
Monthly Premium	\$6,056.49	\$4,967.58	\$5,231.90	\$4,534.50
Annual Premium	\$72,677.88	\$59,610.96	\$62,782.80	\$54,414.00
Rate Guarantee	4 years		4 years	
Contribution Requirement	Voluntary		Voluntary	
Participation Requirement	505 eligible employees		Minimum 10 enrolled	
Notes/Comments				

*Actual rates will be based on final enrollment.*  
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Assumptions - Based on medical participation

EE	254
E + S	60
E + C	83
E + Family	130
Total	<u>527</u>

BOARD OF COUNTY COMMISSIONERS, SUMTER COUNTY, FLORIDA

10/1/2012 Vision Marketing

PLAN HIGHLIGHTS	HUMANA				NVA			
	OPTION 1 (12/12/12)		OPTION 2 (12/24/12)		OPTION 1 (12/12/12)		OPTION 2 (12/24/12)	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>General Plan Information</b>								
Examination Copay	\$10	\$35 allowance	\$10	\$35 allowance	\$10	Reimbursed up to \$35	\$10	Reimbursed up to \$35
Materials Copay	\$25	Varies, see below	\$25	Varies, see below	\$25	Varies, see below	\$25	Varies, see below
<b>Benefit Frequency</b>								
Examinations	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Lenses	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Frames	Once every 12 months		Once every 24 months		Once every 12 months		Once every 24 months	
Contacts (in lieu of Lenses and Frames)	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
<b>Plan Provisions</b>		<b>After Copay</b>		<b>After Copay</b>		<b>After Copay</b>		<b>After Copay</b>
Single Vision Lens	Covered in full after copay	\$25 allowance	Covered in full after copay	\$25 allowance	Covered in full after copay	Reimbursed up to \$25	Covered in full after copay	Reimbursed up to \$25
Bifocal Lens	Covered in full after copay	\$40 allowance	Covered in full after copay	\$40 allowance	Covered in full after copay	Reimbursed up to \$35	Covered in full after copay	Reimbursed up to \$35
Trifocal Lens	Covered in full after copay	\$60 allowance	Covered in full after copay	\$60 allowance	Covered in full after copay	Reimbursed up to \$45	Covered in full after copay	Reimbursed up to \$45
Frames	\$50 wholesale allowance	\$45 retail allowance	\$50 wholesale allowance	\$45 retail allowance	\$130 retail allowance, plus 20% off balance	Reimbursed up to \$45	\$130 retail allowance, plus 20% off balance	Reimbursed up to \$45
<b>Contacts</b>	<i>In lieu of lenses and frames</i>		<i>In lieu of lenses and frames</i>		<i>In lieu of lenses and frames</i>		<i>In lieu of lenses and frames</i>	
Medically Necessary	Covered in full	\$150 allowance	Covered in full	\$150 allowance	Covered in full	Reimbursed up to \$210	Covered in full	Reimbursed up to \$210
Elective (fitting follow up & lenses)	\$150 allowance	\$150 allowance	\$150 allowance	\$150 allowance	\$105 retail allowance	Reimbursed up to \$105	\$105 retail allowance	Reimbursed up to \$105
Contact Fitting Fee	Included in above	Included in above	Included in above	Included in above	Covered in full	Daily Wear - \$20 Extended Wear - \$30	Covered in full	Daily Wear - \$20 Extended Wear - \$30
<b>Lens Options</b>								
Standard Progressive	\$60	Not Covered	\$60	Not Covered	\$50	Not Covered	\$50	Not Covered
UV Coating	\$15	Not Covered	\$15	Not Covered	\$12	Not Covered	\$12	Not Covered
Tint (Solid & Gradient)	Solid - \$13 Gradient - \$15	Solid - \$10 Gradient - \$12	Not Covered	Solid - \$10 Gradient - \$12	Not Covered			
Scratch Resistance	\$16	\$16	\$16	\$16	\$10	Not Covered	\$10	Not Covered
Basic Polycarbonate	Non-aspheric - \$28 Aspheric - \$49	Non-aspheric - \$32 Aspheric - \$56	Non-aspheric - \$28 Aspheric - \$49	Non-aspheric - \$32 Aspheric - \$56	Children - Covered in full Adults - up to \$30	Not Covered	Children - Covered in full Adults - up to \$30	Not Covered
Standard Anti-Reflective	\$44	Not Covered	\$44	Not Covered	\$40	Not Covered	\$40	Not Covered
<b>Other Services</b>								
Corrective Vision Services (e.g. Laser Surgery)	Discounts	Not Covered	Discounts	Not Covered	Discounts	Not Covered	Discounts	Not Covered
<b>Network</b>								
Independent Practitioners	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A
Retail Chain Stores	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A

PLAN HIGHLIGHTS	HUMANA		NVA	
	OPTION 1 (12/12/12)	OPTION 2 (12/24/12)	OPTION 1 (12/12/12)	OPTION 2 (12/24/12)
<b>PREMIUM ANALYSIS</b>	<b>Proposed</b>	<b>Proposed</b>	<b>Proposed</b>	<b>Proposed</b>
Employee	\$6.10	\$4.87	\$6.19	\$5.40
Employee + Spouse	\$12.21	\$9.74	\$11.14	\$9.71
Employee + Child	\$11.59	\$9.25	\$9.90	\$8.63
Family	<u>\$18.22</u>	<u>\$14.54</u>	<u>\$16.09</u>	<u>\$14.03</u>
Monthly Premium	\$5,612.57	\$4,479.33	\$5,154.06	\$4,494.39
Annual Premium	\$67,350.84	\$53,751.96	\$61,848.72	\$53,932.68
Rate Guarantee	2 years Year 3 will be capped at +5% and guaranteed from 10/1/14 to 9/30/16.		4 years	
Contribution Requirement	Voluntary		Voluntary	
Participation Requirement	Minimum 10 enrolled		Minimum 10 enrolled	
Notes/Comments				

Actual rates will be based on final enrollment.

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Assumptions - Based on medical participation

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E + S	60
E + C	83
E + Family	130
Total	<u>527</u>

BOARD OF COUNTY COMMISSIONERS, SUMTER COUNTY, FLORIDA

10/1/2012 Vision Marketing

PLAN HIGHLIGHTS	SUPERIOR VISION				UNITED HEALTHCARE			
	OPTION 1 (12/12/12)		OPTION 2 (12/24/12)		PLAN V1006 - OPTION 1 (12/12/12)		PLAN V1008 - OPTION 2 (12/24/12)	
General Plan Information	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Examination Copay	\$10	Reimbursed up to \$33	\$10	Reimbursed up to \$33	\$10	Reimbursed up to \$40	\$10	Reimbursed up to \$40
Materials Copay	\$25	Varies, see below	\$25	Varies, see below	\$25	Varies, see below	\$25	Varies, see below
<b>Benefit Frequency</b>								
Examinations	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Lenses	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Frames	Once every 12 months		Once every 24 months		Once every 12 months		Once every 24 months	
Contacts (in lieu of Lenses and Frames)	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
<b>Plan Provisions</b>		<b>After Copay</b>		<b>After Copay</b>		<b>After Copay</b>		<b>After Copay</b>
Single Vision Lens	Covered in full after copay	Reimbursed up to \$29	Covered in full after copay	Reimbursed up to \$29	Covered in full after copay	Reimbursed up to \$40	Covered in full after copay	Reimbursed up to \$40
Bifocal Lens	Covered in full after copay	Reimbursed up to \$43	Covered in full after copay	Reimbursed up to \$43	Covered in full after copay	Reimbursed up to \$60	Covered in full after copay	Reimbursed up to \$60
Trifocal Lens	Covered in full after copay	Reimbursed up to \$53	Covered in full after copay	Reimbursed up to \$53	Covered in full after copay	Reimbursed up to \$80	Covered in full after copay	Reimbursed up to \$80
Frames	\$25 copay; \$125 retail allowance	Reimbursed up to \$65	\$25 copay; \$125 retail allowance	Reimbursed up to \$65	Up to \$130 retail allowance	Reimbursed up to \$45	Up to \$130 retail allowance	Reimbursed up to \$45
<b>Contacts</b>	<i>In lieu of lenses and frames</i>		<i>In lieu of lenses and frames</i>		<i>In lieu of lenses and frames</i>		<i>In lieu of lenses and frames</i>	
Medically Necessary	Covered in full	Reimbursed up to \$210	Covered in full	Reimbursed up to \$210	Covered in full	Reimbursed up to \$210	Covered in full	Reimbursed up to \$210
Elective (fitting follow up & lenses)	\$100 retail allowance	Reimbursed up to \$100	\$100 retail allowance	Reimbursed up to \$100	Up to \$105 retail allowance	Reimbursed up to \$105	Up to \$105 retail allowance	Reimbursed up to \$105
Contact Fitting Fee	Standard - Covered in full after copay Specialty - \$50 retail allowance	Not Covered	Standard - Covered in full after copay Specialty - \$50 retail allowance	Not Covered	Included in above	Included in above	Included in above	Included in above
<b>Lens Options</b>								
Standard Progressive	Covered to providers retail trifocal allowance, after \$10 copay	Not Covered	Covered to providers retail trifocal allowance, after \$10 copay	Not Covered	\$70	Not Covered	\$70	Not Covered
UV Coating	\$15	Not Covered	\$15	Not Covered	\$16	Not Covered	\$16	Not Covered
Tint (Solid & Gradient)	\$25	Not Covered	\$25	Not Covered	Solid - \$13 Gradient - \$15	Not Covered	Solid - \$13 Gradient - \$15	Not Covered
Scratch Resistance	\$13	Not Covered	\$13	Not Covered	\$13	Not Covered	\$13	Not Covered
Basic Polycarbonate	\$40	Not Covered	\$40	Not Covered	\$25	Not Covered	\$25	Not Covered
Standard Anti-Reflective	\$50	Not Covered	\$50	Not Covered	\$40	Not Covered	\$40	Not Covered
<b>Other Services</b>								
Corrective Vision Services (e.g. Laser Surgery)	Discounts	Not Covered	Discounts	Not Covered	Discounts	Not Covered	Discounts	Not Covered
<b>Network</b>								
Independent Practitioners	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A
Retail Chain Stores	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A



SUPERIOR VISION			UNITED HEALTHCARE	
PLAN HIGHLIGHTS	OPTION 1 (12/12/12)	OPTION 2 (12/24/12)	PLAN V1006 - OPTION 1 (12/12/12)	PLAN V1008 - OPTION 2 (12/24/12)
PREMIUM ANALYSIS	Proposed	Proposed	Proposed	Proposed
Employee	\$8.22	\$7.32	\$6.57	\$5.51
Employee + Spouse	\$16.26	\$14.50	\$13.30	\$10.15
Employee + Child	\$15.92	\$14.22	\$13.94	\$10.64
Family	<u>\$24.20</u>	<u>\$21.62</u>	<u>\$17.63</u>	<u>\$15.92</u>
Monthly Premium	\$7,530.84	\$6,720.14	\$5,915.70	\$4,961.26
Annual Premium	\$90,370.08	\$80,641.68	\$70,988.40	\$59,535.12
Rate Guarantee	4 years		3 years	
Contribution Requirement	Voluntary		Voluntary	
Participation Requirement	Minimum 10 enrolled		No minimum enrollment required	
Notes/Comments				

Actual rates will be based on final enrollment.

THIS BENEFIT SUMMARY IS FOR ILLUSTRATION PURPOSES ONLY.

This insurance proposal is not to be construed as an exact or complete analysis of the policies nor as legal evidence of insurance. The provisions of the actual policies will prevail.

THIS INFORMATION IS PROPRIETARY AND SHOULD NOT BE DISTRIBUTED.

Assumptions - Based on medical participation

EE	254
E + S	60
E + C	83
E + Family	130
Total	<u>527</u>

BOARD OF COUNTY COMMISSIONERS, SUMTER COUNTY, FLORIDA

10/1/2012 Vision Marketing

VSP				
PLAN HIGHLIGHTS	OPTION 1 (12/12/12)		OPTION 2 (12/24/12)	
<b>General Plan Information</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>
Examination Copay	\$10	Reimbursed up to \$45	\$10	Reimbursed up to \$45
Materials Copay	\$25	Varies, see below	\$25	Varies, see below
<b>Benefit Frequency</b>				
Examinations	Once every 12 months		Once every 12 months	
Lenses	Once every 12 months		Once every 12 months	
Frames	Once every 12 months		Once every 24 months	
Contacts (in lieu of Lenses and Frames)	Once every 12 months		Once every 12 months	
<b>Plan Provisions</b>		<b>After Copay</b>		<b>After Copay</b>
Single Vision Lens	Covered in full after \$25 copay	Reimbursed up to \$30	Covered in full after \$25 copay	Reimbursed up to \$30
Bifocal Lens	Covered in full after \$25 copay	Reimbursed up to \$50	Covered in full after \$25 copay	Reimbursed up to \$50
Trifocal Lens	Covered in full after \$25 copay	Reimbursed up to \$65	Covered in full after \$25 copay	Reimbursed up to \$65
Frames	\$25 copay then \$130 allowance; plus 20% off balance	Reimbursed up to \$70	\$25 copay then \$130 allowance; plus 20% off balance	Reimbursed up to \$70
<b>Contacts</b>	<b>In lieu of lenses and frames</b>		<b>In lieu of lenses and frames</b>	
Medically Necessary	Covered in full after \$25 copay	Reimbursed up to \$210	Covered in full after \$25 copay	Reimbursed up to \$210
Elective (fitting follow up & lenses)	\$130 allowance	Reimbursed up to \$105	\$130 allowance	Reimbursed up to \$105
Contact Fitting Fee	15% discount, \$60 max out of pocket	Included in above	15% discount, \$60 max out of pocket	Included in above
<b>Lens Options</b>				
Standard Progressive	\$55	Not Covered	\$55	Not Covered
UV Coating	\$16	Not Covered	\$16	Not Covered
Tint (Solid & Gradient)	up to \$17	Not Covered	up to \$17	Not Covered
Scratch Resistance	\$17	Not Covered	\$17	Not Covered
Basic Polycarbonate	Children - Covered in full Adults - up to \$37	Not Covered	Children - Covered in full Adults - up to \$37	Not Covered
Standard Anti-Reflective	\$43	Not Covered	\$43	Not Covered
<b>Other Services</b>				
Corrective Vision Services (e.g. Laser Surgery)	15% discount on retail or 5% discount on promotional pricing	Not Covered	15% discount on retail or 5% discount on promotional pricing	Not Covered
<b>Network</b>				
Independent Practitioners	Yes	N/A	Yes	N/A
Retail Chain Stores	Yes	N/a	Yes	N/a

**BOARD OF COUNTY COMMISSIONERS, SUMTER COUNTY, FLORIDA**

**10/1/2012 Vision Marketing**

VSP		
PLAN HIGHLIGHTS	OPTION 1 (12/12/12)	OPTION 2 (12/24/12)
PREMIUM ANALYSIS	Proposed	Proposed
Employee	\$7.85	\$5.94
Employee + Spouse	\$12.56	\$9.50
Employee + Child	\$12.82	\$9.70
Family	<u>\$20.67</u>	<u>\$15.64</u>
Monthly Premium	\$6,498.66	\$4,917.06
Annual Premium	\$77,983.92	\$59,004.72
Rate Guarantee	2 years	
Contribution Requirement	Voluntary	
Participation Requirement	Minimum 10 enrolled	
Notes/Comments		

*Actual rates will be based on final enrollment.*

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Assumptions - Based on medical participation

EE	254
E + S	60
E + C	83
E + Family	130
Total	527

BOARD OF COUNTY COMMISSIONERS, SUMTER COUNTY, FLORIDA  
10/1/2012 Vision Network Match

Access Standards	ADVANTICA Network	AETNA Network	DAVIS VISION Network	EYEMED Network	HUMANA Network	NVA Network	SUPERIOR VISION Network	UNITED HEALTHCARE Network	VSP Network									
<b>Independent Practitioners</b>																		
1 in 10 miles																		
Percent/Providers <sup>(1)</sup>	85.7%	97	96.6%	155	83.5%	47	86.9%	142	91.3%	367	83.5%	45	98.5%	128	16.9%	23	96.2%	276
Employees	451		508		439		457		480		439		518		89		506	
<b>Retail Chains</b>																		
1 in 10 miles																		
Percent/Providers <sup>(1)</sup>	81.6%	49	12.9%	39	78.5%	104	10.8%	40	10.1%	127	74.1%	57	84.6%	101	93.5%	174	Not Provided	
Employees	429		68		413		57		53		390		445		492			
Total Employees in calculation	526		526		526		526		526		526		526		526		526	
<b>Top 5 Locations Outside Access Standards<sup>(2)</sup></b>																		
<b>Independent Practitioners</b>	Astor, FL Altoona, FL Fort McCoy, FL Webster, FL Crystal River, FL	Astor, FL Fort McCoy, FL Dunnellon, FL Webster, FL Dade City, FL	Fort McCoy, FL Astor, FL Ocklawaha, FL Weirdale, FL Dunnellon, FL	Ocklawaha, FL Groveland, FL Dade City, FL Webster, FL Brooksville, FL	Fort McCoy, FL Astor, FL Center Hill, FL Altoona, FL Ocklawaha, FL	Dunnellon, FL Ocklawaha, FL Center Hill, FL Dade City, FL Webster, FL	Astor, FL Dunnellon, FL Ocklawaha, FL Fort McCoy, FL Brooksville, FL	Sumterville, FL Leesburg, FL Bushnell, FL Webster, FL Center Hill, FL	Fort McCoy, FL Astor, FL Altoona, FL Dunnellon, FL Ocklawaha, FL									
<b>Retail Chains</b>	Fort McCoy, FL Altoona, FL Astor, FL Floral City, FL Dade City, FL	Bushnell, FL Inverness, FL Webster, FL Lake Panasoffkee, FL Floral City, FL	Fort McCoy, FL Astor, FL Dade City, FL Altoona, FL Lake Panasoffkee, FL	Inverness, FL Bushnell, FL Webster, FL Lake Panasoffkee, FL Sumterville, FL	Bushnell, FL Webster, FL Lake Panasoffkee, FL Wildwood, FL Center Hill, FL	Lake Panasoffkee, FL Sumterville, FL Center Hill, FL Groveland, FL Ocklawaha, FL	Astor, FL Dade City, FL Altoona, FL Webster, FL Brooksville, FL	Altoona, FL Astor, FL Ocklawaha, FL Groveland, FL Dade City, FL	N/A									

<sup>(1)</sup> Some carriers may count a provider more than one time (i.e., multi-office locations).

<sup>(2)</sup> The Top 5 Locations Outside Access Standards is based on the number of employees impacted.

