



Maritz
HEALTHY YOU!

Maritz Vision Plan EyeMed

January 1, 2024



Vision Plan Rates

| Coverage Tier | Your Semi-Monthly Cost |
|-----------------------|------------------------|
| Employee Only | \$3.56 |
| Employee + Spouse | \$7.56 |
| Employee + Child(ren) | \$6.98 |
| Employee + Family | \$12.07 |

No increase in rates



Maritz Vision Plan

- This plan utilizes the **Insight** network
- Enhanced coverage when using Insight network providers with the **PLUS** designation
 - \$0 copay for eye exam
 - \$50 additional allowance for frames (\$225 instead of \$175)
- To find a provider in the network, go to **eyemed.com**
- Confirm both facility and doctor are in-network
 - If facility in-network but doctor out of network, exam not covered
 - Eyewear would be covered
- Out of coverage available, but must pay in full and submit for reimbursement
 - Much lower coverage for out of network providers



Vision Plan Summary

| Description of Service | In-network coverage | Out of network Plan reimbursement amount |
|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| Vision Exam <ul style="list-style-type: none"> PLUS providers All other Insight providers | \$0 Copay \$20 Copay | Up to \$45 |
| Contact Lenses Exam (fitting & eval.) | \$40 Copay for Standard fitting, 10% off Premium fitting | |
| Frames <ul style="list-style-type: none"> PLUS providers All other Insight providers | \$225 allowance for selected frames; 20% off over allowance \$175 allowance for selected frames; 20% off over allowance | Up to \$88 |
| Standard Plastic Lenses | | |
| Single Vision | \$25 Copay | Up to \$30 |
| Bifocal | \$25 Copay | Up to \$50 |
| Trifocal | \$25 Copay | Up to \$65 |
| Lenticular | \$25 Copay | Up to \$100 |
| Progressive - Standard | \$80 Copay | Up to \$50 |
| Progressive - Premium Tier 1 | \$100 Copay | Up to \$50 |
| Progressive – Premium Tier 2 | \$110 Copay | Up to \$50 |
| Progressive – Premium Tier 3 | \$125 Copay | Up to \$50 |
| Progressive – Premium Tier 4 | \$80 – 20% off retail price less \$120 allowance | Up to \$50 |

Vision Plan Summary (continued)

| Description of Service | In-Network Coverage | Out of Network Plan Reimbursement Amt |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------|
| Lenses Options | | |
| Polycarbonate—Std < 19 years of age | \$0 copay | Up to \$5 |
| Contact Lens (in lieu of eyeglasses) | | |
| Conventional | \$0 copay, 15% off balance > \$175 allowance | Up to \$140 |
| Disposable | \$0 copay, patient pays 100% of balance > \$175 allowance | Up to \$140 |
| Medically Necessary | \$0 copay, plan pays in full | Up to \$210 |
| Diabetic Care Services <i>covered every 6 months</i> | \$0 copay for Medical Follow Up Eye Exam (following the initial Comprehensive Eye Exam) | Up to \$15 to \$77 depending on service |
| Laser Vision Correction | Lasik or PRK from US Laser Network 15% off retail price or 5% off promotional price | |

Additional discounted lens options available such as anti-reflective or scratch coating, tinting, and UV treatments

Frequency – Once Every Calendar Year

Lenses (in lieu of contact lenses)

Contact Lenses (in lieu of glasses)

Frames



Maritz Vision Plan

- ID cards mailed to new members who enroll
 - Current members continue to use current ID card
- Still have questions?
 - Call EyeMed at 866.800.5457 or
 - Maritz Benefits department at Benefits@Maritz.com or 636.827.4088

