





### **Current Rates**

Employee Only	\$8.10		
Employee + Spouse	\$13.82		
<b>Employee with One Dependent</b>	\$14.54		
Employee + 2 or more Dependents	\$21.37		

peoplelease.com



#### **PeopleLease**

## Additional discounts

**40**% of F

Complete pair of prescription eyeglasses

**20**% of F

Non-prescription sunglasses

 $20^{\circ}$ OFF

Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

# Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

Frame

	SUMMARY OF BENEFITS		
Vision Care	In-Network	Out of Network	
Services	Member Cost	Reimbursement	
Exam With Dilation as Necessary	\$10 Copay	Up to \$40 N/A	
Retinal Imaging	Up to \$39		
Frames	\$0 Copay; \$130 allowance, 20% off balance over \$130	Up to \$91	
Standard Plastic Lenses			
Single Vision	\$25 Copay	Up to \$30	
Bifocal	\$25 Copay	Up to \$50	
Trifocal	\$25 Copay	Up to \$70	
Lenticular	\$25 Copay	Up to \$70	
Standard Progressive Lens	\$80 Copay	Up to \$50	
Premium Progressive Lens <sup>△</sup>	\$110 Copay - \$200 Copay	Up to \$50	
Tier 1	\$110 Copay	Up to \$50	
Tier 2	\$120 Copay	Up to \$50	
Tier 3	\$135 Copay	Up to \$50	
Tier 4	\$200 Copay	Up to \$50	
Lens Options (paid by the member and added to the base price of	f the lens)		
UV Treatment	\$15	N/A	
Tint (Solid and Gradiant)	\$15	N/A	
Standard Plastic Scratch Coating	\$15	N/A	
Standard Polycarbonate - age 19 and over	\$40	N/A	
Standard Polycarbonate - under age 19	\$0	Up to \$32	
Standard Anti-Reflective Coating	\$45	Up to \$5	
Premium Anti-Reflective Coating <sup>a</sup>	\$57 - \$85	Up to \$5	
Tier 1	\$57	Up to \$5	
Tier 2	\$68	Up to \$5	
Tier 3 Photochromic/Transitions	\$85 \$75	Up to \$5 N/A	
Polarized	20% off Retail Price	N/A	
Other Add-Ons and Services	20% off Retail Price	N/A	
	w-up visits are available once a comprehensive eye exam has been completed.,		
Standard Contact Lens Fit & Follow-Up: Premium Contact Lens Fit & Follow-Up:	\$40 10% off Retail Price	N/A	
Premium Contact Lens Fit & Pollow-Op:	10% Off Retail Price	N/A	
Contact Lenses (Contact Lens allowance includes materials only)			
Conventional	\$0 copay, \$130 allowance, 15% off balance over \$130	Up to \$130	
Disposable	\$0 copay, \$130 allowance, plus balance over \$130	Up to \$130	
Medically Necessary	\$0 copay, Paid-In-Full	Up to \$210	
Laser Vision Correction			
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A	
Hearing Care			
Hearing Health Care from	40% off hearing exams and low price guarantee		
Amplifon Hearing Network	on discounted hearing aids		
Frequency			
Examination	Once every 12 months		
Lenses (in lieu of contact lenses)	Once every 12 months		
Contacts (in lieu of lenses)	Once every 12 months		

Once every 12 months

QL-0000068387

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

<sup>&</sup>lt;sup>a</sup> Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.



### Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections. Required sections are marked with an  $^\star$ .

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer						
Employer Name*		1 1 1 1			1 1 1 1	Effective Date*^
			<u> </u>			
Group Number*		Sı	ubgroup*			^Date set by employer in accordance with EyeMed
						proposal. Employer also sets effective date for new adds
Location Code						during contract period.
Employee Inforn	<b>nation</b> : to be comple	ted by Employe	e			
Change Type*:	☐ Add ☐ T	erm 🔲 U	odate	Membe	r ID:	
Last Name*						Date of Birth*
						/ /
First Name*			MI Ger	nder*		Phone Number
				Male $\square$ F	emale (	
Street Address*						
I <del>I                                   </del>	<del></del>			<del>++++</del>	<del>         </del>	
City #				Ct : t =:	. C	Castral Castral III II II II
City*				State* Zi	p Code*	Social Security Number* <sup>^</sup>
			$\perp$			
Employee Email Ad	ddress:					^Last four digits of Employee's Social Security Number are required.
Family Informat	ion: to be completed				e enrolled.	
Dependent 1	Change Type*:	Add	☐ Term	Update	_	_
-	Relationship*:	☐ Husband	☐ Wife	☐ Son ☐	<b>]</b> Daughter	☐ Domestic Partner
Last Name*						Gender*:
						☐ Male ☐ Female
First Name*			MI Soc	ial Security Nur	nber	Date of Birth*
			ШШ		]- [	/ / /
5 1 10	Change Type*:	☐ Add	☐ Term	☐ Update		
Dependent 2	Relationship*:	☐ Husband	☐ Wife	· ·	<b>]</b> Daughter	☐ Domestic Partner
Last Name*						Gender*:
						☐ Male ☐ Female
First Name*			MI Soc	ial Security Nur	mber	Date of Birth*
				$\neg \neg$	1. 🗆 🗆	/ / /
	Chara T A					
Dependent 3	Change Type*:	☐ Add	☐ Term	Update	1 Danie le 1	Domostis Desite
Last Name*	Relationship*:	☐ Husband	<b>⊔</b> Wife	☐ Son ☐	<b>]</b> Daughter	☐ Domestic Partner  Gender*:
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First N			MI 2	:-10- :: 11		☐ Male ☐ Female
First Name*			MI Soc	ial Security Nur	mber	Date of Birth*
			<u>⊔ Ц</u>		] - [	/ / /
Donondont 4	Change Type*:	☐ Add	☐ Term	Update		
Dependent 4	Relationship*:	☐ Husband	■ Wife	☐ Son ☐	<b>]</b> Daughter	☐ Domestic Partner
Last Name*						Gender*:
						☐ Male ☐ Female
First Name*			MI Soc	ial Security Nur	mber	Date of Birth*
			ПП	$\Box$ - $\Box$	1-	/ /
			<u> </u>			
Employee Signatu	re*:					Date*: / /