

# OPEN ENROLLMENT

# People Lease

Payroll • Benefits • Compliance

People Lease is pleased to offer all employees, at no cost to the employer, the option to enroll into our Dental, Vision, Telemedicine, Supplemental Insurance Plans and Flexible Spending Accounts.

**Open Enrollment is November 1st- December 15th,  
with an effective date of January 1st.**

To enroll or if you have any questions please contact People Lease.



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

### Current Rates

**\$8.10**

**\$13.82**

**\$14.54**

**\$21.37**



<b>Employee Only</b>	<b>Current Rates</b>
<b>Employee with One Dependent</b>	<b>\$41.92</b>
<b>Employee and Family</b>	<b>\$81.93</b>
	<b>\$120.41</b>

### Current Rates

**\$41.92**

**\$81.93**

**\$120.41**



**FLEXIBLE SPENDING  
ACCOUNT**



**Colonial Life**



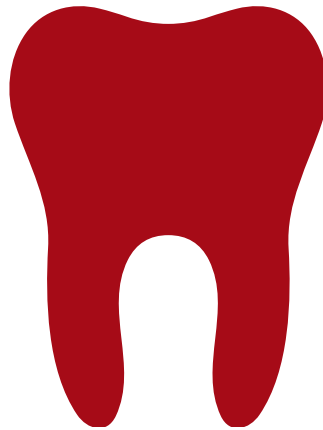
**Aflac**  
Enroll Now

[peoplelease.com](http://peoplelease.com)

# People Lease

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# DENTAL PLAN



	<b>Current Rates</b>
<b>Employee Only</b>	<b>\$41.92</b>
<b>Employee with One Dependent</b>	<b>\$81.93</b>
<b>Employee and Family</b>	<b>\$120.41</b>

[peoplelease.com](http://peoplelease.com)

601-987-3025 ● 689 Towne Center Boulevard Ridgeland, MS 39157

# ENROLLMENT/CHANGE FORM



P.O. Box 1809  
Alpharetta, GA 30023-1809  
1-800-521-2651  
Fax: 770-641-5393

For Employer Use Only	
Effective Date / /	Group No 18113
Full Time Hire Date / /	Sublocation

**Check One** (\*\*Enrollees can change plans only during open enrollment.)

- New Hire
- Open Enrollment
- Change Dental Plans\*\*
- COBRA
- Add/Delete Dependent
- Terminate Employee Coverage
- Spouse Employment Change
- Marital Change
- Other \_\_\_\_\_

Indicate qualifying date:

/  /   
(Month) (Day) (Year)

**COBRA Enrollment Only**

Please indicate qualifying event:

- Termination
- Reduction in Hours
- Divorce
- Widowed/Surviving Dependent
- Dependent Child No Longer Eligible

Indicate qualifying date:

/  /   
(Month) (Day) (Year)

**Primary Enrollee Information**

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: \_\_\_\_\_  
(Last, First)

Mailing Address: \_\_\_\_\_  
(Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Name of Employer/Group PEOPLELEASE Location \_\_\_\_\_

Marital Status: Single  Married  Gender: Male  Female  Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Do you have dependent children? Yes  No  Are you or your dependents covered under another dental plan? Yes  No

**Dependent Information**

VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth:			
Spouse: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

I decline coverage at this time.

*Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

Signature of Enrollee \_\_\_\_\_

Date \_\_\_\_\_

Plan Benefit Highlights for: People Lease

Group No: 18113

Effective Date: 1/1/2021

<b>Eligibility</b>	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
<b>Deductibles</b> Deductibles waived for Diagnostic and Preventive (D & P) and Orthodontics?	\$50 per person / \$150 per family each calendar year Yes			
<b>Maximums</b> D & P counts toward maximum?	\$1,500 per person per calendar year Yes			
<b>Waiting Period(s)</b>	Basic Benefits None	Major Benefits 12 months	Prosthodontics 12 months	Orthodontics 24 months
<b>Benefits and Covered Services*</b>	<b>Delta Dental PPO dentists**</b>		<b>Non-Delta Dental PPO dentists**</b>	
<b>Diagnostic &amp; Preventive Services (D &amp; P)</b> Exams, cleanings, x-rays and sealants	100 %		100 %	
<b>Basic Services</b> Fillings and simple tooth extractions	80 %		80 %	
<b>Endodontics</b> (root canals) Covered Under Basic Services	80 %		80 %	
<b>Non-Surgical Periodontics</b> (non-surgical gum treatment) Covered Under Basic Services	80 %		80 %	
<b>Surgical Periodontics</b> (surgical gum treatment) Covered Under Major Services	50 %		50 %	
<b>Oral Surgery</b> Covered Under Major Services	50 %		50 %	
<b>Major Services</b> Crowns, inlays, onlays and cast restorations, denture reline/rebase and repair	50 %		50 %	
<b>Prosthodontics</b> Bridges and dentures	50 %		50 %	
<b>Orthodontic Benefits</b> Dependent childrento age 19	50 %		50 %	
<b>Orthodontic Maximums</b>	\$1,000 Lifetime		\$1,000 Lifetime	
<b>Rates are effective</b> <b>1/1/2021 – 12/31/2021</b>	<b>Employee Only</b>		<b>\$41.92</b>	
	<b>Employee &amp; 1 Dependent</b>		<b>\$81.93</b>	
	<b>Employee &amp; Family</b>		<b>\$120.41</b>	

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

\*\* Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the 90th percentile for non-Delta Dental dentists.

**Delta Dental Insurance Company**  
1130 Sanctuary Parkway, Suite 600  
Alpharetta, GA 30009

**Customer Service**  
800-521-2651

**Claims Address**  
P.O. Box 1809  
Alpharetta, GA 30023-1809

**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

# People Lease

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## Current Rates

<b>Employee Only</b>	<b>\$8.10</b>
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VISION PLAN



# PeopleLease

## Additional discounts

**40% OFF**

Complete pair of prescription eyeglasses

**20% OFF**

Non-prescription sunglasses

**20% 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](http://eyemed.com) or call 1-866-804-0982

- For LASIK providers, call 1-877-5LASER6

## SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
<b>Exam With Dilation as Necessary</b>	\$10 Copay	Up to \$40
<b>Retinal Imaging</b>	Up to \$39	N/A
<b>Frames</b>	\$0 Copay; \$130 allowance, 20% off balance over \$130	Up to \$91
<b>Standard Plastic Lenses</b>		
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>A</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
<b>Lens Options</b> (paid by the member and added to the base price of the lens)		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$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	\$85	Up to \$5
Photochromic/Transitions	\$75	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
<b>Contact Lens Fit and Follow-up</b> (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard Contact Lens Fit & Follow-Up:	\$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off Retail Price	N/A
<b>Contact Lenses</b> (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
<b>Laser Vision Correction</b>		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
<b>Hearing Care</b>		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
<b>Frequency</b>		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contacts (in lieu of lenses)	Once every 12 months	
Frame	Once every 12 months	

QL-000068387

<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 any Workers' 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.





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## **FLEXIBLE SPENDING ACCOUNT**

**Save Money on your out of  
pocket Medical/Dental or Day  
Care Expenses!**

[peoplelease.com](http://peoplelease.com)



**FLEXIBLE SPENDING PLAN ELECTION**  
EMPLOYER NAME: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

I decline to participate in the employer sponsored Flex Plan. I have been given the opportunity to participate, and the benefits of the Plan have been explained to me. I understand that I may only participate at the beginning of the next **Plan Year**.

I elect to participate in the employer sponsored Flex Plan. I agree to and understand that:

Elections cannot be changed during the Plan Year unless there is a change in the family status (marriage, divorce, death of a spouse or child, birth or adoption of a child or a change in spouse's condition of employment: i.e., becomes employed, unemployed, or changes employers).

Salary reduction for the Medical and Dependent Care Expense Reimbursement programs will be credited to my "Flexible Spending Account" and the employer will reimburse me during the Plan Year as I submit paid documentation for incurred expenses, for approved un-reimbursed medical and/or dependent care expenses. I further understand that any amount remaining in my "benefit bank" as of March 2022 will be forfeited to the employer.

The opportunity to change my benefit elections for the following Plan Year will be given to me prior to each Plan Year. **Benefit selections will continue from one Plan Year to the next without completing a new election form.** However, if I wish to make a change or decline further participation for the next Plan Year, a new election form is required.

The employer may have to reduce or cancel the amount of my salary reduction or otherwise modify this agreement to satisfy new provisions of the Internal Revenue Code as they may occur during the plan year. Should I terminate my employment and the reimbursements I have received are greater than the amount that has been deposited into my Flexible Spending Account, I agree to reimburse the difference to People Lease.

Having selected the benefits checked below, I hereby elect to be reimbursed for the indicated expenditures and authorize my employer to reduce my gross compensation per pay period in the total amount stated below in conformity with Section 125 of the Internal Revenue Code.

Un-reimbursed Medical/Dental/Vision Expenses (Not to exceed \$2,500 for the 2021 Plan Year) \$ \_\_\_\_\_

Dependent Child Care Expenses (Not to exceed \$5,000 for the 2021 Plan Year) \$ \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\***FOR OFFICE USE ONLY**\*\*\*\*\*

Total number of pay periods remaining in 2021 (12, 24 or 48)

Divide the Total Annual Eligible Expenses amount by the number of pay periods in 2021 to get your pay period election.

\$ \_\_\_\_\_ (Deducted per period/Medical)

\$ \_\_\_\_\_ (Deducted per period/Dependent care)

SUPPLEMENTAL INSURANCES

**People  Lease**

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**Aflac**<sup>®</sup>  
Enroll Now

**Colonial Life**<sup>®</sup>

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Enrolling by phone is NOW available for your convenience!

**Nichole LeVern Festervan** Employee Benefits Consultant for Aflac at  
The Sanders Group Inc 601.991.1115  
(Cell) 601.606.2466 or (Email) Nicole\_levern@us.aflac.com

PRE-TAX  
BENEFITS

Aflac options are available to you that fit your budget – plans offered through payroll deduction at a group discounted rate through People Lease.

EMPLOYER: \_\_\_\_\_ Ph # \_\_\_\_\_

Employee Name: \_\_\_\_\_ Cell # \_\_\_\_\_

I AM INTERESTED IN GETTING MORE INFORMATION ON THE FOLLOWING POLICIES:

- ACCIDENT     CANCER     CRITICAL ILLNESS     HOSPITAL CHOICE
- LIFE (TERM & WHOLE LIFE)     SHORT TERM DISABILITY

**Please return this form to People Lease or fax to Nichole at 601.991.1012 or call her at 601.606.2466**

*I look forward to working with you in regards to your supplemental planning for you and your family. Please feel free to reach out to me over the next 30+ days to enroll in Aflac coverage.*

*Nichole LeVern Festervan ~ The Sanders Group, Inc*

Remember enrolling by phone is Now an Option! 601.606.2466 or 601.991.1115

**People★Lease**  
Payroll • Benefits • Compliance

Colonial Life can enroll your group in person or virtually on the phone or video call

**MDLive Telemedicine**

**Offered FREE to each employee for NEW groups      \$2/month for existing Colonial Groups**

Have a doctor's office visit over the phone 24 hours a day/365 days a year – use it for your family members, too! Stay at home, talk to a physician, get prescriptions for minor illnesses



THE NATION'S LARGEST TELEMEDICINE NETWORK

**MDLIVE**

EMPLOYEES AND ALL DEPENDENTS GET:  
ACCESS TO DOCTORS 24/7 FREE

Allergies  
Ear problems  
Respiratory

Cough  
Flu  
Rashes

Urinary / UTI  
Nausea / Vomiting  
Sore Throat

*Peace of mind*

Other Complimentary Services **for each employee**

**LawAssure**

FREE access to Wills, Power of Attorney, and more



Pharmacy and many other Medical discounts  
Save 40% to 60%

We answer your questions and enroll you in these **affordable benefits, at no cost to the employer:**

- Life Insurance** - Term Life Insurance; Whole life Insurance and Juvenile Whole Life Insurance offered – everyone needs life insurance!
- Short Term Disability Insurance** - Sends 60% of your salary home if you can't work due to illness or injury; a must-have before a maternity leave
- Cancer Insurance** – Because out-of-pocket costs are so high, get affordable financial protection for you and your family members
- Critical Care** for Heart, Stroke and other major illnesses; lump sum payments help greatly with hospital costs
- Medical Bridge Insurance** – Can cover deductibles and other out of pocket costs during a hospital stay that can financial stress you
- Accident Insurance** – On/off the job, a comprehensive plan for you and the whole family

**Your healthcare is PERSONAL and we want you to be SAFE**

Each employee gets a one-on-one session on the telephone or a safe face-to-face with a licensed benefits counselor to answer questions and explain how MDLive Telemedicine and other benefits can work for you and your family.



A Voluntary Benefits Partner of **PeopleLease**

**It's time to set a date for your enrollment!**

Call or email People Lease at **601-987-3025** or **mail@PeopleLease.com** to set up an Enrollment Planning Session now.

Employer name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee Email: \_\_\_\_\_

Employee Phone: \_\_\_\_\_