PeopleLease

Monthly Rates for 2022

- Employee Only $8.10
- Employee + Child $14.54
- Employee + Spouse $13.82
- Employee + Family $21.37

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 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
Exam With Dilation as Necessary	$10 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
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[Δ]	$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 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[Δ]	$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
Contact Lens Fit and Follow-up *(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
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 Amplifon Hearing Network	40% off hearing exams and low price guarantee 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	
Frame	Once every 12 months	

QL-0000068387

[Δ] 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.

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.

Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.
Required sections are marked with an *.
Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name*: PEOPLE LEASE

Effective Date*^: 01 / 01 / 2022

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Group Number*

Subgroup*

Location Code

Employee Information: to be completed by Employee

Change Type*: ☐ Add ☐ Term ☐ Update

Member ID:

Last Name*

Date of Birth* / /

First Name*

MI

Gender* ☐ Male ☐ Female

Phone Number ( ) -

Street Address*

City*

State*

Zip Code*

Social Security Number*^ - -

^Last four digits of Employee's Social Security Number are required.

Employee Email Address:

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Dependent 2

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Dependent 3

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Dependent 4

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Employee Signature*: _____

Date*: / /

For additional dependents, please complete a second form.