Vision Plan Announcement

Both you and your covered dependents will be eligible to enroll in one of three comprehensive EyeMed *Premier* plans to replace any current vision plan you are enrolled in through SBPEA Teamsters Local 1932.

You may purchase one of these *Premier* plans via payroll deduction. **Enrollment is optional.**

You and your covered dependents may only cancel enrollment each year during COUNTY Open Enrollment period in June. An exception may be made for a change in status by speaking with SBPEA Teamsters Local 1932's Benefits Division at (909) 889-8377 ext 234.

A complete description of the three comprehensive *Premier* vision plans (EM 2, EM 3, and Dependent Only) is attached. To enroll in one of the optional comprehensive *Premier* vision plans, please do the following:

Select the plan that best suits your needs. EM 2 is designed for members who are currently enrolled in a medical plan that already covers an eye exam. EM 3 is designed for members whose health plan does not cover exams or materials. Dependent Only is for County members who are covered by County Vision Insurance and wish to have their dependents covered with vision insurance. Compare the EyeMed benefit plans with any current SBPEA Teamsters Local 1932 vision plan you are enrolled in for potential savings.

Complete the enrollment card below, detach and send to SBPEA Teamsters Local 1932. EyeMed applications are submitted the last period of the month. Deductions will begin in the first pay period of the month following enrollment. EyeMed requires two payroll deductions in advance. Your benefits will be available the first day of the following month.

Question about your vision care plan should be directed to SBPEA Teamsters Local 1932's Benefits Division at (909)889-8377 ext 234. To learn more about EyeMed or the EyeMed Provider Network, visit www.enrollwitheyemed.com or call EyeMed Member Services at 1-877-226-1115.

EyeMed VISION CARE®

Enrollment Card (New/add or remove)

SBPEA Teamsters Local 1932

Benefits (909)889-8377 EXT 234/ Fax (909)888-7429

PLEASE RETURN THIS FORM
TO SBPEA Teamster Local 1932
P.O BOX 432,
San Bernardino, CA 92402

Social Security No._____ Employee No._____

Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Sex: □ F □ M Date of Birth (mo/day/yr) _____ Work Phone_____

DEPENDENTS

	Last Name	First Name	MI	SEX (M/F)	D.O.B. (mo/day/yr)
Your spouse:					
Each child:					

Date: _____ Signature: _____

Your Authorization:
Please check the benefit of your choice

SEMI-MONTHLY RATES

EM 2 (Materials)
- □ Employee Only $ 3.00
- □ Employee + one $ 5.00
- □ Employee + family $7.00

EM 3 (Exam and Materials)
- □ Employee Only $ 5.00
- □ Employee + one $ 9.00
- □ Employee + family $ 12.50

Dependent Only
(Exam and Materials)
- □ $ 8.00