FREE LANGUAGE ASSISTANCE

If you require Language Assistance at any time including during the course of an eye examination or during the discussion of the diagnosis following an eye examination please contact the "Plan" at **1-800-400-4VPA**. The availability of Language Assistance is FREE to Enrollees.

LASIK BENEFIT ACCESS

VPA is now offering member ACCESS to a laser vision correction preferred pricing plan! The Qualsight Preferred Pricing Program offers an enhancement to your VPA plan Including:

Savings - Experience - Convenience - Financing

To Access Preferred Pricing Call: **877-507-4448** from 7 am - 9 pm (CST) Weekdays and 10 am - 5 pm Sat.
www.Qualsight.com/-vpa

The Qualsight program is not an insured benefit. Vision Plan of America makes access to the Qualsight Program available to its members for preferred pricing for LASIK surgery. Vision Plan of America makes no specific recommendations for or against the Plan. All representations are those of Qualsight.

ADDITIONAL HIGHLIGHTS

*No Deductible
*Guaranteed Enrollment
*Pre-existing Conditions Welcomed
*Contact Lens Benefit
*Orthodontics
*Crowns, Bridges and Dentures

HOW DO YOU RECEIVE CARE?

Upon completion of processing you will receive a personal identification card. Simply call the office you selected for an appointment as you usually would. Present your Plan I.D. Card at the time of your appointment. There are no claim forms to fill out.

WHEN WILL BENEFITS BEGIN?

Those who join prior to the 20th of the month will begin receiving benefits the first day of the following month. Children are eligible up to age 26.

OTHER CHARGES

The member is responsible for the copayments for services listed in the "Description of Benefits and Copayments." Services not listed will be billed to the member at the doctor's usual and customary fee. These fees must be paid directly to the office where the service is received.

The Member will be responsible for 70% of the UCR fees for services provided by a CDN Participating Dental Specialist in the 1st year and 50% discount thereafter, in services up to $1,000.00 per year.

ONE PREMIUM DENTAL/VISION

Dental *and* Vision
4 Outstanding Plans to
Protect You and Your Family

The Choice is Yours!

CHANGING OFFICES

Should the need arise, members are allowed to transfer, with PLAN APPROVAL, to a new office by contacting the Plan. This transfer will become effective on the first day of the following month.

TERMINATION OF BENEFITS

1. On the expiration date.
2. Upon the date of entry into full-time military service.
3. Upon child attaining age 26.
4. The PLAN reserves the right, if after reasonable efforts to establish and maintain a satisfactory Provider/Patient relationship with any Member and is unable to do so, to terminate the rights of such Member and other members of his family under contract effective the last day of the month during which termination notice occurs.
5. In the event that fees or premiums are deliquent, services and benefits under the PLAN shall be terminated effective on the last day of the month during which the deliquency occurred.
6. Permitting or committing fraud. In the event of termination, the plan provider shall complete any treatment in progress. The Member is required to pay all fees and premiums.

PRINCIPAL EXCLUSIONS AND LIMITATIONS

1. Services which are provided without cost to the Member by any municipality, county or other subdivision.
2. Service to which the Member is entitled under any Worker's Compensation Law or Act. This exclusion does not apply to the MediCal Program.
3. Medical or surgical treatment of the eyes (Dilation, tests related to dilation and extended exams) including specialized visual fields.
4. Services that cannot be performed in the Participating Providers office for any reason including the general health of the patient.
5. Any dental procedure for cosmetic, elective or esthetic purposes.
6. Dispensing of drugs.
7. General anesthesia.
8. Loss or theft of dentures or bridgework.
9. Temporomandibular joint syndrome.

GRIEVANCE PROCEDURE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health paln you should first contact your health plan at **1-800-400-4872(TTY: 711)**, by e-mail at www.visionplanofamerica.com or by fax at 213-384-0084 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provde an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's **Internet Web Site http:/www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions on line.

DISCLOSURE

This disclosure form is only a summary of the plans. The plan contract must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract is available upon request at the Plan's administrative office.

Plan administered by:
Vision Plan of America & California Dental Network
1-800-400-4VPA
(for the hearing impaired dial 711)

www.VisionPlanOfAmerica.com

"Focused on Quality"

4 Affordable Dental/Vision Plans

JOIN TODAY!
800-400-4872

(for the hearing impaired dial 711)

NO Hassles
NO Deductibles
NO Claim Forms
NO Waiting Periods
NO Pre-existing Conditions
Guaranteed Issue

INDIVIDUALS
COUPLES
FAMILIES

Family and Individual
Dental & Vision Plans
"4 Plans to Protect You and Your Family"
www. VisionPlanofAmerica.com

Benefits — Dental & Vision Member Co-Payments

DENTAL	ADA Code	Emerald Dental/Vision	Best Choice Dental/Vision	VIP Premier Vision only	California Plan Vision only
Office Visit	D9430	N/C	$5.00		
Oral Exam	D0150	N/C	N/C		
X-Rays	D0210	N/C	N/C		
Porcelain Crown	D2751	$105.00	$275.00		
Cleaning	D1110	N/C	N/C		
Ant. Root Canal (EFR)	D3310	$45.00	$125.00		
Amalgam One Surface Filling	D2140	$2.00	$10.00		
Denture Upper or Lower	D5110/20	$90.00	$350.00		

Additional dental procedures are covered. Please see the complete schedule for services and co-payments.

VISION	Benefit Frequency	Emerald Dental/Vision	Best Choice Dental/Vision	VIP Premier Vision Only	Unlimited Use Vision Only
Complete Eye Exam	each 12 months if needed	N/C After Annual Copay	$36.00	N/C After Annual Copay	$36.00
Standard Single Vision Lenses	each 12 months if needed	N/C	$42.00	N/C	$42.00
Lined Bi-Focals	each 12 months if needed	N/C	$55.00	N/C	$55.00
Lined Tri-Focals	each 12 months if needed	N/C	$79.00	N/C	$79.00
Progressive Lenses (generic)	each 12 months if needed	-20%	$139.00	-20%	$139.00
Thin Lens	each 12 months if needed	$45.00-$60.00	-20% UCR	$45.00-$60.00	-20% UCR
Tint #1 Plastic Lenses Only	each 12 months if needed	N/C	N/C	N/C	N/C
Scratchcote	each 12 months if needed	$35.00	$20.00	$35.00	$20.00
Frames	each 12 months if needed	$100.00 credit	-25% UCR	$100.00 credit	-25% UCR
Contact Lenses	each 12 months if needed	Various Co-pays and Discounts	Various Co-pays and Discounts	Various Co-pays and Discounts	Various Co-pays and Discounts
LASIK		Co-pays apply see reverse	Co-pays apply see reverse	Co-pays apply see reverse	Co-pays apply see reverse
Annual Co-Payment		$25.00 per person	N/A	$25.00 per person	N/A
Monthly Premium		Individual-$29 Couple-$49 Family-$79	Individual-$15 Couple-$25 Family-$39	Individual-$12 Couple-$22 Family-$33	Individual-$6 Couple-$9 Family-$12
Annual Premium $16 Enrollment Fee WAIVED w/Annual Payment		Individual-$348 Couple-$588 Family-$948	Individual-$180 Couple-$300 Family-$468	Individual-$144 Couple-$264 Family-$396	Individual-$72 Couple-$108 Family-$144

Detach and mail with payment — — — — — — — — DENTAL/VISION ENROLLMENT FORM — — — — — — — — Please Print

Welcome & Thanks for applying!

Step 1 - Choose a Plan
Step 2 - Choose a Payment mode
Step 3 - Complete, Sign, & Submit

4 Plans to Choose from:

Emerald Plan - Dental & Vision
Best Choice Plan - Dental & Vision
VIP Premier Plan - Vision Only
California Plan - Vision Only

AGENT'S NAME (Print)_____

Call Now **(800) 400-4VPA** (for the hearing impaired dial 711)
Offered by: **Vision Plan of America**

NAME_____ ☐ MALE ☐ FEMALE
LAST First Initial Gender

ADDRESS_____ APT.#_____

CITY_____ STATE___ ZIP_____

PHONE (___)_____ BIRTHDATE_____

LANGUAGE PREFERENCE_____ SOC. SEC.#_____

COVERED DEPENDENTS - List Eligible Dependents (Same Residence)

SPOUSE BIRTHDATE_____

CHILDREN BIRTHDATE_____

CHILDREN BIRTHDATE_____

CHILDREN BIRTHDATE_____

DENTAL CODE NUMBER

VISION CODE NUMBER

All enrollment information received prior to the 20th of the month will be effective on the 1st of the following month.

Make all checks payable to: **VISION PLAN OF AMERICA**
Mail to: **Vision Plan of America, 3250 Wilshire Blvd., Ste 1610, Los Angeles, CA 90010**
Or fax to **213-384-0084**
www.VisionPlanOfAmerica.com

****ANNUAL PAYMENT SAVES YOU MONEY****

☐ **I Wish To Pay My Annual Premium In Full**

	Individual	Couple	Family
Emerald	☐$348.00	☐$588.00	☐$948.00
Best Choice	☐$180.00	☐$300.00	☐$468.00
VIP Premier	☐$144.00	☐$264.00	☐$396.00
California	☐$72.00	☐$108.00	☐$144.00

* The $16 one-time, non-refundable enrollment fee is **WAIVED.**

☐ Annual Payment by Check or Money Order (Payable to Vision Plan of America)
☐ Annual Payment by Credit Card, Please fill in Credit Card info below**

☐ **I Wish To Pay My Premium MONTHLY (ACH/CC)**

	Individual	Couple	Family
Emerald	☐$29.00	☐$49.00	☐$79.00
Best Choice	☐$15.00	☐$25.00	☐$39.00
VIP Premier	☐$12.00	☐$22.00	☐$33.00
California	☐$6.00	☐$9.00	☐$12.00

☐ Monthly Payment by ACH (Automatic Check Draft) - Please include 1st month's premium **WITH** a $16.00 one-time, non-refundable enrollment fee **ADDED** to the premium.
☐ Monthly Payment by Credit Card, Please fill in Credit Card info below**
(A $16 one-time, non-refundable enrollment fee will be added to the 1st month's draft)

☐ Visa ☐ Mastercard ☐ Discover ☐ Amex Exp. Date_____

Credit Card#_____ _____ _____ _____

I wish to enroll in the Vision Plan of America Program. THIS CONTRACT IS FOR A MINIMUM OF 12 MONTHS from the effective date and renews at 12 month increments. I understand that all necessary services will be provided as described in the Evidence of Coverage. I hereby authorize **Vision Plan of AMERICA** or its designate to charge my credit card/checking account each month's applicable Dental and/or Vision premium to be credited to my account with Vision Plan of America. This authority is to remain in full force and effect until I notify Vision Plan of America in writing of my termination, thirty days thereafter Dental and/or Vision benefits will end. If the benefits are utilized the contract will remain in effect until the end of the term. This policy may be cancelled within three days of application with written notice to Vision Plan of America.

Signature X_____

Date_____

*******PLEASE BE SURE TO SIGN THIS FORM*******