FREE LANGUAGE ASSISTANCE

If you require Language Assistance at any time including during the course of an aye examination or during the diagnosis following an eye examination Please contact the "Plan" at 1-800-400-4VPA (TTY: 711). 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.

ENROLLMENT BENEFIT KIT DISCLOSURE

Vision Plan of America offers you two very important things:

Quality Vision Care: Through a large number of carefully selected Optometrists in private practice in your community. These Optometrists have met our rigid quality control standards, and we continually review them to insure that our high standards are maintained. All Vision Plan of America participating Optometrists care about your eyes and visual comfort.

Low Costs: So low that good vision is within reach of everyone. You and your family deserve the best vision care, without the burden of inflationary costs. In fact as a member, most of your costs are reduced by as much as 50%, and some benefits cost you nothing. You will find all the information you need in this brochure to join thousands of people who have discovered how Vision Plan of America helps them enjoy good vision and save money too!

FINANCIAL RESPONSIBILITY OF MEMBER

IN THE EVENT THE PLAN FAILS TO PAY THE PARTICIPATING PROVIDER, THE PROVIDER WILL NOT LOOK TO THE MEMBER FOR PAYMENT. THE MEMBER WILL NOT BE LIABLE.

LIMITATIONS

Extra Cost: This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, there will be an extra charge; a) blended lenses; b) contact lenses (except as noted elsewhere herein); c) progressive multifocal lenses; d) photochromic lenses or tinted lenses (except as noted elsewhere herein); e) coated lenses; f) laminated lenses; or g) a frame that costs more than the plan allowance (Schedule of Extras applies)

Not Covered: There is no benefit for professional services or materials connected with:

1. Plano lenses.
2. Two pairs of glasses in lieu of bifocals.
3. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
4. Medical or surgical treatment of the eyes.
5. Any eye examination, or any corrective eye wear required by an employer as a condition of employment.
6. No vision therapy or training.

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 plan, you should first contact your health plan **at 800-400-4VPA (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 invo;ving 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 assitance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage for treatments that are experimental or investigational in nature and payment disputes for emergency urgent medical services. The department also has a toll-free no. **(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.

20/20 PLAN

Eye Examination
Contact Lenses
AND Eye Glasses
Every Year

Individual Vision Plan
No Waiting Period

JOIN TODAY!

www.visionplanofamerica.com

JOIN TODAY

NAME _____ (LAST) (FIRST) (INITIAL)

ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP _____

PHONE (___) _____ BIRTHDATE _____

LANGUAGE PREFERENCE _____ SOC. SEC.# _____

COVERED DEPENDENTS - List Eligible Dependents (Same Residence) (LIST)

_____ BIRTHDATE _____
SPOUSE

_____ BIRTHDATE _____
CHILDREN

_____ BIRTHDATE _____
CHILDREN

_____ BIRTHDATE _____
CHILDREN

OPTOMETRIST CODE NUMBER (CHILDREN)

AGENT'S NAME (Print) _____

IMPORTANT

FILL OUT, DETACH AND RETURN

I WISH TO PAY MY PREMIUM MONTHLY

[ ] Member $12.75 [ ] Couple $25.00 [ ] Family $37.00

[ ] Monthly payment by **credit card**, please fill in credit card information below**

[ ] Monthly payment by (ACH) Check-o Matic, 1st month's payment enclosed **(please add a $15.00 one time, non-refundable enrollment fee).**

[ ] I hereby authorize **VISION PLAN OF AMERICA** to charge my credit card/checking account each months applicable Vision Plan 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 vision benefits will end. **A one time, non-refundable $15.00 enrollment fee will be added to the credit card draft.**

[ ] I wish to enroll in the Vision Plan of America Vision Program. I understand that all necessary services will be provided as described in the Subscriber Contracts. **This contract is for a minimum of 12 months. You may cancel this contract with written notice within three days unless Plan is utilized.**

[ ] Visa [ ] Mastercard [ ] Discover [ ] AmEx Exp. Date _____

Credit Card# _____ _____ _____ _____

SignatureX _____ Date _____

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

ENROLLMENT INFORMATION

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

BOTH BENEFITS EVERY 12 MONTHS

BENEFIT #1 - EYE EXAMINATION & GLASSES ($20 Co-Pay for Exam & Glasses)
BENEFIT #2 - CONTACT LENS PACKAGE ($20 Co-Pay for Contacts Lens Package)

BENEFITS AFTER COPAYMENT(S)	COSTS	FREQUENCY
COMPLETE EYE EXAM AND PRESCRIPTION (With a follow-up visit at Enrollee request)	$20.00 Co-Pay	EVERY 12 MONTHS
LENSES (Medically Necessary-Ophthalmic)	NO CHARGE	EVERY 12 MONTHS (If needed)
SINGLE VISION LENS	NO CHARGE	EVERY 12 MONTHS (If needed)
BIFOCAL LENS	NO CHARGE	EVERY 12 MONTHS (If needed)
TRIFOCAL LENS	NO CHARGE	EVERY 12 MONTHS (If needed)
TINT #1 ANY COLOR (Plastic Lenses Only)	NO CHARGE	EVERY 12 MONTHS (if needed)
FRAMES (Standard - VPA Metal or ZYL)	NO CHARGE UP TO $100 RETAIL	EVERY 12 MONTHS (If needed)
COSMETIC CONTACT LENS PACKAGE Package includes **$100** allowance for contact lens examination, fitting and contact lenses.	$20.00 Co-Pay	EVERY 12 MONTHS

MEDICALLY (VISUALLY) NECESSARY CONTACT LENSES are available each 24 months if a change is indicated. A $75.00 co-payment is paid by the member to the provider which includes: A special contact lens examination, follow-up visits and **Medically necessary lenses. This is a $250 benefit, the Plan will pay $175.**

How do I join?

1. Complete the attached enrollment form.
2. Choose an Optometrist from our list and enter their code number. Provider codes are also available at: **www.visionplanofamerica.com**
3. Sign and date the enrollment form. Please be sure we have your correct mailing address.
4. Submit the enrollment form with your payment (Credit card info, check or money order) to your insurance agent or Vision Plan of America at: 3255 Wilshire Blvd., # 1610, Los Angeles, CA 90010.
5. Your $20.00 annual co-payment(s) and any additional charges not covered by the plan will be paid directly to the Provider at the time of your visit. Please refer to your "Evidence of Coverage" for details of your plan and your co-payment schedule.

HOW DO I RECEIVE CARE?

Upon completion of processing of your enrollment you will receive a personal identification card which includes your Provider's contact information. 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 benefits the first day of the following month. Participants, members must agree to remain enrolled for a minimum of 12 months and pay for 12 full months of coverage, once benefits have been utilized. Children are eligible up to age 26.

For more information call:
1-800-400-4872