LANGUAGE ASSITANCE

If you require Language Assistance at anytime 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
*Orthodonture
*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 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 75% of the UCR fees for services provided by a CDN Participating Dental Specialist.

SPECIAL ANNUAL PREMIUM

Individual..$180.00 per year
Member plus 1 Dependent................$300.00 per year
Family...$468.00 per year

A one time non-refundable $16.00 enrollment fee is included in this annual fee.

Your rate is guaranteed for 2 years, thereafter the Plan shall not increase the premium to a member except after a period of 30 days from and after the postage paid mailing to the member at the member's address of record.

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 resonable 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. Dentistry for cosmetic purposes unless listed as a benefit.
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 plan, you should first telephone your health plan at **1-800-400-4VPA** 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 provide 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
(hearing impaired dial 711)

INDIVIDUAL

Best Choice Plan

NO Waiting Period
NO Claim Forms
NO Deductibles
Guaranteed Enrollment

www.visionplanofamerica.com

A Guaranteed Proven Health Benefit

ONE VISION + ONE DENTAL = ONE PREMIUM

COMBINATION VISION + DENTAL

What are the BENEFITS *and* SAVINGS?

* DENTAL	MEMBER PAYS	AVERAGE SAVINGS	NON MEMBER PAYS
OFFICE VISIT	$5	SAVE $30	$35
ORAL EXAM	NO CHARGE	SAVE $47	$47
X-RAYS FULL SET	NO CHARGE	SAVE $90	$90
X-RAYS SINGLE	NO CHARGE	SAVE $20	$20
TEETH CLEANING	NO CHARGE	SAVE $70	$70
BI-ROOTED CANAL	$150	SAVE $230	$380
AMALGAM ONE SURFACE	$10	SAVE $50	$60
YOUR PREMIUM COST $149.00			

VISION	MEMBER PAYS	AVERAGE SAVINGS	NON MEMBER PAYS
EYE EXAMINATION	$36	SAVE $49	$85
SINGLE VISION LENSES	$42	SAVE $48	$90
BI-FOCAL LENSES	$55	SAVE $114	$169
SCRATCHCOTE	$20	SAVE $15	$35
LASIK BENEFIT ACCESS	SEE REVERSE SIDE		
FRAMES	CHOOSE ANY FRAME AND SAVE 25% OFF OF UCR		
CONTACT LENSES	SAVE ON ALL TYPES OF LENSES		
YOU SAVE OVER $700 AVERAGE			

*When performed by a participating CDN general dentist. These are partial lists of covered services.

How do I join?

1. Complete the attached enrollment form.
2. You will find the Provider Office Code Numbers on the attached Participating Providers lists or on line at www.visionplanofamerica.com or www.caldental.net. Choose conveniently located Dental and Vision Providers and transfer the Code Numbers onto the Enrollment Form.
3. Sign and date the Enrollment Form. Please be sure we have your correct address.
4. Submit the Enrollment Form to your benefits manager or mail to Vision Plan of America.
5. Co-payments, if any, or any additional fees you incur not covered by the plan will be paid directly to the Provider. Please refer to your "Evidence of Coverage".

How do I save?

Pay the premium monthly or save with our **Special Annual Premium**

Individual = *$180.00 ***You Save $16.00***

Individual + 1 = *$300.00 ***You Save $16.00***

Family = *$468.00 ***You Save $16.00***

*The $16.00 one time non-refundable enrollment fee is WAIVED.

RETAIN FOR YOUR RECORDS

Best Choice Plan

INDIVIDUAL

VISION + DENTAL
ONE PREMIUM

Administered by:
VISION PLAN OF AMERICA
and
CALIFORNIA DENTAL NETWORK
1 (800) 400-4VPA(Hearing impaired dial 711)

To Enroll: Follow these "5" steps...

STEP 1: Complete the attached Enrollment Form.
STEP 2: You will find the **Vision/Dental Office Code Numbers** on the attached Provider lists or on line at www.visionplanofamerica.com or www.caldental.net. Choose a conveniently located **OPTOMETRIST** and **DENTIST** and **transfer the Code Numbers onto the Enrollment Form.**
STEP 3: We offer a convenient **Monthly Credit Card Payment Plan. (Individual $15, Member plus 1 Dependent $25, Family $39).** Complete the **monthly premium section** and **credit card information** on the Enrollment Form. We will take care of the rest. Reliable and automatic. *A one time, non-refundable $16.00 enrollment fee will be added.* If you wish to pay monthly by check (Check-o-matic), please enclose a check for the 1st month's applicable premium **plus a one time, non-refundable $16.00 enrollment fee.**
STEP 4: If you decide to pay the **annual premium** in full, enclose a check or money order for the appropriate amount. *The one time, non-refundable $16.00 enrollment fee is **WAIVED.*** **(Individual $180, Member plus 1 Dependent $300, Family $468). We also accept annual payment by credit card.** Fill in your card number on the Enrollment Form where indicated. Sign and show expiration date.
STEP 5: Enclose your Enrollment Form and payment for the appropriate amount. *Make check payable to:* **VISION PLAN OF AMERICA**, or use your **credit card**, and mail to: **VISION PLAN OF AMERICA, 3255 Wilshire Blvd., Suite 1610, Los Angeles, CA 90010.**

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

NAME____
LAST FIRST INITIAL
ADDRESS______________________________APT.#________
CITY______________________STATE______ZIP__________
PHONE (________)______________BIRTHDATE____________
EMPLOYER_____________________SOC. SEC.#____________
NAME
COVERED DEPENDENTS - List Eligible Dependents (Same Residence)
______________________________BIRTHDATE____________
SPOUSE
______________________________BIRTHDATE____________
CHILDREN
______________________________BIRTHDATE____________
CHILDREN
______________________________BIRTHDATE____________
CHILDREN

VISION CODE NUMBER [   ]   [   ] DENTAL CODE NUMBER

AGENT'S NAME (Print)______________________________

Plans 460 & M-PLUS

[ ] I WISH TO PAY MY ANNUAL PREMIUM IN FULL
[ ] Individual $180.00 [ ] Couple $300.00 [ ] Family $468.00
(The one time non-refundable $16.00 enrollment fee has been **WAIVED**).
****Annual by credit card - see CREDIT CARD INFORMATION below**
***Annual by check - Payable to: Vision Plan of America**
[ ] I WISH TO PAY MY PREMIUM MONTHLY
[ ] Individual $15.00 [ ] Couple $25.00 [ ] Family $39.00
[ ] Monthly payment by ACH (Automatic Check Draft)-Please include 1st month's premium and ADD a $16.00 one time, non-refundable enrollment fee payable to **Vision Plan of America.**
[ ] Monthly by credit card, Please fill in Credit Card information below. (A $16.00 one time non-refundable enrollment fee will be added to the 1st month's draft)

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 renewed 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 to charge my credit card/checking account each month's applicable 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 plan 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.

[ ] 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.