All enrollment information NO RETRO DELETIONS

### **Family and Individual**

## **Dental & Vision Plans**

www.VisionPlanofAmerica.com

#### **Emerald Best Choice VIP Premier** Pair & A Spare **DENTAL ADA Code** Vision/Dental Vision/Dental **Vision Only Vision Only** \$0.00 D9430 \$0.00 Office Visit D0150 \$0.00 \$0.00 Oral Exam X-Rays D0210 \$0.00 \$10.00 D2751 \$145.00 \$280.00 Porcelain Crown D1110 \$0.00 \$10.00 Cleaning D3310 \$90.00 \$150.00 Ant. Root Canal (EFR) Amalgam One D2140 \$25.00 \$10.00 Surface Filling D5110/20 \$220.00 \$350.00 Denture Upper/Lowe Additional dental procedures are covered. Please see the complete schedule for services and co-payments. **Benefit Emerald Best Choice VIP Premier** Pair & A Spare VISION Frequency Vision/Dental Vision/Dental **Vision Only Vision Only** Complete Eye Covered After Covered After \$36.00 \$36.00 **Annual Copay Annual Copay** Standard Single \$42.00 \$42.00 No Copay Vision Lenses No Copay Lined Bi-Focals No Copay \$55.00 No Copay \$55.00 each 12 months if needed No Copay \$79.00 No Copay \$79.00 **Lined Tri-Focals** -20% \$139.00 -20% \$139.00 **Progressive Lenses** \$45.00-\$60.00 20% off \$45.00-\$60.00 20% off Thin Lens each 12 months if needed Tint #1 Plastic \$0.00 \$0.00 No Copay No Copay Lenses Only \$35.00 \$35.00 \$20.00 \$20.00 Scratchcote each 12 months if needed \$100.00 Credit 25% UCR **Frames** \$100.00 Credit 25% UCR Various Copays Various Copays Various discounts Various discounts and Discounts and Discounts Contact Lenses Copays apply see Co-pays apply see Copays apply see Copays apply see reverse reverse LASIK reverse reverse **Annual Deductible** \$25.00 per person \$25.00 per person **Emerald Best Choice VIP Premier** Pair & Spare Individual - \$35.00 Individual - \$25.00 Individual - \$16.00 Individual - \$9.00 Couple - \$60.00 **Monthly Premium** Couple - \$45.00 Couple - \$26.00 Couple - \$12.00 Family - \$95.00 Family - \$70.00 Family - \$36.00 Family - \$18.00 Individual - \$420.00 **Annual Premium** Individual - \$300.00 Individual - \$192.00 Individual - \$108.00 Couple - \$720.00 Couple - \$540.00 Couple - \$312.00 Couple - \$144.00 \$16.00 Enrollment Fee Family - \$1,140.00

Family - \$840.00

Family - \$432.00

Family - \$216.00

## 4 Plans to Protect You and Your Family "

# Plans to Choose

from

## BEST CHOICE EMERALD

¥₽ PREMIER

SPARE

] I WISH TO

AY MY PREMIUM MONTHLY (CHECK-O-MATIC)

credit card, please fill in

st Choice

AGENT'S Offered by: Vision Plan of America Call Now (800) 400-4872 (for the hearing NAME

DENTAL CODE NUMBER	CHILDREN	CHILDREN	CHILDREN	SPOUSE	COVERED DEPENDENTS - List Eligible Dependents (Same Residence BIRTHDATE_	PREFERENCE PREFERENCE	PHONE ( )	СІТУ	ADDRESS_	NAME	
		BIRTHDATE	BIRTHDATE	BIRTHDATE	Dependents (Same Residence BIRTHDATE	SOC.SEC#	BIRTHDATE	STATE	FIRST		

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DENTAL/VISION ENROLLMENT FORM SELECT A PLAN: [ ] Emerald

] I WISH TO PA \*\*\*ANNUAL PAYMENT SAVES Y MY ANNUAL PREMIUM IN FULL ] Best Choice YOU MONEY\* [ ] VIP Premier [ California

Print

**WAIVED w/Annual Payment** 

The \$16.00 time, non-refundable

enrollment fee is WAIVED ble to: VISION PLAN OF AN annual premium

Annual payment by A one time, non-r ent by credit card, please fill in credit card information below\*\* non-refundable \$16.00 enrollment fee will be added to the draft. yment enclosed (please add a \$16.00 one-time, payable to: VISION PLAN OF AMERICA

ANNUAL Payment CHECK or MONEY C VISION PLAN

Int can be made by ORDER payable to:
N OF AMERICA

MasterCard

Exp. Dat

APT.

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 (VPA) to charge my credit card/checking account each month's applicable Dental/Vision Permium to be credited to my account with VPA. This authority is to remain in full force and effect until I notify VPA in writing of my desire to terminate coverage. A completed cancellation form and/or written notice will be sent to VPA 30 days prior to the charge date, then thirty days thereafter Dental/Vision

SURE TO SIGN THIS FORM

#### 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 **1-800-400-4872**. 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 ill out.

#### WHEN WILL BENEFITS BEGIN?

Those who join prior to the 20th of the month will begin receiving benefits on 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 DHS 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.
- 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.
- In the event that fees or premiums are delinquent, services and benefits under the PLAN shall be terminated effective on the last day of the month during which the delinquency occurred.
- 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.
- Service to which the Member is entitled under any Worker's Compensation Law or Act. This exclusion does not apply to the MediCal Program.
- Medical or surgical treatment of the eyes (Dilation, tests related to dilation and extended exams) include specialized visual fields.
- Services that cannot be performed in the Participating Providers office for any reason including the general health of the patient.
- Any dental procedure for cosmetic, elective or esthetic purposes.
- Dispensing of drugs.
- 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 (800) 400-4872 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 telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.

#### **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 & Dental Health Services 1-800-400-4872

(for the hearing impaired dial 711)

#### www.VisionPlanofAmerica.com

"Focused on Quality"

#### 4 Affordable Dental/Vision Plans



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

INDIVIDUAL COUPLE FAMILY