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
- **Use the plan as often as you wish**
- Pre-existing conditions welcomed
- Contact lens benefit
- Guaranteed Enrollment

PRINCIPAL BENEFITS & COVERAGES

Vision Examination: A complete diagnostic exam which includes: a detailed history, Visual acuity testing, an examination of ocular mobility and pulillary reflexes, glaucoma, retinoscopy, refraction* and binocular tests; interocular examination, copy of lens prescription, if necessary.
Lenses: The VPA program requires the finest quality lenses fabricated to exacting standards. The Provider also verifies the accuracy of the finished lenses.
Frames: The 25% reduction in cost is applied to any frame you choose. The VPA Provider will offer a wide selection of frames.

All benefits chosen by the Plan Member are available at a reduced fee-for-service. You may use your Benefit Schedule as often as you wish.

Refer to your Benfit Schedule for your eligibility period.

All family members and individuals will use the same Provider's office.

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 service is received.

PROVIDERS

Providers are located throughout California. After VPA receives your enrollment card a memberchip card will be mailed to you indicating the name, address and phone number of the office near your home that will provide your services.

TERMINATION OF BENEFITS

1. On the expiration date.
2. Upon the date of entry into full-time military service.
3. Upon unmarried 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.

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
1-800-400-4VPA

9/1/14

Vision Plan of America

"a PAIR and a SPARE"

- Computer Glasses
- Reading Glasses
- Sunglasses
- Bifocals

As many as you wish
in the same benefit year
One Low Monthly Premium

NO Waiting Periods
NO Claim Forms
NO Deductibles

1-800-400-4VPA

SPECIAL ANNUAL PREPAYMENT FEES

Member.....$72.00
Member + 1.....$108.00
Family.....$144.00

Your rate is guaranteed for 2 years. 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 member's the address of record.

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. 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. Those who join after the 20th will begin on the 1st day of the second month thereafter. Children are eligible up to age 26.

Description of Benefits and Copayments

MEMBER SERVICES	MEMBER PAYS
Preventive Eye Care Analysis	NO CHARGE
Cataract Analysis	NO CHARGE
Glaucoma Test (IOP Measurement)	NO CHARGE
Frame Repairs-screw, nose pad replacement	NO CHARGE
Frame Adjustments	NO CHARGE
Tint #1, (solid color) plastic lenses	NO CHARGE
Computerized Vision Analysis (where available)	NO CHARGE
Frames	25% Off UCR
Refraction (See Note #1)	$36.00
(Determines Glasses Prescription)	
LENSES (CR-39) (See Notes #2 & 3)	
Single Vision Lenses	$42.00
Bifocal Lenses (Rnd. 22 - FT 25-28)	$55.00
Trifocal Lenses (FT 7 x 25)	$79.00
Progressive (Generic)(i.e.-sola, v.i.p.,image)	$139.00
Progressive (Premium)	20% Off UCR
Lenticular Lenses (S.V.)	$180.00
Lenticular Lenses (B.F.)	$240.00

ALL LENS PRICES ARE PER PAIR

ANY PROCEDURE OR LENS NOT LISTED AND PROVIDED BY THE SELECTED OPTOMETRIST IS AVAILABLE ON A FEE-FOR-SERVICE BASIS

LASIK ACCESS (See Reverse Side)

MEMBER SERVICES	MEMBER PAYS
LENS EXTRAS: (Add to lens cost)	
Oversize (over 58mm E.D.)	$15.00
Fashion Tints (each color, CR-39)	
Single gradient	$15.00
Double gradient	$25.00
Photoxtra (S/V)	20% Off UCR
Photoxtra (B/F)	20% Off UCR
Photoxtra (Progressive)	20% Off UCR
Photochromic(i.e. transitions, sun sensor, etc.)	20% Off UCR
Scratchcote (Plastic lenses)	$20.00
Polycarbonate	$45.00
Thin Lenses (other than polycarbonate)	20% Off UCR
UV Coating	$10.00
Rimless (Edge Groove or Drill Mount)	20% Off UCR
Prism	$4.00 per Diopter
CONTACT LENSES (See Note #4)	
Contact Lens Evaluation & Fitting	25% Off UCR
Hard Lenses (PMMA)	10% Off UCR
R.G.P.	20% Off UCR
Colors for cosmetic eye color changes	20% Off UCR
Custom Contact Lenses (See Note #5)	15% Off UCR
(Orthokeratology, CRT)	**Not Covered**
Conventional Contact Lenses	15% Off UCR
Multifocal 20% Off UCR (except where prohibited byMfg)	

Daily & Planned Replacement Contact Lenses
10% Off 12 month supply or 5% Off 6 month supply
Multifocal Contact Lenses 20% Off annual supply (except where prohibited by mfg)

NOTE #1
Refraction determines the need for prescription. The $36.00 co-payment must be paid directly to the doctor at the time of service. These benefits are part of and used in conjunction with your HMO packcge.
NOTE #2 (eye glasses or contact lenses)
Cost of lenses may have an additional charge when power of lenses exceeds ±6.00 D SPH or when combined with ±2.00 D CYL.
NOTE #3
Any Multifocal add of ±3.25 or more may be charged an added laboratory fee per pair. SEGS larger than 28mm may be charged an added laboratory fee per pair. Glass lenses may have an additional charge.
NOTE #4
When purchasing contact lenses you may require a contact lens evaluation in addition to a refraction.
NOTE #5
Contact lens powers over ±6.25 D SPH and/or ±2.00 D CYL (combined) are considered custom, and will be charged extra. Medically necessary contact lenses may be considered custom; however, require prior authorization.

"a PAIR and a SPARE"

Vision Program

1-800-400-4VPA

VISION PLAN OF AMERICA
3255 Wilshire Blvd., Suite 1610
Los Angeles, California 90010

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

STEP 1: Complete the attached Enrollment Form.
STEP 2: You will find the **optometric Office Code Numbers** on the enclosed Participating Optometrists list. Choose a conveniently located OPTOMETRIST and **transfer the CODE Number onto the Enrollment Form.**
STEP 3: We offer a convenient **Monthly Credit Card Payment Plan. (Individual $6.00 Member + 1 Dependent $9.00, Family $12.00).** 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 $72.00, Member + 1 Dependent $108.00, Family $144.00). We also accept annual payment by credit card.** Fill in your credit card information 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 — — — — — — — VISION ENROLLMENT FORM — — — — — — — — — — — — — — — Please Print

NAME_____
LAST FIRST INITAIAL

ADDRESS_____APT.#_____

CITY_____STATE_____ZIP_____

PHONE(____)_____BIRTHDATE_____

LANG. PREF._____SOC. SEC.#_____

COVERED DEPENDENTS - List Eligible Dependents (Same Residence)

_____BIRTHDATE_____
SPOUSE

_____BIRTHDATE_____
CHILD

_____BIRTHDATE_____
CHILD

_____BIRTHDATE_____
CHILD

OPTOMETRIST CODE NUMBER [ ] ☜ **IMPORTANT**

AGENT'S NAME (PRINT)_____

I WISH TO PAY MY ANNUAL PREMIUM IN FULL
[ ] Member $72.00 [ ] Member + 1 Dependent $108.00 [ ] Family $144.00
[X] The $16.00 one time, non-refundable enrollment fee is **waived**.
[ ] Annual by check (payable to VISION PLAN OF AMERICA)
[ ] Annual by credit card, please fill in credit card information below

I WISH TO PAY MY PREMIUM MONTHLY
[ ] Member $6.00 [ ] Member + 1 Dependent $9.00 [ ] Family $12.00
[ ] Monthly payment by credit card, please fill in credit card information below. **(a $16.00 one time non-refundable enrollment fee will be added to the draft)**
[ ] Monthly payment by check, 1st month's payment enclosed **(please add a $16.00 one time, non-refundable enrollment fee)**.

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) or its designate to charge my credit card/checking account each month's applicable Vision premium 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. Written notice will be sent to VPA 30 days prior to the charge date, then thirty days thereafter Vision benefits will end. If the benefits are utilized during the current benefit period, the contract will remain in effect until the end of the term. This policy may be cancelled within 3 days of application with written notice to VPA. Vision Plan of America will not process or provide retroactive terminations or refunds.

☐ Visa ☐ Mastercard ☐ Discover ☐ Amex Exp. Date _____

Credit Card # _____ _____ _____ _____

Signature X _____ Date _____

***********PLEASE BE SURE TO SIGN THIS FORM************
All enrollment information received prior to the 20th of the month will be effective on the first of the following month.