
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.

ASISTENCIA DE IDIOMAS GRATIS

Si requiere asistencia de idiomas en cualquier momento incluyendo durante el proceso de su examinacion de los ojos o durante la discusion de la diagnosis despues de su examinacion de los ojos por favor llame al "Plan" 1-800-400-4VPA. La asistencia de idiomas es GRATIS para todos los miembros de Vision Plan of America.

LASIK ACCESS BENEFIT

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**
7am -9pm (CST) Weekdays & 10am - 5pm 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. VPA makes no specific recommendations for or against the Plan. All representations are those of Qualsight.

PRINCIPAL BENEFITS AND COVERAGES

Vision Examination: A complete diagnostic exam which includes: a detailed history, visual acuity testing, an examination of ocular mobility and pupillary 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 Benefit Schedule for your eligibility period.

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

ADDITIONAL HIGHLIGHTS

- No Deductible
- Use the plan as often as you wish
- Pre-existing conditions welcomed
- Contact lens benefit
- Guaranteed Enrollment

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 membership 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 child attaining age 26.
4. PLAN reserves the right if, after reasonable efforts to establish and maintain satisfactory Provider/patient relationship with any Member and are unable to do so, the rights of such Member and other members of his family under contract may be terminated effective the last day of the month during which termination notice occurs.
5. 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.
6. Permitting or committing fraud. In the event of termination, the PLAN shall complete any contracted procedure listed under PRINCIPAL BENEFITS AND COVERAGES. 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. Services to which the Member is entitled under any Workers' Compensation Law or Act. This exclusion does not apply to MediCal Program.
3. Medical or surgical treatment of the eyes. (Tests related to dilation and extended exams) including specialized visual fields.
4. Services that cannot be performed because of 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 plan, you should first telephone your health plan at 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.

FIANANCIAL LIABILITY 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.

DISCLOSURE

THIS DISCLOSURE FORM IS ONLY A SUMMARY OF THE VISION PLAN. 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.

Vision Plan of America

\$4.00 a month

A Guaranteed Proven Health Benefit

INDIVIDUAL VISION PROGRAM

PLAN M-PLUS

No waiting period
No claim forms
No deductibles
Guaranteed Enrollment

www.visionplanofamerica.com

CALL 800 • 400-4872
(for the hearing impaired dial 711)

Description of Benefits and Copayments

MEMBER SERVICES	MEMBER PAYS	MEMBER PAYS
CONTACT LENSES (See Note #4)	NO CHARGE	25% Off UCR
Contact Lens Evaluation & Fitting	NO CHARGE	Normal Retail Price
Contact Lens Service Agreement	NO CHARGE	Normal Retail Price
Contact Lens Care Kits	NO CHARGE	\$10.00
Additional C.L. Visits (each)	NO CHARGE	\$85.00
Hard Lenses (PMMA)	NO CHARGE	\$145.00
R.G.P. (Sphere)	NO CHARGE	
Soft (Daily):		
Bausch & Lomb (or similar)	25% Off UCR	\$90.00
Cooper (or similar)	\$36.00	\$99.00
Soft (Extended Wear):		
Bausch & Lomb (or similar)		\$90.00
Ciba (or similar)		\$99.00
Toric Contact Lenses:		
Soft...Hard...R.G.P.	\$42.00	20% Off UCR
Soft Custom Colors for Cosmetic	\$55.00	
Eye Color Changes	\$79.00	
Disposable (1st 3 months supply only)	\$139.00	20% Off UCR
Custom Contact Lenses (See Note #5)	20% Off UCR	
(Orthokeratology, CRT)	\$180.00	
Multifocal Contact Lenses	\$240.00	Not Covered
(Soft Disposable 1st 3 months supply only)		10% Off UCR

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)

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 package.

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 ±2.0 D CYL (combined) are considered custom, and will be charged extra. Medically necessary contact lenses may be considered custom; however, require prior authorization.

Medically necessary contact lenses may be considered custom; however, require prior authorization.

INDIVIDUAL VISION PROGRAM VISION PLAN OF AMERICA PLAN M-PLUS

Corporate Office
VISION PLAN OF AMERICA
3255 Wilshire Blvd., #1610
Los Angeles, California 90010
(213) 384-2600 • (800) 400-4-VPA
(for the hearing impaired dial 711)

STEP 1: Complete the attached Enrollment Form.

STEP 2: You will find the Vision Office Code Numbers on the attached Provider list or on line at www.visionplanofamerica.com Choose a conveniently located **OPTOMETRIST** and **transfer the Code Numbers onto the Enrollment Form.**

STEP 3: We offer a convenient **Monthly Credit Card Payment Plan. (Individual \$4.00, Member + 1 Dependent \$5.25, Family \$6.25).** 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 \$10.00 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. *A one time, non-refundable \$16.00 enrollment fee is included.* (Individual \$55, Member + 1 dependent \$70, Family \$82). 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.*

FILL OUT, DETACH AND RETURN

NAME _____

LAST _____ FIRST _____ INITIAL _____

ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ BIRTHDATE _____

LANGUAGE _____ SOC. SEC.# _____

PREFERENCE _____

LIST

COVERED DEPENDENTS - List Eligible Dependents (Same Residence)

_____ BIRTHDATE _____

SPOUSE _____ BIRTHDATE _____

CHILDREN _____ BIRTHDATE _____

CHILDREN _____ BIRTHDATE _____

CHILDREN _____ BIRTHDATE _____

OPTOMETRIST CODE NUMBER **IMPORTANT**

AGENT'S NAME (Print) _____

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I WISH TO PAY MY ANNUAL PREMIUM IN FULL

****Annual by credit card - see CREDIT CARD INFORMATION below**
***Annual by check - Payable to: Vision Plan of America**
 Individual \$55.00 Member + 1 Dependent \$70.00 Family \$82.00
 This includes a one time non-refundable \$16.00 enrollment fee.

I WISH TO PAY MY PREMIUM MONTHLY

Individual \$4.00 Member + 1 Dependent \$5.25 Family \$6.25
 Monthly payment by **credit card, please fill in credit card information below****
 Monthly payment by check, 1st month's payment enclosed (Check-O-Matic)
(Please add a \$16.00 one time, non-refundable enrollment fee).
 I hereby authorize **VISION PLAN OF AMERICA** to charge my credit card/ checking account each month's 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 unless benefits have been utilized.
A one time, non-refundable \$16.00 enrollment fee will be added to the credit card draft.
 I wish to enroll in the Vision Plan of America Program. I understand that all necessary services will be provided as described in the Evidence of Coverage

Visa Mastercard Discover AmEx Exp. Date _____

Credit Card # _____

Signature _____ 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.