

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 - You can now save 40-50% off the overall national average charge for LASIK!

Experience - Only Board Certified Ophthalmologists who use state-of-the-art, FDA approved LASIK equipment.

Convenience - Care Managers provide a thorough prescreening along with education about LASIK technologies and benefits.

Financing - Flexible financing is available to qualified candidates.

To Access Preferred Pricing Call: **877-507-4448** from 7 am - 9 pm (CST) Weekdays and 10 am - 5 pm Sat.
www.Qualsight.us

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).

Orthoptics or vision training and any associated supplemental testing at reduced fees.

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.

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.

www.visionplanofamerica.com

“Focused on Quality”

JOIN TODAY!
800-400-4872

NO Deductibles
NO Claim Forms
NO Waiting Periods
Guaranteed Issue

VIP PREMIER

Individual Vision Plan

JOIN TODAY

VIP Premier - Individual Vision Plan

What are the Benefits? \$25.00 Annual Co-Payment Per Person

AFTER THE ANNUAL CO-PAYMENT PER PERSON	COSTS	FREQUENCY
COMPLETE EYE EXAM AND PRESCRIPTION (With a follow-up visit at Enrollee request) *LENSES (Medically Necessary-Ophthalmic)	NO CHARGE	EACH 12 MONTHS
SINGLE VISION LENS	NO CHARGE	EACH 12 MONTHS (If needed)
BIFOCAL LENS	NO CHARGE	EACH 12 MONTHS (If needed)
TRIFOCAL LENS	NO CHARGE	EACH 12 MONTHS (If needed)
FRAME (Standard - VPA Metal or ZYL) <small>*See Schedule of Extras for basic benefit</small>	NO CHARGE	EACH 12 MONTHS (If needed)
LASIK Benefit Access - See Reverse Side	UP TO \$100 RETAIL	EACH 12 MONTHS (If needed)

COSMETIC CONTACT LENSES are available in addition to your Basic Benefit (see Schedule of Extras provided at your doctor's office); or, if desired in lieu of all other services, \$100 applies to the doctor's usual and customary package fee. Package fee includes eye examination, fitting and contact lenses. Cosmetic Contacts are available each 12 months if a change is indicated.

MEDICALLY NECESSARY CONTACT LENSES are available each 12 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 \$25.00 annual co-payment 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 YOU 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 19 and extended to age 23 if a full time student and claimed by you for Federal Income Tax purposes.

THIS FORM IS ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN EVIDENCE OF COVERAGE MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE EVIDENCE OF COVERAGE IS AVAILABLE ON REQUEST FOR EXAMINATION AT THE ADMINISTRATIVE OFFICE OF VISION PLAN OF AMERICA.

FILL OUT, DETACH AND RETURN

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 \$129.00 Member + 1 Dependent \$234.00 Family \$327.00

This includes a one time non-refundable \$15.00 enrollment fee.

I hereby authorize **VISION PLAN OF AMERICA** to charge my credit card the applicable Vision Plan of America 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.

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 and this contract is for a minimum of 12 months.

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.

VISION PLAN OF AMERICA

3255 Wilshire Blvd., #1610, Los Angeles, CA 90010
(800) 400-4872 • www.visionplanofamerica.com

NAME LAST _____ FIRST _____ APT. # _____ INITIAL _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 PHONE () _____ BIRTHDATE _____
 EMPLOYER _____ SOC. SEC. # _____
 COVERED DEPENDENTS - List Eligible Dependents (Same Residence)
 NAME BIRTHDATE
 SPOUSE BIRTHDATE
 CHILDREN BIRTHDATE
 CHILDREN BIRTHDATE
 CHILDREN BIRTHDATE
 OPTOMETRIST CODE NUMBER **IMPORTANT**
 AGENT'S NAME (Print) _____