FREE LANGUAGE ASSISTANCE

If you require Language Assistance at any time including during the course of an aye examination or during the diagnosis following an eye examination Please contact the "Plan" at 1-800-400-4VPA (TTY: 711). The availability of Language Assistance is FREE to Enrollees.

HOW DOYOU 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.

WHENWILL 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.

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 thefollowing, 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) coatedlenses; 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 not covered.

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 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 contact your health plan **at 800-400-4VPA (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 invo;ving 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 assitance. 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 for treatments that are experimental or investigational in nature and payment disputes for emergency urgent medical services. The department also has a toll-free no. **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department **Internet Web Site http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions on line.

VisionPlanOfAmerica.com

800-400-4VPA (4872)

NO DEDUCTIBLES
NO CLAIM FORMS
NO WAITING PERIODS
GUARANTEED ISSUE

Pediatric Vision Plan

For Kids 18 & Under

JOIN TODAY

NAME _____ (LAST) (FIRST) (INITIAL)

ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP _____

PHONE (___) _____ BIRTHDATE _____

LANGUAGE PREFERENCE _____ SOC. SEC.# _____

EACH CHILD MUST BE ENROLLED SEPARATELY.

GUARDIAN/PARENT NAME: _____

GUARDIAN/PARENT SOCIAL SECURITY #: _____

ENROLLMENT INFORMATION: All enrollment information received prior to the 20th of the month will be effective on the 1st of the following month.

OPTOMETRIST CODE NUMBER | | | | |

IMPORTANT

AGENT'S NAME (Print) _____

FILL OUT, DETACH AND RETURN

[ ] **I wish to pay my ANNUAL premium in full - Individual $130.00**
(This includes a one time non-refundable $16.00 enrollment fee)
****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 $9.95 per month.**
[ ] 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 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 # _____ _____ _____ _____

Guardian/Parent Signature X _____ Date _____

************PLEASE BE SURE TO SIGN THIS FORM************

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

PEDIATRIC - 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)	NO CHARGE	EACH 12 MONTHS
***LENSES** (Medically Necessary-Ophthalmic)	NO CHARGE	EACH 12 MONTHS (If needed)
(POLYCARBONATE LENSES)		
***SINGLE VISION or**		
***BIFOCAL**		
FRAME (Standard - VPA Metal or ZYL) (From Vision Plan Selection)	NO CHARGE	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, $50 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.

***EACH CHILD MUST BE ENROLLED SEPARATELY.**

***LENSES AND FRAMES ONE YEAR BREAKAGE GUARANTEE.**

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.

Present this card to a participating pharmacy to receive discounts of up to **85%** on your medications. Discounts vary by pharmacy and drug purchased. Valid for both generic and brand name medications.

CUT OUT AND USE THIS CARD

WHOLESALE MEDICATIONS!

Save up to 85%

PRESCRIPTION DRUG CARD

Vision Plan of America
Personal Vision Benefits
(800) 400-4VPA

RxBIN: 610704
RxPCN: APSRX
RxGRP: HOPE2577

Cardholder ID# (_____) _____
(Cardholder ID# is person's 10-digit phone no.)
Member Support: (800) 870-9096
Pharmacy Help Desk: (877) 277-7934

Present this card and your prescription(s) to any participating pharmacy.
THIS IS NOT INSURANCE - PRESCRIPTION SAVINGS CARD ONLY
This program is VOID WHERE PROHIBITED BY LAW.

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.