VISION PLAN OF AMERICA

Vision Plan of America
(800) 400-4VPA

Employee Enrollment Form

for HMO Vision Benefits

Employer (Group) Name: California Real Estate Benefit		**Employer (Group) Number:** S04		
Last Name:	**First Name:**	**Middle Initial:**	☐ **Active** ☐ **Retiree**	☐ **Male** ☐ **Female**
Social Security Number:	**Phone Number:**	**Date of Birth:** (Mo/Day/Year)	**Language Preference:** (Please List)	
Street Address:	**City:**	**State:**	**Zip Code:**	

Optometrist Office #: **See Provider List or go online to www.visionplanofamerica.com**

Vision Plan: ☒ **A (12/12/12/12)** ☐ **B (12/12/24/12)** ☐ **C (12/24/24/24)** ☐ **M-Plus** (co pay plan)

☒ **Voluntary** ☐ **Employer Paid** _____ **%** **Annual Co Payment** $25.00

Coverage Effective Date:	**Waive Coverage:** (please sign)

Please list all eligible dependents you wish to have covered under this plan in the section below

LAST NAME	FIRST	INITIAL	STUDENT (Yes / No)	M / F	DATE OF BIRTH (Mo/Day/Year)
Spouse:					
Children:					

I authorize my employer to deduct from my wages the required premium, if any, for myself and/or listed eligible dependents. This agreement shall remain in effect for a term of 12 or 24 months to coincide with the group application and agreement based upon plan selection, or until my employment is terminated.

SIGNATURE: X _____ **DATE:** _____

Vision Plan of America
3250 Wilshire Boulevard, Suite 1610
Los Angeles, CA 90010
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HMO Summary of Benefits for:

California Real Estate Benefit Plan

Group #: S04

HMO Vision Plan A-25

Benefits	Frequency	(In-Network)
Plan Year Co Payment	**(Once Every 12 Months)**	**$25.00 Copay**
Examination	**(Once Every 12 Months)**	**Covered 100%**
Lenses -X- **Standard Plastic** **Single Vision** **Lined Bifocals** **Lined Trifocals**	**(Once Every 12 Months)**	**Covered 100%** **(Limitations Apply)**
Frames	**(Once Every 12 Months)**	**Covered 100%** **(Up to allowance $100.00 Retail)**
Contact Lenses (In lieu of basic benefit)	**(Once Every 12 Months)**	**$100.00 allowance** **(In lieu of basic benefits)**
Elective/Cosmetic* **Medically Necessary****	**(Once Every 24 Months)**	**$250.00 allowance** **(With pre-approval from VPA)**

-X- The proposed benefits are designed to cover visual needs rather than cosmetic/elective options. If covered participants choose extra options (such as blended lenses, progressive lenses, UV coatings, colored contact lenses, etc.), they are responsible for the additional cost of the options.

* Cosmetic Contact Lenses are available in addition to your Basic Benefit (see Schedule of Extras provided at the doctor's office); or if desired in lieu of all other services, $100 allowance applies to the Doctor's usual and customary package fee. Package fee includes eye examination, fitting and contact lenses.

** With Pre-approval from VPA. Medically Necessary Contact Lenses are a $250 benefit, which includes a special contact lens examination, follow-up visits and Medically Necessary Contacts. Lenses are available each 24 months if a change is indicated.

- **For a list of providers, please go to www.visionplanofamerica.com/providers**

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 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 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 eyewear required by an employer as a condition of employment.

LASIK Benefit

Vision Plan of America is now providing members 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 40-55% off the overall national average charge for LASIK!
- **Experienced Physicians** – national access to credentialed, Board Certified Ophthalmologists who use state-of-the-art, FDA approved LASIK equipment
- **Convenience** – our Care Managers provide a thorough prescreening process along with education about LASIK technologies, cost and benefits
- **Financing** – flexible financing available to qualified candidates.

To Access Preferred Pricing Call: 877 507 4448
Hours: 7 am - 9 pm (CST) Weekdays; 10 - 5 pm Saturdays
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 recommendation for or against the Plan. All representations are those of Qualsight