

# Vision Plan of America EMERALD PLAN

(Vision Plan A-20 + Dental Plan 495 Benefits)

## Dental Plan 495: (No Annual Deductible)

Examination	No Charge
Office Visit	No Charge
X-rays	No Charge
Prophylaxis (child or adult)	No Charge
Fluoride (to age 14)	No Charge
1 Surface Amalgam	\$2.00
Full Banded Ortho	\$1,775/Child / \$1,975/Adult
NO WAITING PERIOD	

\*Please see attached complete list of dental plan benefits

## Vision Plan A-20 (included)

### Benefit

### Frequency

(After \$20 co-pay)

### ***Examination***

12 months **(Covered 100%)**

### ***Lenses***

(Tint #1, any color (plastic lenses only))

12 months **(Covered 100%)**

### ***Frames***

(\$100 Frame Allowance)

12 months **(Covered up to plan allowance)**

### **Cosmetic Contact Lenses**

12 months (or if a change is indicated)

(are available in addition to the Basic Benefit (see schedule of extras provided at the doctor's office) ; or, if desired in lieu of all other services. \$100 applies towards doctors usual and customary rate.

### **Medically Necessary Contact Lenses** 24 months

(This is a \$250 benefit which includes a contact lens examination, follow-up visits, and MEDICALLY NECESSARY LENSES)

For providers, go to [www.visionplanofamerica.com](http://www.visionplanofamerica.com)

## Rates

Individual	\$24.00/month
Individual + 1	\$42.00/month
Individual + Family	\$59.00/month

## Emerald Plan

(Dental plan 495 Summary of Benefits)

The following procedures are covered benefits only when provided by a participating General Dentist:

<u>ADA CODE</u>	<u>PROCEDURE</u>	<u>MEMBER COPAYMENT</u>	<u>ADA CODE</u>	<u>PROCEDURE</u>	<u>MEMBER COPAYMENT</u>
<b><u>DIAGNOSTIC</u></b>			<b>Other Restorative Services # (Continued)</b>		
	Office Visit	No Charge	2940	Temporary Sedative Filling	No Charge
120	Periodic Oral Exam.	No Charge	2950	Crown Build –Up w/ Any Pins	No Charge
140	Limited Oral Exam/Problem. Focused	No Charge	2951	Pin Retention, Per Tooth, In Addition to Restoration	No Charge
150	Comprehensive Exam	No Charge	2952	Cast Post & Core In Addition to crown	\$ 50.00
<b>Radiographs</b>			2954	Prefabricated Post & Core In Addition to Crown	\$ 30.00
210	Intraoral,Complete Series w/ Bitewings	No Charge	2970	Temporary Crown, w/ Fractured Tooth, When Not Part of Crown Preparation	No Charge
220	Intraoral,Periapical, First Film	No Charge	<b><u>ENDODONTICS</u></b>		
230	Intraoral,Periapical,Each Addittional Film	No Charge	3110,20	Direct or Indirect Pulp Capping, w/out Final Restoration	\$ 5.00
240	Intraoral,Occlusal Film	No Charge	3220	Therapeutic Pulpotomy, Excluding Final Restoration	\$ 5.00
270	Bitewings, Single Film	No Charge	<b>Root Canal Therapy, w/ Treatment Plan, Clinical Procedures &amp; Follow Up Care</b>		
272	Bitewings, Two Films	No Charge	3310	One Canal w/out Final Restoration	\$ 45.00
274	Bitewings, Four Films	No Charge	3320	Two Canals w/out Final Restoration	\$ 90.00
330	Panoramic Film	No Charge	3330	Three Canals, w/out Final Restoration	\$130.00
<b>Tests &amp; Laboratory Examinations</b>			<b>Other Endodontic Procedures</b>		
460	Pulp Vitality Tests	No Charge	3410,21,		
470	Diagnostic Cast-Non-Ortho	\$ 5.00	25,26	Apicoectomy/Periradicular Surgery	\$ 45.00
471	Diagnostic Photographs	No Charge	3430	Retrograde Filling, Per Root	\$ 20.00
501	Histopathologic Examination	No Charge	3950	Canal Preparation, & Fitting of Pre-formed Dowel or Post	No Charge
<b><u>PREVENTIVE</u></b>			<b><u>PERIODONTICS</u></b>		
1110,20	Prophylaxis, Child or Adult	No Charge	<b>Surgical Services, w/ Usual Post Operative Services</b>		
1201,03	Topical Application of Fluoride, to Age 14, w/ or w/ out Prophylaxis	No Charge	4210	Gingivectomy or Gingivoplasty Per Quadrant	\$ 50.00
1310	Nutritional Counseling for control of Dental Disease	No Charge	4211	Gingivectomy Gingivoplasty, Per tooth	\$ 10.00
1330	Oral Hygiene Instruction	No Charge	4240	Gingival Flap Procedure,w/Root Planning,per Quadrant	\$100.00
1351	Sealant,Per tooth, Under Age 14	\$ 5.00	4250	Mucogingival Surgery, Per Quadrant	\$250.00
<b>Space Maintenance, Passive Appliances</b>			<b>Other Periodontal Services</b>		
1510,15	Fixed Unilateral or Bilateral	\$ 20.00	4341	Root Planning,Per Quadrant	\$ 40.00
1520,25	Removable,Unilateral or Bilateral	\$ 20.00	4910	Periodontic Recall, w/ Prophylaxis	No Charge
1550	Recementation of Space Maintainer	No Charge	4920	Unscheduled Dressing Change, By Dental Assistant	No Charge
<b><u>RESTORATIVE</u></b>			<b><u>REMOVABLE PROSTHODONTICS</u></b>		
<b>Amalgam Restorations, with Polishing</b>			<b>Complete Dentures w/ Routine Post Delivery Care</b>		
2110	One Surface, Primary	\$ 2.00	5110,20	Upper or Lower	\$ 90.00
2120	Two Surfaces, Primary	\$ 3.00	5130,40	Immediate Upper or Lower	\$ 90.00
2130	Three Surfaces, Primary	\$ 4.00	<b>Partial Dentures, w/Routine Post Delivery Care</b>		
2131	Four or More Surfaces, Primary	\$ 5.00	5211,12	Upper or Lower, Resin Base, Conventional Clasps & Rests	\$ 70.00
2140	One Surface, Permanent	\$ 2.00	5213,14	Upper or Lower, Cast Metal Base w/ Acrylic Saddles	\$ 90.00
2150	Two Surfaces, Permanent	\$ 3.00	<b>Adjustments to Dentures</b>		
2160	Three Surfaces, Permanent	\$ 4.00	5410,11	Complete Upper or Lower	No Charge
2161	Four or more Surfaces, Permanent	\$ 5.00	5421,22	Partial Upper or Lower	No Charge
<b>Resin Restorations, Anterior</b>			<b>Repairs to Complete Dentures</b>		
2330,			5510	Broken Base	\$ 5.00
31,32	One, Two or Three Surfaces	\$ 10.00	5520	Missing or Broken Teeth, Per Tooth	\$ 5.00
2335	Four or More Surfaces, or Involving Incisal Angle	\$ 12.00	<b>Repairs to Partial Dentals</b>		
<b>Crowns, Single Restoration Only #</b>			5610	Acrylic Saddle or Base	\$ 5.00
2710	Resin, Laboratory	\$105.00	5620	Cast Framework	\$ 5.00
2720,21,22	Resin with Metal	\$105.00	5630	Repair or Replace Broken Clasp	\$ 5.00
2750,51,52	Porcelain Fused to Metal For Molars	\$185.00	5640	Replace Broken Teeth, Per Tooth	\$ 5.00
2790,91,92	Full Cast Metal	\$105.00			
2810	% Cast Metal	\$105.00			
<b>Other Restorative Services #</b>					
2910	Recement Inlay	No Charge			
2920	Recement Crown	No Charge			
2930	Prefabricated Stainless Steel Crown, Primary Tooth, When Suggested By, Dentist	\$5.00			
2931	Prefabricated Stainless Steel Crown, Permanent tooth, when suggested by Dentist	\$5.00			

<u>ADA CODE</u>	<u>PROCEDURE</u>	<u>MEMBER COPAYMENT</u>
5650	Add Tooth	\$ 5.00
<b>Denture Reline Procedures</b>		
5730,31	Complete Upper or Lower Chairside	No Charge
5740,41	Partial Upper or Lower, Chairside	No Charge
5750,51	Complete, Upper or Lower Laboratory	\$ 25.00
5760,61	Partial, Upper or Lower laboratory	\$ 25.00
<b><u>FIXED PROSTHODONTICS</u></b>		
<b>Bridge Pontics #</b>		
6210,11		
12	Cast Metal	\$105.00
6240,41		
42	Porcelain fused to Metal	\$105.00
6250,51		
52	Resin w/ Metal	\$105.00
<b>Retainers #</b>		
6520	Metallic Inlay, Two Surfaces	\$30.00
6530	Metallic Inlay, Three or More Surfaces	\$35.00
6540	Metallic Onlay, Per Tooth, In Addition to Inlay	\$25.00
<b>Bridge Retainers-Crowns #</b>		
6720, 21,		
22	Resin w/ Metal	\$105.00
6750,51,		
52	Porcelain Fused , to Metal	\$105.00
6780	¾ Cast Metal	\$105.00
6790,91,		
92	Full Cast Metal	\$105.00
<b>Other Fixed Prosthetic Services</b>		
6930	Recement Bridge	No Charge
6970	Cast Post & Core, In Addition to Bridge Retainer	\$ 50.00
6971	Cast Post, As part of Bridge Retainer	\$ 30.00
6972	Prefabricated Post & Core, in Addition to Bridge Retainer	\$ 30.00
6973	Core Build-Up for Retainer, Including Any Pins	No Charge
6975	Coping, Metal	No Charge
<b><u>ORAL SURGERY</u></b>		
<b>Extractions, Local Anesthesia, Routine Post-Op Care</b>		
7110	Single Tooth	\$ 5.00
7120	Each Additional Tooth	\$ 5.00
7130	Root Removal, Exposed Roots	\$ 5.00
<b>Surgical Extractions, Local Anesthesia Routine Post-Op</b>		
7210	Surgical Removal of Erupted Tooth, Requiring Evaluation of Mucoperiosteal Flap	\$25.00
7220	Removal of Impacted Tooth, Soft Tissue	\$30.00
7230	Removal of Impacted Tooth Partially, Bony	\$40.00
<b>Other Surgical Procedures</b>		
7285	Biopsy of Oral Tissue, Hard	\$ 6.00
7286	Biopsy of Oral Tissue, Soft	\$ 5.00
7310,20	Alveoplasty w/ or w/ out Extractions, Per Quadrant.	\$50.00
7510	Surgical Incision w/ Drainage of Abscess, Intraoral Soft Tissue	No Charge
<b>Other Repair Procedures</b>		
7960	Frenulectomy, Frenectomy, or Frenotomy Separate Procedure	No Charge

# The member is responsible for the co-payment plus the actual lab cost of gold.

<u>ADA CODE</u>	<u>PROCEDURE</u>	<u>MEMBER COPAYMENT</u>
<b><u>ADJUNCTIVE GENERAL SERVICES</u></b>		
9110	Unclassified Treatment, Minor Palliative (Emergency) Treatment for Pain	\$ 5.00
9215	Local Anesthesia	No Charge
<b>Professional Visits</b>		
9310	Consultation	No Charge
9430	Office Visit for Observation, No other Services Performed	No Charge
9440	Office Visit After Regularly Scheduled Hours	\$ 10.00
<b>Miscellaneous Services</b>		
9930	Treatment of Complication, Post-Surgical Unusual Circumstances	No Charge
9951	Occlusal Adjustment, Limited	No Charge

### **ORTHODONTICS**

The following procedures are covered benefits ONLY when provided by a participating Network Orthodontist:

#### **Standard 24-Month Case\***

Full Banded, Upper & lower, Children & Adults	\$1,695.00
Banded, upper or Lower, Children & Adults	\$1,000.00

#### **Retention After Treatment**

Full Banded, Children	\$250.00
Full Banded, Adults	\$300.00
Banded, Upper or Lower, Children	\$125.00
Banded, Upper or Lower, Adults	\$200.00

#### **Other Fees**

Consultation	\$ 40.00
Diagnosis & Records **	UCR **
Appliances (Head Gear)	UCR **
Broken Appointments, w/ out 24 Hr. Notice	\$ 40.00

\* Orthodontist may charge members an additional fee for the costs of cases over 24 months, based upon the difference in orthodontist's UCR fees for the needed treatment period, less the orthodontist's UCR fees for a 24 month treatment period.

\*\* Includes x-rays, tracings, photographs and study models.

\*\*\* Means the Orthodontist's Usual, Customary & Reasonable fees.

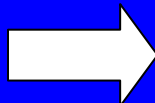
### **SPECIALTY REFERRALS**

Not all general dentists are capable of performing each of the services listed herein and, based upon the member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such cases, the general dentist will refer the member to a dental specialist. The member will be responsible for 75% of the UCR fees for services provided by a participating dental specialist during the first year of enrollment, and 50% thereafter, for up to \$ 1,000.00 in service per year.

# EMERALD PLAN

(COMBINATION VISION & DENTAL PLAN)

Mail To:  
**Vision Plan of America**  
**ATTN: Melissa Monge**  
**3255 Wishire Blvd. ste. 1610**  
**Los Angeles, CA 90010**  
 or fax to:  
**(213) 384-0084**



**JOIN TODAY**

NAME \_\_\_\_\_

LAST FIRST INITIAL

ADDRESS \_\_\_\_\_ APT.# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE(\_\_\_\_) \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

EMPLOYER \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

NAME

COVERED DEPENDENTS – List Eligible Dependents (Same Residence)

BIRTHDAY \_\_\_\_\_

SPOUSE

BIRTHDAY \_\_\_\_\_

CHILDREN

BIRTHDAY \_\_\_\_\_

CHILDREN

BIRTHDAY \_\_\_\_\_

CHILDREN

**OPTOMETRIST  
 CODE NUMBER**

**DENTAL CODE  
 NUMBER**

**\* IMPORTANT\***

**I WISH TO PAY MY PREMIUM MONTHLY**

**Monthly premium paid by credit card or check-o-matic ONLY**

Individual \$24.00  Member + 1 Dependent \$42.00  Family \$59.00

Monthly payment by **credit card**, please fill in credit card information below\*\*

Monthly payment by check, 1<sup>st</sup> month's payment enclosed (**please add a \$15.00 one time non-refundable enrollment fee**).

I hereby authorize **VISION PLAN OF AMERICA** to charge my credit card/checking account each months 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. **A one time, non-refundable \$15.00 enrollment fee will be added to the credit card draft.**

I wish to enroll in the Vision Plan of America Vision & Dental Program. I understand that all necessary services will be provided as described in the Subscriber Contracts and **this contract is for a minimum of 12 months.**

Visa  MasterCard  Discover  Amex Exp. Date \_\_\_\_\_

Credit Card # \_\_\_\_\_

Signature X \_\_\_\_\_ Date \_\_\_\_\_

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

**AGENT / BROKER NUMBER :**

1607	
1668	