

VISION PLAN*
ENROLLMENT INSTRUCTIONS

Please Type or Print Clearly using only Black Ink, DO NOT USE Felt Tip Pens.

**MEMBER /
APPLICANT
INFORMATION:**

Member/Applicant: _____
Local REALTOR® Assoc. Name: _____
E-Mail Address: _____
Requested effective date of coverage: 1st of _____, 2007

New Enrollee [] Current Benefits Store Member Changing Plans []

Remember to attach your business card and this form to your application
The applicant must be a member of a Local REALTOR® Association or a W2 Employee
of a member firm.

**SELECTING
YOUR PLAN:**

[] Vision Plan of America
[] Spectera Vision

**COMPLETING THE
APPLICATION:**

USE BLACK INK AND COMPLETE ALL SECTIONS

**EFFECTIVE
DATE OF
COVERAGE:**

Applications are accepted (must be received in our office) be the 15th of the current month for coverage to be effective the 1st of the following month.

To avoid confusion about the effective date of coverage, make sure to clearly show the requested effective date of coverage you are applying for on the application, your premium check and this form.

Applications are batched by group to the insurers monthly. Any application received after the 15th of the current month will be part of the next month's application batch.

TO ENROLL:

Review the application for accuracy, sign, date, and return to us with your premium. **Make Checks Payable to The Benefits Store Trust Account.**

U.S. MAIL (1st Class or Priority)
ATTN: OPEN ENROLLMENT
Benefits Store, Inc.
PO Box 68, Orinda, CA 94563-0068

OVERNIGHT/EXPRESS DELIVERY ONLY
ATTN: OPEN ENROLLMENT
Benefits Store, Inc.
85 High Eagle Road, Alamo, CA 94507-2009

**PROCESSING
REQUIREMENT:**

NOTE: Incomplete applications or applications without the correct premium included cannot be processed.

One (1) months premium is required with your application.

VISION PLAN*

ENROLLMENT INSTRUCTIONS

PREMIUM PPAYMENTS:

You have four (4) ways to pay your monthly premium:

- **Electronic Funds Transfer (EFT)**
- **Monthly Invoice/Check**
- **On-Line Bill Payment**
- **Credit Card Payment/Visa or MasterCard**

For your convenience we have included an EFT Authorization form with the Enrollment Form.

APPLICATION PROCESSING:

Allow 7 business days after the 15th of the current month for the processing of your application and for you to appear in the Vision Plan's database. An Email Confirmation will be automatically generated to you with your group policy number and plan information. **DON'T DELAY – ENROLL TODAY!** To avoid this delay we urge you to submit your application to us as soon as possible.

You should not cancel your current coverage until you are notified of your new coverage.

For verification of your new coverage, E-mail:

Enrollment@BenefitsStore.com

*This program is a special benefit for members of local REALTOR® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.



California Real Estate Benefit Plan
November 1, 2004
Underwritten by UnitedHealthcare Insurance Company

BENEFITS AT A SPECTERA PARTICIPATING PROVIDER

Your vision is important to your health. Whether it's 20/20 or less than perfect vision, everyone needs to receive regular vision care. The Vision Care Program is being offered as a part of our commitment to your well being.

Spectera's Vision Care Program provides affordable, quality vision care, nationwide. Through Spectera's provider network, you will receive a complete eye examination, as well as materials (if needed).

Carefully review the summary of your new Vision Care Program. Please, don't take chances with your most precious possession - the gift of sight. Take advantage of this very important benefit.

When using a Network Provider, enrolled participants and eligible dependents are eligible for the following:	
COMPREHENSIVE VISION EXAM (Once Every 12 Months)	100% covered once every 12 months. A comprehensive vision examination is provided by a network optometrist or ophthalmologist after a \$15 copay.
MATERIALS:	After the material copay, lenses are 100% covered every 12 months. After the material copay, frames within the Spectera selection or allowance are 100% covered every 24 months. The material copay is \$30. This applies to the entire purchase, not the lens and frame individually.
PAIR OF LENSES (for glasses) (Once Every 12 Months) ➤ Clear single vision ➤ Clear lined bifocal ➤ Clear lined trifocal ➤ Clear Lenticular	If prescribed, a pair of single vision or standard multi-focal lenses. Patient Options - Should you choose patient options not covered by the program such as tints, progressive lenses, UV, and anti-reflective coating, you may be able to purchase these options at a discount. Standard scratch coating is covered-in-full.
FRAMES (Once Every 12 Months) ➤ Selection frame ➤ Non-Selection frame	Your choice from a wide selection of fashionable frames will be covered. If you select a frame from outside the Spectera selection, you will be given a \$50.00 wholesale frame allowance at our private practice providers and a \$120.00 retail frame allowance at our retail optical providers.
CONTACT LENSES (Once Every 12 Months) ➤ Selection contact lenses ➤ Non-Selection contact lenses	In lieu of lenses and a frame, you may select contact lenses. Spectera offers a wide variety of selection contact lenses from many leading manufacturers (over 75% of participants choose from the Spectera selection). Four boxes (12 pairs) of covered disposables are included when obtained from a network provider. A \$105 allowance will be applied toward the evaluation, fitting, and purchase of non-selection contact lenses once every 12 months. Please note: To receive the full \$105 allowance, you must receive your exam, fitting and evaluation at the same provider.
LASER EYE SURGERY:	Spectera participants receive access to discounted refractive eye surgery procedures from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.spectera.com .

BENEFITS AT AN OUT-OF-NETWORK PROVIDER

If you elect vision coverage and choose to use a non-network provider, you will be reimbursed up to:

<u>SERVICE</u>	<u>AMOUNT</u>	<u>SERVICE</u>	<u>AMOUNT</u>
Exam		Frames	\$45
Optometrist	\$40		
Ophthalmologist	\$40	Contact Lenses (in lieu of spectacle lenses and frames)	
Lenses		Medically Necessary*	\$210
Single Vision	\$40	Elective	\$105
Bifocal	\$60		
Trifocal	\$80		
Lenticular	\$125		

*If your contacts are medically necessary the provider must submit to Spectera for approval prior to dispensing the contact lenses.

If you choose a non-network provider, you will need to send your itemized receipts, with the primary-insured's Social Security number and the patient's name and date of birth, to:

Spectera Claims Department
P. O. Box 26618
Baltimore, MD 21207-6618

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

Spectera will reimburse you according to the schedule shown above.

Participating provider (Network) - provider copays and non-covered patient options are paid to participating provider by program participant.

Non-network provider (Out-of-Network) - participant pays full fee to the provider and Spectera reimburses the member for services rendered up to maximum allowance. All receipts must be submitted at the same time. Copays do not apply to out-of-network benefits.

Important to Remember:

- Always identify yourself as a Spectera member when making your appointment. This will assist your provider in obtaining a claim authorization prior to your visit.
- Benefits available every 12 months.
- Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
- Benefits for contact lenses are in lieu of a lens and frame. Your provider will help you determine which contact lenses are covered under your benefit.
- Your \$105 contact lens allowance is applied to the fitting fee and evaluation as well as the purchase of contact lenses. For example, if the fitting fee and evaluation is \$33, you will have \$72 towards the purchase of contact lenses. The allowance may be separated at some retail locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are examples of non-selection contacts which may result in some out-of-pocket expense.
- Patient options such as UV coating, progressive lenses, etc., are not covered-in-full but are provided to Spectera members at a savings below usual and customary charges.

CHOICE AND ACCESS OF VISION CARE PROVIDERS

With Spectera, you are able to choose from network private practice providers and retail optical providers. Prior to enrolling in or using the Spectera Vision Care Program, if you would like to identify a network provider, visit Spectera's Web site (www.spectera.com) and provider locator, or call Spectera's Provider Locator Service at 1-800-638-3120 and follow the voice prompts:

- Enter the primary insured's Social Security number
- Enter the ZIP code for the area you wish to check
- After each entry, the system will repeat what you have entered and ask that you "Press 1" if correct, or "Press 2" if incorrect
- The system will then identify up to three network providers in the requested ZIP code's area
- If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2".

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a Spectera participant.

This system will allow you to find providers in your area prior to enrolling in or using the Spectera Vision Care Program.

Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll free at 1-800-638-3120 from 8:30 am to 8:00 pm Monday thru Friday and from 9:00 am to 5:00pm on Saturday.

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease, which requires the services of a physician
4. Worker's Compensation services or materials
5. Services or materials which the patient, without cost, obtains from any governmental organization or program
6. Services or materials which are not specifically covered by the Policy
7. Sunglasses, plain or prescription
8. Replacement or repair of lenses and/or frame which have been lost or broken
9. Cosmetic extras, except as stated in the Policy's Table of Benefits

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.

TO BE COMPLETED BY BENEFITS OFFICE:
 Effective Date: ____/____/____
 Sub Code: _____ Client Code: _____
 G/L Account: _____

Vision Plan Enrollment Form

Organization Name: _____

I. Check the Appropriate Boxes

Coverage Desired		REASON FOR CHANGE IN STATUS	
<input type="checkbox"/> Employee Only \$_____	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Termination	<input type="checkbox"/> Death
<input type="checkbox"/> Employee + Spouse \$_____	<input type="checkbox"/> Change of Status/Address	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce
<input type="checkbox"/> Employee + Child(ren) \$_____	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Newborn Child	<input type="checkbox"/> Last Name/Address Change
<input type="checkbox"/> Employee + Family \$_____	<input type="checkbox"/> COBRA	<input type="checkbox"/> Other Insurance	<input type="checkbox"/> Adoption/legal custody of child
		<input type="checkbox"/> Move to COBRA	<input type="checkbox"/> Legal custody of parent
			<input type="checkbox"/> Dependent child married/reached age limit

II. Employee Information (please print clearly):

Unique Member ID Number ____ - ____ - _____

Your Name _____
 (First) (Middle Initial) (Last)

Birth Date ____/____/____

Address _____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____

III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Full Time Student?	Sex
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 months
 Your Signature _____ Date _____

Spectera, Inc. administers vision benefits underwritten by the following entities United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only).

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I authorize Benefits Store, Inc. to initiate periodic deductions from my account shown below.

<p><u>ATTACH YOUR PREMIUM CHECK HERE!!!</u></p>
--

I understand this authority is to remain in full force and effect until Benefits Store, Inc. has received a written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to Benefits Store, Inc. twenty (20) business days or more before this payment is scheduled to be made.

Choice of Payment Dates – [] 5th or [] 15th of each Month

A \$5.00 Service Charge may be added for any item returned by the bank.

Signature of Depositor _____ Date _____

For Benefits Store, Inc. Use Only

Account Information

Policy Holder Name: _____

Policy Number _____

Deduction Amount \$ _____

Once a Month beginning on the 5th/15th day of _____

Once a Month beginning on the 5th/15th day of _____