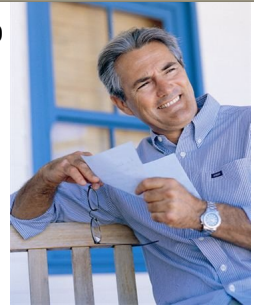




# Individual Vision Plan

**Kansas**

Rates effective through 12/31/2009



**Vision Care Direct: A simple, flexible, affordable vision plan designed to meet YOUR needs!**

Visit our website at [www.vcdplans.com](http://www.vcdplans.com) to find a provider in your area.

**Vision Care Direct is a membership plan, not insurance.**

## How to Enroll

- STEP 1:** Select from Complete (includes Exam), Materials Only or Exam Only
- STEP 2:** Select your Frame and Contact lens allowance (for Complete and Materials Only plans)
- STEP 3:** Complete the attached enrollment form, elect payment option, and mail or fax to the address at the top of the form

**All benefits are covered once every 12 months**

| <b>COMPLETE PLAN</b><br><br><i>Savings at time of service can range from \$225-350+ per person</i> | <b>\$15</b> member payment at time of services for a complete, comprehensive eye-health examination including refraction and dilation.<br><b>PLUS</b><br><b>\$15</b> member payment at time of services for materials. Member receives:<br><b>\$100, \$130 or \$160</b> frame allowance towards retail price of frames. Member responsible for amount over allowance.<br>Choice of glass or plastic (CR-39) spectacle lenses for single vision, lined bifocal, lined trifocal (FT25-28) or lenticular. Upgrades to specialty lenses such as high index and polycarbonate, and cosmetic options such as tinting and coatings are member responsibility.<br>Progressive (no-line) lens allowance equal to retail cost of standard trifocal lens (approx. \$120). Member pays overage.<br><b>\$105, \$130 or \$160</b> contact lens allowance in lieu of frames and spectacle lenses. Member responsible for professional fitting fees. |        |  |        |  |        |  |  |
|--|--|--------|--|--------|--|--------|--|--|
|  | Number of family members enrolling   |        | Plan 100:<br>\$100 frame allowance or \$105 contact lens allowance |        | Plan 130:<br>\$130 frame allowance or \$130 contact lens allowance |        | Plan 160:<br>\$160 frame allowance or \$160 contact lens allowance |  |
|  | Monthly  | Annual | Monthly  | Annual | Monthly  | Annual |  |  |
| Single/Individual  | \$ 16.22   | \$ 190 | \$ 18.72   | \$ 221 | \$ 21.22   | \$ 252 |  |  |
| Family of 2  | 29.32  | 352    | 33.94  | 410    | 38.56  | 467    |  |  |
| Family of 3  | 44.88  | 544    | 52.04  | 633    | 59.18  | 722    |  |  |
| Family of 4+   | 58.60  | 714    | 67.98  | 830    | 77.36  | 946    |  |  |

| <b>MATERIALS ONLY PLAN</b><br><br><i>Savings at time of service can range from \$145-230+ per person</i> | <b>\$15</b> member payment at time of services for materials. Member receives:<br><b>\$100, \$130 or \$160</b> frame allowance towards retail price of frames. Member responsible for amount over allowance.<br>Choice of glass or plastic (CR-39) spectacle lenses for single vision, lined bifocal, lined trifocal (FT25-28) or lenticular. Upgrades to specialty lenses such as high index and polycarbonate, and cosmetic options such as tinting and coatings are member responsibility.<br>Progressive (no line) lens allowance equal to retail cost of standard trifocal lens (approx. \$120). Member pays overage.<br><b>\$105, \$130 or \$160</b> contact lens allowance in lieu of frames and spectacle lenses. Member responsible for professional fitting fees. |        |  |        |  |        |  |  |
|--|---|--------|--|--------|--|--------|--|--|
|  | Number of family members enrolling  |        | Plan 100:<br>\$100 frame allowance or \$105 contact lens allowance |        | Plan 130:<br>\$130 frame allowance or \$130 contact lens allowance |        | Plan 160:<br>\$160 frame allowance or \$160 contact lens allowance |  |
|  | Monthly   | Annual | Monthly  | Annual | Monthly  | Annual |  |  |
| Single/Individual  | \$ 11.22  | \$ 128 | \$ 13.72   | \$ 160 | \$ 16.22   | \$ 191 |  |  |
| Family of 2  | 20.07   | 238    | 24.70  | 295    | 29.32  | 353    |  |  |
| Family of 3  | 30.59   | 368    | 37.74  | 457    | 44.88  | 545    |  |  |
| Family of 4+   | 39.86   | 482    | 49.24  | 599    | 58.60  | 715    |  |  |

| <b>EXAM ONLY PLAN</b><br><br><i>Savings at time of service can range from \$80-150+ per person</i> | <b>\$15</b> member payment at time of services for a complete, comprehensive eye-health examination including refraction and dilation. |       |         |        |
|--|--|-------|---------|--------|
|  | Number of family members enrolling   |       | Monthly | Annual |
|  | Single/Individual  |       | \$ 5.80 | \$ 61  |
| Family of 2  |  | 10.05 | 114     |        |
| Family of 3  |  | 15.10 | 176     |        |
| Family of 4+   |  | 19.65 | 231     |        |

*Note: Savings and lens prices are for illustrative purposes only. Actual savings and costs will vary and your savings could be higher or lower*

**For questions or inquiries contact Vision Care Direct:**  
**Kaden James, Kansas Sales Director**  
 (913) 424-4980 or e-mail [kaden.james@vcdplans.com](mailto:kaden.james@vcdplans.com)



## How to use your Vision Care Direct plan benefits

1. Complete and submit your enrollment form along with required information for payment option selected.
2. Member ID cards are not necessary to receive care with Vision Care Direct providers but we do provide them for your convenience.

You will receive a Member ID card from Vision Care Direct in 10-14 days after acceptance. It can also be downloaded from the internet usually within 72 hours of receipt of your application. Go to [www.vcdplans.com](http://www.vcdplans.com), click on "Members" from the blue bar, and then select "Reprint ID Card."



3. When you are ready to schedule an eye examination, go to [www.vcdplans.com](http://www.vcdplans.com) and select one of our providers from the "Find a Doctor" section. When you call to set an appointment, identify yourself as a Vision Care Direct member and make sure they acknowledge acceptance of the plan. **Benefits are ONLY available from our network providers.**

**Note:** If a doctor's office indicates they do not accept Vision Care Direct, please call our National Sales Office at 877-823-2552. This may be a recent doctor termination from the plan and we have not yet been notified, or the staff member may be new and this is an opportunity for us to educate the doctor's staff.

4. Your doctor's office will verify your eligibility for benefits by checking our on-line Eligibility system. They will ask for your Member ID number, but they can also look you up in our system using any of the following criteria: your social security number, last name, first name, date of birth, city (from your mailing address), or state. **You are not responsible for providing a claim form to the doctor.**

If for some reason your doctor's office still cannot locate you in our system, they should contact our Administrative office at 877-488-8900, ext. 502.

5. The staff at your doctor's office will calculate out-of-pocket costs you are responsible for, after allowances, and you will pay that amount directly to the doctor. The doctor will file your claim on-line with Vision Care Direct – you will not have to file a claim with us!

### General Limitations and Exclusions

This vision plan is designed for routine eye care and materials expense incurred while the membership is in force. Plan benefits cannot be combined with any other discounts, promotional offers or other advertised specials including, but not limited to, discounts, coupons, or two-for-one materials specials offered by the providers at their individual offices. Members must choose between using their Vision Care Direct benefits or the provider's special offers. **Unused benefits do not roll over into next benefit period.** We do not provide benefits for the following:

- Services and materials not included on Benefit Summary including cosmetic items and add-ons
- Orthoptics or vision training and any associated supplemental testing
- Subnormal vision aids, non-prescription or aniseikonic lenses
- Contact lenses for cosmetic enhancement such as changing eye color except as covered in the Benefit Summary
- Oversized 61 and above lens or lenses
- Experimental or non-conventional treatment or device
- Medical or surgical treatment of the eyes other than qualifying discount on refractive surgery
- Any services or materials where benefits are provided under your medical insurance
- Any injury or illness covered by Workers Compensation or similar law
- Services or materials previously paid by another vision plan
- Two pairs of glasses in lieu of bifocals, trifocals, or progressives
- Care for services or materials received while traveling in a foreign country without a detailed receipt in English
- Charges incurred after membership ends



Offered by Vision Care Plus - Kansas

To Enroll: Simply complete the enrollment form below and Return To: Vision Care Direct, 2178 S. 900 E. #6, Salt Lake City, UT 84106. Enroll only family members for whom membership is desired. You need not enroll all family members. If paying annually via credit/debit card, you may fax this application to (801) 466-4113.

LAST NAME FIRST NAME MIDDLE

ADDRESS CITY STATE ZIP

MONTH TO BEGIN PLAN (STARTS ON 1ST) BIRTHDATE (MM/DD/YY) SEX SOCIAL SECURITY NO OPTIONAL 9-DIGIT ID NO

WORK PHONE HOME PHONE EMAIL ADDRESS

MARITAL STATUS SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE - LAST NAME FIRST NAME MIDDLE INITIAL BIRTHDATE (MM/DD/YY) SEX

DEPENDENT- LAST NAME FIRST NAME MIDDLE INITIAL BIRTHDATE (MM/DD/YY) SEX FULL-TIME STUDENT

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DEPENDENT- LAST NAME FIRST NAME MIDDLE INITIAL BIRTHDATE (MM/DD/YY) SEX FULL-TIME STUDENT

Annual Payment Option Please mark your choice of plans, and method of payment

Complete 100: Single \$190 Family of Two \$352 Family of Three \$544 Family of Four + \$714
Complete 130: Single \$221 Family of Two \$410 Family of Three \$633 Family of Four + \$830
Complete 160: Single \$252 Family of Two \$467 Family of Three \$722 Family of Four + \$946
Materials Only 100: Single \$128 Family of Two \$238 Family of Three \$368 Family of Four + \$482
Materials Only 130: Single \$160 Family of Two \$295 Family of Three \$457 Family of Four + \$599
Materials Only 160: Single \$191 Family of Two \$353 Family of Three \$545 Family of Four + \$715
Exam Only: Single \$61 Family of Two \$114 Family of Three \$176 Family of Four + \$231

Check # Credit Card Type: Mastercard Visa Discover / Novus American Express
Credit Card Number: Exp. Date Billing zip code:

Cardholder's Name: Card Security Code: (3 digits on back of card. American Express is 4 digits on front of card.)

Cardholder's Signature: Daytime Phone: Date:

Make annual payment payable to Vision Care Direct. I authorize Vision Care Direct to process payment as specified above. I understand that rates are subject to change upon renewal.

Monthly Bank Draft Option Please mark your choice of plans and authorize Surepay Electronic Funds Transfer Payment

Complete 100: Single \$16.22 Family of Two \$29.32 Family of Three \$44.88 Family of Four + \$58.60
Complete 130: Single \$18.72 Family of Two \$33.94 Family of Three \$52.04 Family of Four + \$67.98
Complete 160: Single \$21.22 Family of Two \$38.56 Family of Three \$59.18 Family of Four + \$77.36
Materials Only 100: Single \$11.22 Family of Two \$20.07 Family of Three \$30.59 Family of Four + \$39.86
Materials Only 130: Single \$13.72 Family of Two \$24.70 Family of Three \$37.74 Family of Four + \$49.24
Materials Only 160: Single \$16.22 Family of Two \$29.32 Family of Three \$44.88 Family of Four + \$58.60
Exam Only: Single \$5.80 Family of Two \$10.05 Family of Three \$15.10 Family of Four + \$19.65

Please charge my checking account monthly. I have enclosed a check for my First Month's Payment of \$ made payable to Vision Care Direct, plus a voided check from the account to be debited monthly. Failure to include may delay effective date.

Bank Name: City: Account #:

Draft Authorization/Member Agreement: Unless I have elected Annual Payment by check or credit card, I hereby authorize Vision Care Direct to charge my account the application membership fee, to be credited to my account with Vision Care Direct. This authorization is to remain in full force and effect until I notify Vision Care Direct in writing of its termination. (My bank is authorized to make corrections if necessary). I have read and understand the terms of this authorization. I agree to maintain membership for a period of one year and to authorize monthly bank drafts during that year. Less than one year membership may result in being billed by the doctors at their usual and customary rate, minus membership fees paid. All membership fees are non refundable.

Authorized Signature: Date:

SIGNATURE AUTHORIZING ENROLLMENT IN VISION PLAN

Subscribers Signature: Date:

SALES AGENT INFORMATION - VISION CARE DIRECT REPRESENTATIVE

Sales Agent: IPA Sales Rep: Kaden James #547 Date: