

Our vision plans center around providing the highest-quality eye exam while allowing you to select the vision plan that best meets your personal needs.

Our plans provide:*

- Annual comprehensive eye-health examination covered in full
- Single, bifocal, trifocal or lenticular lenses covered in full
- Progressive lens option for no-line bifocal or trifocals with \$200 allowance
- Choice of frames allowance - \$100, \$130 or \$160
- Choice of contact lenses allowance in lieu of glasses
- Specialty plans to be added to any plan or selected separately including a second Materials Only plan, Rx Sunwear, or Computer Eyewear.

Plan Benefits from Participating In-Network Doctors

(After fee at time of service/Up to plan limits)

Eye Exam	Paid in full after fee at time of service
Lenses (per pair)	
Single	Paid in full after fee at time of service
Bifocal	Paid in full after fee at time of service
Trifocal	Paid in full after fee at time of service
Lenticular	Paid in full after fee at time of service
Progressive	Platinum Plan: \$200 allowance
	All other plans: allowance equal to retail price of standard trifocal lens
Contact Lenses	
Note: contact lens benefit can be chosen in lieu of glasses. Professional fees may be extra.	
Elective – lenses only	Allowance of \$105, \$130 or \$160
Medically necessary**	Allowance of \$250
Frame	Allowance of \$100, \$130 or \$160
Specialty Plans that can be added to any plan or selected separate:	
RxSunwear Plan	Covers lenses and frames as indicated above plus tint on plastic lens
Computer Eyewear	Covers single vision lens with A/R coating & VDT filter. Frame allowance of \$100, \$130 or \$160

Fees at time of service
based on plan(s) selected:

Exam: \$15
Materials: \$15
No materials fee for contact lenses

Locate a VCD provider in your area at www.VisionCareDirect.com

Out-of-network reimbursement is not available on individual or family vision plans.

For sales assistance contact Choice Plus Insurance at (970) 226-3416 or info@choiceplusins.com.

Vision Care Direct is a Membership Plan not insurance. There is no consumer risk.

* For a complete listing of benefits, exclusions and limitations, please reference the benefit summary.

**Medically necessary contacts require prior authorization from your Doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; or 2) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary.

Complete Plans

Member pays \$15 at time of service for exam and/or \$15 for materials plus excesses above allowances and add-ons.
Materials fee does not apply to contact lens.

Frame/contact lens allowance	Individual	Individual +1	Individual/Children	Individual/Family
Platinum Plan - <u>12 month exam, lens and frame benefit</u> - Includes \$200 Progressive lens allowance				
\$100 frame or \$105 contact lens	\$194.94	\$360.72	\$557.60	\$731.05
\$130 frame or \$130 contact lens	\$224.86	\$420.55	\$647.35	\$850.72
\$160 frame or \$160 contact lens	\$254.77	\$480.38	\$737.10	\$970.38

Gold Plan - 12 month exam, lens and frame benefit

\$100 frame or \$105 contact lens	\$178.63	\$330.59	\$511.06	\$670.03
\$130 frame or \$130 contact lens	\$208.55	\$390.42	\$600.80	\$789.70
\$160 frame or \$160 contact lens	\$238.46	\$450.25	\$690.55	\$909.36

Specialty Plans (Add to any Complete plan or purchase as standalone)

Exam Only Plan

Exam Only—every 12 months	\$57.78	\$106.81	\$165.13	\$216.54
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Materials Only Plan (Single vision, bifocal, trifocal or lenticular lens) Lens/Frame Benefits every 12 months

Adding a Materials Only plan is perfect for the employee who wants both frame/spectacle lenses and contacts in the same year!

\$100 frame or \$105 contact lens	\$120.96	\$223.78	\$345.82	\$453.49
\$130 frame or \$130 contact lens	\$150.88	\$283.61	\$435.56	\$573.16
\$160 frame or \$160 contact lens	\$180.79	\$343.44	\$525.31	\$692.82

Rx Sunwear Plan - (Single vision, bifocal, trifocal or lenticular lens) Lens/Frame Benefits every 12 months

\$100 frame allowance	\$131.44	\$243.11	\$375.84	\$492.91
\$130 frame allowance	\$161.35	\$302.94	\$465.59	\$612.58
\$160 frame allowance	\$191.27	\$362.77	\$555.34	\$732.24

VCD ComputerWear™ - Materials Only Plan - Lens/Frame Benefits every 12 months

\$100 frame allowance	\$168.16	\$311.15	\$481.03	\$630.72
\$130 frame allowance	\$198.07	\$370.98	\$570.78	\$750.38
\$160 frame allowance	\$227.99	\$430.81	\$660.53	\$870.05

How to use your Vision Care Direct Plan Benefits

- Complete and submit attached enrollment form along with required information based on payment option selected.
- Member ID cards are not necessary to receive care but are provided for convenience. You should receive a Member ID card within 10-14 days after acceptance. Cards can also be downloaded usually within 72 hours of receipt of your application. Go to www.VisionCareDirect.com, click on "Members" and select "Reprint ID Card."
- To schedule an appointment, go to www.VisionCareDirect.com, click on "Members" and select a provider from the "Find a Doctor" section. When setting up an appointment, identify yourself as a Vision Care Direct member and confirm the doctor accepts 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 contact us at 877-823-2552. The doctor may have recently terminated the plan without notification or the office may require training on plan usage.
- After eligibility for benefits has been verified, please provide your Member ID number for verification. If you do not have your number, verification may also be granted by providing: social security number, last name, first name, date of birth, city (from mailing address), or state. **You are not responsible for providing a claim form to the doctor.**
 If the doctor's office still cannot locate you in our system, they should contact us at 877-488-8900, ext. 502.
- Your doctor's office will calculate out-of-pocket costs after allowances to be paid directly to the doctor. Filing a claim with Vision Care Direct is the doctor's responsibility and not the responsibility of the patient.

Benefit Summary

Description of Benefits dependent on selection at time of enrollment. THERE IS NO REIMBURSEMENT FOR OUT-OF-NETWORK

EXAM BENEFIT (Not applicable on Materials Only Plans)

Description of Benefits	Plan Covers	Member Responsibility
Comprehensive eye-health vision examination includes refraction, and dilation if indicated.	100% after exam fee	Exam Fee

MATERIALS BENEFIT (Not applicable on Exam Only Plan)

Spectacle Lens	100% for glass or plastic (CR-39) for single vision, bifocal, trifocal (FT25-28) or lenticular	Materials Fee
Progressive lens allowance - all complete plans except Platinum Plan	Up to retail price of standard trifocal lens regardless of Rx	Overage
Platinum Plan Only	\$200 benefit for progressive lenses	Overage
Cosmetic upgrades and add-ons	Not covered	Usual and customary fee
Contact Lens		
In lieu of frames and spectacle lens (including multi-focal contacts)	Elective: selected allowance Medically necessary: \$250	Overage above allowance Materials fee does not apply
Allowance applies to fitting fees.		
Frame Allowance	Any frame from provider's inventory	Overage above allowance

SPECIALTY PLAN VARIATIONS

Rx Sunwear Plan	Lenses covered as indicated above. 100% tint on plastic lens	Member pays difference in retail price for Polarized, glass tints, or photo-chromic, plus Materials Fee
VCD ComputerWear™ Plan	100% for Single Vision lens including A/R Coating and VDT Filter	Materials fee
	UPGRADES: Single vision with power boost: \$13; Near variable focus \$63 (paid at time of service)	

ADDITIONAL BENEFITS - ALL PLANS

LASIK/REFRACTIVE BENEFIT Ask your VCD provider for participating providers in your area or call 877-488-8900	Up to 15% discount	Cost after discount
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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 injury or illness covered by Workers Compensation or similar law
- 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
- Services obtained out of network

CONTACT INFORMATION

National Sales Office	Ph: (877) 823-2552	Fx: (801) 607-7468	Email: sales@visioncaredirect.com
Claims & Administration Office	Ph: (877) 488-8900	Fx: (801) 466-4113	Email: admin@visioncaredirect.com

Vision Care Direct is a provider-based plan. You can locate a provider at www.visioncaredirect.com.



INDIVIDUAL ENROLLMENT FORM - Colorado

This is a membership plan, not insurance

Offered by Colorado Eye Care Specialists

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 1 ST)	BIRTHDATE (MM/DD/YY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F		SOCIAL SECURITY NO	OPTIONAL 9-DIGIT ID NO
WORK PHONE	HOME PHONE		EMAIL ADDRESS		
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED					
SPOUSE – LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	FULL –TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	FULL –TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	FULL –TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	FULL –TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT

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

- Platinum 100:** Single \$194.94 Family of Two \$360.72 Family of Three \$557.60 Family of Four + \$731.05
- Platinum 130:** Single \$224.86 Family of Two \$420.55 Family of Three \$647.35 Family of Four + \$850.72
- Platinum 160:** Single \$254.77 Family of Two \$480.38 Family of Three \$737.10 Family of Four + \$970.38
- Gold 100:** Single \$178.63 Family of Two \$330.59 Family of Three \$511.06 Family of Four + \$670.03
- Gold 130:** Single \$208.55 Family of Two \$390.42 Family of Three \$600.80 Family of Four + \$789.70
- Gold 160:** Single \$238.46 Family of Two \$450.25 Family of Three \$690.55 Family of Four + \$909.36
- Materials Only 100:** Single \$120.96 Family of Two \$223.78 Family of Three \$345.82 Family of Four + \$453.49
- Materials Only 130:** Single \$150.88 Family of Two \$283.61 Family of Three \$435.56 Family of Four + \$573.16
- Materials Only 160:** Single \$180.79 Family of Two \$343.44 Family of Three \$525.31 Family of Four + \$692.82
- Rx Sunwear 100:** Single \$131.44 Family of Two \$243.11 Family of Three \$375.84 Family of Four + \$492.91
- Rx Sunwear 130:** Single \$161.35 Family of Two \$302.94 Family of Three \$465.59 Family of Four + \$612.58
- Rx Sunwear 160:** Single \$191.27 Family of Two \$362.77 Family of Three \$555.34 Family of Four + \$732.24
- VCD ComputerWear 100:** Single \$168.16 Family of Two \$311.15 Family of Three \$481.03 Family of Four + \$630.72
- VCD ComputerWear 130:** Single \$198.07 Family of Two \$370.98 Family of Three \$570.78 Family of Four + \$750.38
- VCD ComputerWear 160:** Single \$227.99 Family of Two \$430.81 Family of Three \$660.53 Family of Four + \$870.05
- Exam Only:** Single \$57.78 Family of Two \$106.81 Family of Three \$165.13 Family of Four + \$216.54

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.

SIGNATURE AUTHORIZING ENROLLMENT IN VISION PLAN

Subscribers Signature: _____ Date: ____ / ____ / ____

SALES AGENT INFORMATION – VISION CARE DIRECT REPRESENTATIVE

Sales Agent: _____ Choice Plus Insurance #65 IPA Sales Rep: _____ Denise O'Malley #54 Date: ____ / ____ / ____