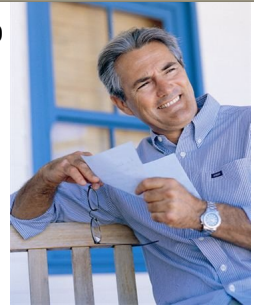




Individual Vision Plan

South Dakota

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 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

COMPLETE PLAN <i>Savings at time of service can range from \$225-350+ per person</i>	\$15 member payment at time of services for a complete, comprehensive eye-health examination including refraction and dilation. PLUS \$15 member payment at time of services for materials. Member receives: \$100, \$130 or \$160 frame allowance towards retail price of frames. Member responsible for amount over allowance. 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. Progressive (no-line) lens allowance equal to retail cost of standard trifocal lens (approx. \$120). Member pays overage. \$105, \$130 or \$160 contact lens allowance in lieu of frames and spectacle lenses. Member responsible for professional fitting fees.							
	Number of family members enrolling		Plan 100: \$100 frame allowance or \$105 contact lens allowance		Plan 130: \$130 frame allowance or \$130 contact lens allowance		Plan 160: \$160 frame allowance or \$160 contact lens allowance	
		Monthly	Annual	Monthly	Annual	Monthly	Annual	
	Single/Individual	\$ 17.50	\$ 207	\$ 19.44	\$ 230	\$ 21.38	\$ 254	
Family of 2	31.70	382	35.28	426	38.88	471		
Family of 3	48.58	591	54.12	659	59.66	728		
Family of 4+	63.46	774	70.72	864	77.98	954		

MATERIALS ONLY PLAN <i>Savings at time of service can range from \$145-230+ per person</i>	\$15 member payment at time of services for materials. Member receives: \$100, \$130 or \$160 frame allowance towards retail price of frames. Member responsible for amount over allowance. 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. Progressive (no line) lens allowance equal to retail cost of standard trifocal lens (approx. \$120). Member pays overage. \$105, \$130 or \$160 contact lens allowance in lieu of frames and spectacle lenses. Member responsible for professional fitting fees.							
	Number of family members enrolling		Plan 100: \$100 frame allowance or \$105 contact lens allowance		Plan 130: \$130 frame allowance or \$130 contact lens allowance		Plan 160: \$160 frame allowance or \$160 contact lens allowance	
		Monthly	Annual	Monthly	Annual	Monthly	Annual	
	Single/Individual	\$ 12.92	\$ 150	\$ 14.86	\$ 174	\$ 16.80	\$ 198	
Family of 2	23.22	277	26.82	322	30.40	366		
Family of 3	35.48	429	41.02	497	46.56	566		
Family of 4+	46.26	562	53.52	652	60.80	742		

EXAM ONLY PLAN <i>Savings at time of service can range from \$80-150+ per person</i>	\$15 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		\$ 5.38	\$ 57
	Family of 2		9.28	105
Family of 3		13.90	162	
Family of 4+		17.98	212	

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:
 Sidney Gran, South Dakota Sales Director
 (605) 553-8890 or e-mail sidney.gran@vcdplans.com**



Offered by Dakota Eye Care Associates, Inc.

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.

Form fields for personal information: LAST NAME, FIRST NAME, MIDDLE, ADDRESS, CITY, STATE, ZIP, BIRTHDATE, SEX, SOCIAL SECURITY NO, MONTH TO BEGIN PLAN, WORK PHONE, HOME PHONE, EMAIL ADDRESS, MARITAL STATUS, SPOUSE, and DEPENDENTS.

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

Payment plan options: Complete 100, Complete 130, Complete 160, Materials Only 100, Materials Only 130, Materials Only 160, Exam Only. Includes checkboxes for Single, Family of Two, Family of Three, Family of Four+ and their respective costs.

Credit Card information fields: Check #, Credit Card Type (Mastercard, Visa, Discover/Novus, American Express), Credit Card Number, Exp. Date, Billing zip code, Cardholder's Name, Card Security Code, 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

Monthly payment plan options: Complete 100, Complete 130, Complete 160, Materials Only 100, Materials Only 130, Materials Only 160, Exam Only. Includes checkboxes for Single, Family of Two, Family of Three, Family of Four+ and their respective costs.

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 draft information fields: Bank Name, City, Account #, Draft Authorization/Member Agreement text, Authorized Signature, Date.

SIGNATURE AUTHORIZING ENROLLMENT IN VISION PLAN

Subscriber Signature: _____ Date: ____/____/____

SALES AGENT INFORMATION - VISION CARE DIRECT REPRESENTATIVE

Sales Agent: _____ IPA Sales Rep: Sidney Gran #515 Date: ____/____/____