GVS | GENERAL® VISION SERVICES

Management Benefits Fund

Member Name: _____ ID #: _____ Account #: _____

Service Date: _____ Authorization #: _____ Store Receipt #: _____

Location Address: _____

BENEFIT OUTLINE	CO-PAYS	PATIENT PAYS
EYE EXAMINATION		
Provider Office **MUST NOT Bill Medical Insurance Plan** for Eye Exam or Office Visit		
☐ Eye Exam (including dilation when professionally indicated)	INCLUDED	
FRAME ALLOWANCE		
☐ GVS Collection Frame	$300 allowance	
☐ Non-Collection Frame	$200 allowance	
SPECTACLE LENSES		
☐ Single Vision	INCLUDED	
☐ Bifocal	INCLUDED	
☐ Trifocal	INCLUDED	
☐ Oversize	INCLUDED	
☐ Standard Progressive	INCLUDED	
☐ Premium Progressive	INCLUDED	
☐ Ultra Progressive	$50	
☐ Plastic Photosensitive Lenses (single vision)	INCLUDED	
☐ Plastic Photosensitive Lenses (bifocal)	INCLUDED	
MATERIALS		
☐ Plastic	INCLUDED	
☐ Polycarbonate for dependent children (up to age 19)	INCLUDED	
☐ Polycarbonate	INCLUDED	
☐ High-Index	INCLUDED	
☐ Photochromic Lenses	INCLUDED	
☐ Intermediate Lenses	INCLUDED	
☐ Blended Segment Lenses	INCLUDED	
COATINGS		
☐ Tints	INCLUDED	
☐ Ultra Violet	INCLUDED	
☐ Scratch Resistant Coating	INCLUDED	
☐ Polarized	INCLUDED	
☐ Anti-reflective - Standard Coating	INCLUDED	
☐ Anti-reflective - Premium Coating	$13	
☐ Anti-Reflective - Ultra Coating	$25	
☐ Blue Light Filtering	$25	
CONTACT LENSES		
☐ Non Plan Contact Lenses	$200	
☐ Non Plan Evaluation, Fitting and Follow-up	$50 copay	
☐ Plan Contact Lenses	12 Month Supply	
☐ Plan Contact Lenses Eval, Fitting and Follow-up	INCLUDED	
☐ Medically Necessary Contacts	$200	
ANY SERVICE NOT LISTED ABOVE RECEIVES A 30% DISCOUNT		
☐ List any additional upgraded services below		
TOTAL PATIENT RESPONSIBILITY		

By signing below, I acknowledge that I have received the above services and materials and that I am responsible for the amount listed above.

Patient Signature: _____