Here's a Great Vision Offer!

Exclusive Offer for American Seniors The New Voice for America's Seniors Members

Enroll Today! 877-473-6031

A VISION PLAN WITH BIG BENEFITS.

Thanks to the purchasing power of ASA, members can benefit from the kind of quality vision coverage and pricing typically reserved for large groups. This program was specifically designed for ASA by Ameritas Life Insurance Corp. (the plan's underwriter). Ameritas offers vision and dental insurance products nationwide.

RATES*

Member	**$9.44**
Member + 1 Dependent	**$16.20**
Member + 2 or more Dependents	**$21.88**

BENEFITS

SERVICE	IN-PANEL DOCTOR PLAN PAYS:	MAXIMUM COVERED EXPENSE WITH NON-PANEL DOCTOR PLAN PAYS:
Exam	**Covered in Full**	**Up to $52.00**
Frame	**Up to $120.00**	**Up to $45.00**
Single Lenses	**Covered in Full**	**Up to $55.00 Per Pair**
Bifocal Lenses	**Covered in Full**	**Up to $75.00 Per Pair**
Trifocal Lenses	**Covered in Full**	**Up to $95.00 Per Pair**
Lenticular Lenses	**Covered in Full**	**Up to $125.00 Per Pair**
Contact Lenses (NECESSARY)	**Covered in Full**	**Up to $210.00**
Contact Lenses (ELECTIVE)	**Up to $105.00**	**Up to $105.00**

FREQUENCY ALLOWANCE

Exams	**12 Months**
Lens	**12 Months**
Frames	**24 Months**

- Patient is responsible for $25 annual deductible on exams and $25 annual deductible on materials.
- For Single lenses (In-Panel): If insured chooses a frame valued at more than the plan's allowance, you will receive a 20% discount on the amount over your frame allowance.
- When contact lenses are selected: 1) The insured is eligible for an exam and contact lenses. Other limitations and provisions of the policy will apply. The benefit for the examination will be reimbursed as shown above. 2) The exam and lens benefit will not be available for the next 12- or 24-month period following the date of service.
- Excludes members who are residents of AK, AR, ME, NC, NH, NY and RI.

  Rates valid through 5/1/2015.
- **Alternate Benefit Provision.** At times, two or more procedures are considered adequate and appropriate treatment. In this case, the benefit will be based on the charge for the least expensive procedure.

  This highlights brochure is not a contract, certificate of insurance or guarantee of coverage. Full details about waiting periods, exclusions and limitations that may apply are in the policy or certificate.

Ameritas fulfilling life.

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LIMITATIONS

COVERED EXPENSES WILL NOT INCLUDE AND NO BENEFITS WILL BE PAYABLE FOR EXPENSES INCURRED FOR:

1. more than one eye exam in the frequency as indicated on the plan definition page.
2. more than one pair of lenses in the frequency as indicated on the plan definition page.
3. more than one set of frames in the frequency as indicated on the plan definition page.
4. contact lenses more than once in any twelve month period. When chosen, contact lenses shall be in lieu of any other lens benefit during the twelve month period and in lieu of any other frame benefit during the twelve month period. When eyeglass lenses are chosen, expenses for contact lenses are not Covered Expenses during the twelve month period.
5. medically necessary contact lenses, except for the first $105 of expense, when such lenses are purchased for any reason other than for the following conditions:
   - **a.** following cataract surgery;
   - **b.** to correct extreme visual problems that cannot be corrected with spectacle lenses;
   - **c.** certain conditions of anisometropia;
   - **d.** keratoconus.

   Such payment is limited to once in any twelve-month period and is in lieu of lenses and frame benefits under this policy.
6. Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
7. the refitting of contact lenses after the initial (90-day) fitting period.
8. plano contact lenses to change eye color cosmetically.
9. artistically-painted contact lenses.
10. contact lens insurance policies or service contracts.
11. additional office visits associated with contact lens pathology.
12. contact lens modification, polishing or cleaning.
13. orthoptics or eye care training and any associated testing.
14. plano lenses.
15. two pairs of glasses in lieu of bifocals.
16. lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
17. medical or surgical treatment of the eyes.
18. services for which claim is filed more than 180 days after completion of the service.
19. the following materials, over and above the Covered Expense for the basic material. These materials are cosmetic and the Insured will be responsible for the cost of these materials:
   - **a.** blended lenses;
   - **b.** oversize lenses;
   - **c.** photo chromatic lenses; tinted lenses except pink #1 and #2.
20. progressive multi-focal lenses.
21. the coating of the lens or lenses.
22. the laminating of the lens or lenses.
23. frames exceeding the maximum allowance selected by the Policyholder.
24. corrective vision treatment of an experimental nature.
25. Corneal Refractive Therapy (CRT).
26. costs for services and/or materials exceeding plan benefit allowances.
27. services or materials of a cosmetic nature.
28. any procedure not listed on the Schedule of Eye Care Services.

THIS AMERITAS VISION PLAN FOR ASA MEMBERS FEATURES THE MONEY-SAVING EYE CARE PROVIDER NETWORK OF VSP. FOR MORE INFORMATION ABOUT PLAN BENEFITS AND PROVIDERS, PLEASE VISIT WWW.VSP.COM.

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