NESHAMINY SCHOOL DISTRICT

VISION BENEFITS
INDEMNIFICATION PLAN

-WELCOME-

We are pleased to present you with this vision care benefit plan as part of your health and welfare program.

We wish to provide you with a program which will assist you in maintaining your quality of life, maximize your visual efficiency plus prevent the undetected development of a condition which may result in a loss of sight.

Please keep this brochure and read it carefully. It contains an explanation of your benefits and the procedures which you must use. The reverse side is your statement of claim.

What Are Your Benefits?

An INDEMNIFICATION towards:

1. VISION EXAMINATION which will indicate whether you require glasses as well as indicate the presence of other visual problems.

2. LENSES to meet your vision needs as determined by the examination.

3. FRAMES for the lenses.

4. CONTACT LENSES in lieu of glasses.

5. One additional service for medical reasons.

Vision Benefits
of America
Clearly Managed. Clearly Focused.

VBA CUSTOMER SERVICE: 1-800-432-4966

VBA#625 Rp. 08/11/1,000

How To Use The Plan

1. Be sure that you are eligible for coverage.
2. Select a doctor of your choice, receive your examination and select the required frame and lens.
3. Pay your doctor; request itemized receipts; ask to have Part 2 of the statement of claim completed.

   Proper reimbursement can only be made if you identify the individual charges for the examination, lenses (including type of lens) and frame.
4. Within 60 days of service, mail receipts and a completed statement of claim (the backside of this form) to: VISION BENEFITS OF AMERICA.
5. If after the time of your regular examination a medical condition is indicated that requires an additional examination, then upon approval of VBA, this plan will cover one additional examination and lenses (including contacts). Frames will not be covered.

   The procedures for this additional examination and lens benefit are as follows:

   A. Employee completes Part 1 of the backside of this form and submits it to VBA along with a signed doctor's statement indicating the reason for the additional examination and lenses.

   B. If VBA concurs with the doctor's request, an "Additional Service Authorization" will be issued.

   C. Receipts for the examination and lenses must be submitted to VBA with the Additional Service Authorization. Reimbursement will be made in accordance with the regular indemnity schedule.

What Services And Materials Are Not Provided For?

The plan is designed to provide specific assistance in meeting your visual needs. The following services and materials are not covered.

A. Services or supplies for which coverage is available under any other benefit program.

B. Drugs or any medical or surgical treatment.

C. Procedures determined by VBA to be special, or experimental such as but not limited to orthoptics, vision training, anisekonic lenses or tonography;

D. Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;

E. Services or supplies available from any governmental agency or plan for which you are eligible;

F. Examinations or materials furnished for any condition, disease, ailment or injury arising out of or in the course of employment;

G. Vision examination performed and lenses and frames ordered before or after the individual's eligibility period.

H. Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames unless the patient is otherwise eligible.

I. The cost of any insurance premiums indemnifying against losses of lenses or frames.

J. Diagnostic X-ray, medical or pathological examinations.

Frequency of Benefits

Vision Examination	Adults	Every 24 months
	Child	Every 12 months
Lenses	Adults	Every 24 months
	Child	Every 12 months
Fames		Every 24 months

Who Is Eligible?

- Employee, spouse & unmarried dependent children under 19 years of age.
- Unmarried dependent full-time students under 25 years of age.
- Unmarried wholly dependent handicapped children.

How Much Is The Reimbursement?

Professional Fee
Vision Examination, up to ..... $ 50.00

MATERIALS
Lenses (pair):
Single Vision, up to ..... $ 12.00
Bifocal Lenses, up to 18.00
Trifocal Lenses, up to 23.00
Lenticular Lenses, up to 55.00

Frames, up to 12.00

CONTACT LENSES* (in lieu of glasses)
Medical-Hard, up to $150.00
Medical-Soft, up to 150.00
Elective, up to 24.00

* In addition to the allowance for the examination

There is no assurance that this reimbursement will cover the cost of the examination and the materials which you select.

Vision Care Plan • Statement of Claim

ALL INFORMATION BELOW MUST BE COMPLETED ON THIS FORM

INSTRUCTIONS:

1. Employee completes Part 1 of this form.
2. Your optometrist, ophthalmologist, or optician completes Part 2 of this form.
3. A separate Claim Form is required for each family member.
4. One Claim Form is to be used for all services.
5. PLEASE ATTACH ALL BILLS AND RECEIPTS TO THIS CLAIM FORM AND MAIL TO VBA AT ADDRESS LISTED BELOW WITHIN 60 DAYS.

If you have any questions regarding the completion of this form, please contact your Personnel office or Health & Welfare office.

PART 1 To be completed by employee (please print or type)

EMPLOYEE'S FULL NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	CO# 625

HOME ADDRESS NUMBER & STREET	CITY	STATE	ZIP

PATIENT'S FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO EMPLOYEE	BIRTHDATE	IF CHILD IS ELIGIBLE BY ATTENDING SCHOOL FULL-TIME, GIVE SCHOOL NAME
	SELF ❑ SPOUSE ❑ CHILD ❑		

IS TH PATIENT COVERED BY ANY OTHER VISION INSURANCE PLAN?	IF YES, GIVE NAME OF EMPLOYEE	SOCIAL SECURITY NO	CARRIER NAME
YES ❑ 1 NO ❑ 2	NAME OF EMPLOYER		CARRIER ADDRESS

THIS CLAIM IS NOT FOR TREATMENT OF AN OCCUPATIONAL ACCIDENT AND I HEREBY AUTHORIZE ANY OF THE UNDERSIGNED TO DISCLOSE ANY NECESSARY INFORMATION TO THIS CLAIM. I CERTIFY TO THESE STATEMENTS.

MEMBER/EMPLOYEE SIGNATURE _____ DATE _____

USE ONE FORM FOR EACH BENEFICIARY

PART 2 To be completed by optometrist, ophthalmologist, optician (please print or type)

EXAMINATION

PRACTICE NAME	CIRCLE ONE OD MD
NUMBER & STREET	
CITY STATE ZIP CODE	
TELEPHONE NUMBER (AREA CODE)	

PLEASE MARK THE APPROPRIATE SERVICE FOR THE TYPE OF EXAM PERFORMED

Vision Analysis ❑ Tonometry ❑

DID YOU PRESCRIBE? YES ❑ NO ❑	DATE OF EXAMINATION	EXAMINATION CHARGE $

EXAMINING DOCTOR

SIGNATURE _____ DATE _____

LENSES

DISPENSING PRACTICE NAME IF DIFFERENT FROM EXAMINING PRACTICE	CIRCLE ONE OD MD
NUMBER & STREET	
CITY STATE ZIP CODE	
TELEPHONE NUMBER (AREA CODE)	

DISPENSING DOCTOR/OPTICIAN

SIGNATURE _____ DATE _____

DATE ORDERED	

PLEASE INDICATE SEPARATE BASIC LENS CHARGE

SINGLE VISION	$
BIFOCAL	$
TRIFOCAL	$
LENTICULAR	$
ELECTIVE CONTACTS	$
CONTACTS CATARACT	$

FRAME

IF A NEW FRAME IS SUPPLIED, PLEASE INDICATE CHARGE ..... $

TOTAL CHARGE $

ATTACH YOUR RECEIPTS TO THIS CLAIM FORM AND MAIL TO:

VISION BENEFITS OF AMERICA
300 WEYMAN PLAZA
PITTSBURGH, PA 15236-1588