Expert Solutions. Exceptional Service.

NESHAMINY SCHOOL DISTRICT
VBA GROUP #625
HOW TO USE THE PLAN

1. Please verify eligibility for coverage by calling VBA's **Member Service at 1-800-432-4966.**
2. Use the doctor of your choice, receive your examination and select your glasses or contacts.
3. Pay your doctor for all expenses and request itemized receipts; ask your doctor's office to complete Part 2 of the statement of claim. Proper reimbursement can only be made if you identify the individual charges for the examination, lenses (including type of lens) and frame.
4. Mail receipts and a completed statement of claim (the back side of this form) to:

VISION BENEFITS OF AMERICA
400 LYDIA STREET, SUITE 300
CARNEGIE, PA 15106

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

   A. Provide VBA with a signed medical doctor's statement indicating the reasons.
   B. If VBA concurs with the doctor's request, an "Additional Service Authorization" will be issued.
   C. Receipts for this examination and lens must be submitted to VBA with the Additional Service Authorization. Reimbursement will be made in accordance with the regular indemnity schedule.

SCHEDULE OF SERVICE AND REIMBURSEMENT

Employee, Spouse, and Child*

Benefit Available	Frequency of Benefit	Reimbursement
Professional Fees:		
Vision Exam	Once Every 24 months**	$ 50.00
Lenses (Pair):		
Single Vision	Once Every 24 months**	$ 12.00
Bifocal	Once Every 24 months**	$ 18.00
Trifocal	Once Every 24 months**	$ 23.00
Lenticular	Once Every 24 months**	$ 55.00
Frame	Once Every 24 months	$ 12.00
-OR-		
Contact Lenses (*selected in lieu of all eyeglass benefits listed above*)		
Cosmetic	Once Every 24 months**	$ 74.00
Medical	Once Every 24 months**	$ 200.00

* Child: Any unmarried dependent child who has not attained his/her 19th birthday, or 25th birthday. No age limit for wholly dependent mentally retarded/handicapped children.

** Exam and lenses are available to the developing child (up to age 19) once every 12 months.

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Vision Care Plan ● Statement of Claim

ALL INFORMATION MUST BE COMPLETED ON THIS FORM

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 ITEMIZED RECEIPTS TO THIS CLAIM FORM AND MAIL TO VBA AT THE ADDRESS LISTED BELOW WITHIN 1 YEAR FROM THE DATE OF SERVICE.

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	VBA CO# 625
HOME ADDRESS		CITY STATE ZIP	
PATIENT'S FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐	BIRTHDATE	

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 or optician (please print or type)

EXAM

PRACTICE NAME CIRCLE ONE OD MD	PLEASE MARK THE SERVICE FOR THE TYPE OF EXAM PERFORMED VISION ANALYSIS ☐ TONOMETRY ☐		
ADDRESS	DID YOU PRESCRIBE? YES ☐ NO ☐	DATE OF EXAM	EXAM CHARGE $
CITY STATE ZIP CODE	EXAMINING DOCTOR SIGNATURE DATE		
TELEPHONE NUMBER (INCLUDE AREA CODE)			

LENSES

DISPENSING PRACTICE NAME IF DIFFERENT FROM EXAMINING PRACTICE	DATE ORDERED	
ADDRESS	PLEASE INDICATE SEPARATE BASIC LENS CHARGE	
CITY STATE ZIP CODE	SINGLE VISION $_____ BIFOCAL $_____ TRIFOCAL $_____ LENTICULAR $_____	
TELEPHONE NUMBER (INCLUDE AREA CODE)		
DISPENSING DOCTOR/OPTICIAN SIGNATURE DATE	ELECTIVE CONTACTS $_____ MEDICAL REQ'D CONTACTS $_____	

FRAME

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

TOTAL CHARGE $_____

ATTACH YOUR RECEIPTS TO THIS CLAIM FORM AND MAIL TO:

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CARNEGIE, PA 15106