

NORTHERN NEVADA OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND

445 Apple Street ** P. O. BOX 11337
RENO, NEVADA 89510
TELEPHONE (775) 826-7200

request for **VISION BENEFITS**

() CHECK HERE IF NEW ADDRESS

PART I -- EMPLOYEE COMPLETES

Employee's name _____ Employee's Address _____

LAST _____ FIRST _____ STREET _____ CITY _____ ST _____ ZIP _____

EMPLOYEE'S SOCIAL SECURITY NUMBER: _____

_____ daytime phone number (_____)

Patient's name _____ Patient's Address _____

LAST _____ FIRST _____ STREET _____ CITY _____ ST _____ ZIP _____

Patient's DATE OF BIRTH: _____ Relationship to Employee: _____

Is the patient covered by any other insurance plan which provides VISION benefits? YES _____ NO _____

If yes, please provide:

Name of Insured Member Social Security Number of Insured Member

Insurance Company Name Address Phone number

PAYMENT AUTHORIZATION: **PAY MEMBER ()** **PAY PROVIDER ()** I authorize the administrator in its sole discretion to pay directly to the below named provider any benefits otherwise payable to me, but not to exceed any of the charges by the provider.

I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Employee's signature date

I hereby certify that the above statements including any accompanying statements are to the best of my knowledge & belief true and correct.

X _____
Employee's signature date

PART II -- PROVIDER COMPLETES (or attach itemized bill)

SERVICE	DATE	CHARGE	SERVICE	DATE	CHARGE
<input type="checkbox"/> EXAMINATION FEE			<input type="checkbox"/> FRAMES		
PRESCRIPTION LENSES:			<input type="checkbox"/> TINT Photogrey/UV		
<input type="checkbox"/> Single Vision			<input type="checkbox"/> TINT Rose #1 or #2		
<input type="checkbox"/> Bifocal			CONTACTS: <input checked="" type="checkbox"/> cosmetic		
<input type="checkbox"/> Trifocal			<input type="checkbox"/> medically necessary		
<input type="checkbox"/> Lenticular					

TOTAL CHARGES \$

PRACTICE NAME _____ PRINT PHYSICIAN'S NAME & CREDENTIALS _____ PHONE NUMBER _____

ADDRESS _____

STREET _____ CITY _____ STATE _____ ZIP _____

TAX IDENTIFICATION NUMBER _____

I certify that I have performed the services as indicated hereon.

(REQUIRED)

X _____
PROVIDER'S SIGNATURE DATE

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VISION BENEFITS

You must be eligible for vision services on the date of service to receive benefits.

If you are not eligible for benefits, you are responsible for payment of the charges.

Complete PART I of the claim form and sign where indicated. Give the completed claim form to the provider of service to complete PART II. Submit the completed form to the Trust Fund Office for consideration of benefits.

This Plan is designed to cover basic visual needs rather than cosmetic materials. When a patient selects any extras or upgrades, the Plan will pay the scheduled allowance of the covered materials and the patient is responsible for any additional cost.

SERVICE	SCHEDULED ALLOWANCE
EXAMINATION FEE	\$40.00
PRESCRIPTION LENSES:	
Single Vision	\$36.00
Bifocal	\$55.00
Trifocal	\$70.00
Lenticular	\$150.00
FRAMES	\$35.00
TINT Photogrey/UV (employee only)	\$20.00
TINT Rose #1 or #2 (dependents)	\$7.00
CONTACTS: cosmetic	\$96.00
medically necessary	\$225.00

Members who reside in Humboldt, Pershing, White Pine, Elko, Eureka, and Lander Counties, and who use non-PPO providers, please contact the Trust Fund Office for the scheduled allowances.

Services may be obtained from any ophthalmologist, optometrist, or optician, but certain contracted eye care providers (PPO's) offer complete eye exams and a selection of glasses at no cost to you. Upgraded materials are available from PPO's at a discounted rate. Please see your PPO Directory or contact the Trust Fund Office for a list of these professionals.

The Plan provides the following benefits for eligible individuals once each calendar year:

- Eye examination with refraction
- Contact lenses or glasses (if required)

Employee Benefits: Exam, frames, lenses, photogrey or UV coating or tinting.

Dependent Benefits: Exam, frames, lenses, Rose tint #1 or #2.

NOT COVERED:

- 1) Plano (non-prescription) lenses.
- 2) Lenses/frames or contacts furnished under this program which are lost or broken except at the normal intervals when services are available.
- 3) Services or materials provided as a result of any Worker's Compensation Law.

DUPLICATE COVERAGE:

If you or your eligible dependents are also covered by another group vision plan, the benefits payable by this Fund for vision services and materials may be reduced.