OHIO BRICKLAYERS HEALTH and WELFARE FUND
P.O. BOX 99550
TROY, MICHIGAN 48099
(248) 641-4921 or Toll Free (833) 289-4921

Vision and Dental Insurance Claim Form

Instructions: To receive reimbursement for qualified vision and dental claims, you must complete **ONE FORM** per patient, along with the following information:

Reimbursement for:	**Information Required:**
Vision Services ($100.00 annual maximum)	Copy of a detailed invoice listing the services rendered and the charge for each. **Cash register receipts are not acceptable.**
Dental Services ($200.00 annual maximum)	Copy of a detailed invoice listing the services rendered and the charge for each. **Cash register receipts are not acceptable.**

PLEASE NOTE: Once you have met your calendar year maximum benefit under the Plan, you may use your HRA to pay for any outstanding amounts due by submitting a properly completed HRA claim form. You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the member. A claim for reimbursement must be filed within 365 days after it was incurred.

Member's Name: ____________________________________ Member's SS# or alternate ID: ____________________________

Address: ____

Phone Number: (Home) ______________________________ (Work) __________________________________

Patient Name: _____________________________________ Relationship: ______________________________

Type of Service	**Providers Name**	**Date of Service**	**Amount of Claim**
________________	______________________________	____/____/____	____________________
________________	______________________________	____/____/____	____________________
________________	______________________________	____/____/____	____________________
________________	______________________________	____/____/____	____________________
________________	______________________________	____/____/____	____________________

By signing this form, I understand that benefits shall be paid in accordance with the Ohio Bricklayers' Health and Welfare Fund's requirements and limitations established by the Board of Trustees. (See the reverse side of this form for a brief description of covered benefits).

Member's Signature: ______________________________________ Date: ______________________________

OVER

VISION AND DENTAL REIMBURSEMENT

What is the Vision Expense Benefit?
The Plan will pay up to $100.00 (one hundred dollars) per person per calendar year for one eye care visit. The $100.00 (one hundred dollars) benefit may be used for eyeglasses or contact lenses at the option of the participant. This benefit is available to all eligible members (active, retiree and COBRA) and their eligible dependents. The $100.00 (one hundred dollars) maximum also applies for pediatric patients. This benefit is NOT subject to the deductible or coinsurance.

Children (under the age of 19) are entitled to one eye exam annually and one pair of glasses every two (2) years. The annual exam and bi-annual pair of glasses do not count toward the $100.00 calendar year maximum. The bi-annual pair of glasses only includes the glasses, not the eyeglasses frames.

What is the Dental Care/ Pediatric Oral Care Benefit?
The maximum annual (calendar year) benefit per person is $200.
*This benefit is NOT subject to the Deductible or Coinsurance

For pediatric patients only (children up to age 18), the $200 annual maximum for dental services/pediatric oral care does not apply. Note, that orthodontics is not covered under this dental/pediatric oral care benefit.

How do I Request Reimbursement for Vision and Dental Services?
You must send a completed Vision and Dental Insurance Claim Form along a copy of a detailed invoice listing the services rendered and the charge for each. Cash register receipts and balance due statements are not acceptable.

What if I Have Met my Annual Maximum for Vision and/or Dental Services?
If you, or your dependents, have met the maximum annual (calendar year) benefit allowable under the plan, you may request reimbursement from your HRA for additional qualified expenses. **You must submit a separate HRA claim form, with the appropriate documentation, in order to receive reimbursement from your HRA.**

Information Required
A copy of a detailed invoice listing the services rendered and the charge for each. Cash register receipts are not acceptable.

Where do I Obtain a Vision and Dental Insurance Claim Form?
You may call the Fund Office to have a Claim Form mailed to you, or you may download one from the participant website: www.ourbenefitoffice.com/Ohiobrick/Benefits/HealthcareDocuments.aspx

Where do I send my Vision and Dental Insurance Claim Form?
Send these requests to:

Ohio Bricklayers' Health and Welfare Fund
Vision and Dental Insurance Claims
P.O. Box 99550
Troy, MI 48099

Is there a time limit to file for Vision Reimbursement Benefits?
Yes, claims for vision benefits **must be filed** within **365** days after they are incurred.