AmWINS Group Benefits
50 Whitecap Drive
North Kingstown, RI 02852

ARLINGTON VIRGINIA

# Arlington County Government Medicare Retiree Vision Plan Reimbursement Form

PLEASE READ COMPLETE SUBMISSION INSTRUCTIONS
ON THE REVERSE SIDE OF THIS PAGE

Please complete, sign and return this reimbursement form along with a copy of the provider's itemized statement and proof of your payment to
**WebTPA, PO Box 1928, Grapevine, TX 76099-1928**

| Please send reimbursement check to: | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City: | State: | Zip Code: |
| | | |
| Group Number: 2015ACG | | |
| Member number (from your medical ID card): | | |

| I am requesting reimbursement for vision benefits under the Arlington County Medicare Retiree plan | |
|---|---|
| I have included the following items:<br><br>☐ Itemized statement from my vision provider for services rendered. Statement should include description of services or coding of services Must be typed (not handwritten).<br><br>☐ Copy of my receipt confirming payment to the provider | |
| Signature: | Date: |

NEBCO

Administered by National Employee Benefit Companies, Inc., an AmWINS Group Benefits Company

# Arlington County Government Medicare Retiree Vision Plan

| ANNUAL VISION PLAN BENEFITS | Medicare Pays | Plan Pays | You Pay |
|---|---|---|---|
| **Routine Vision Exam** (once per year) | $0 | 100% of usual and customary charges up to $260 per calendar year per covered individual after $10 per visit copay (member) | **$10 copay per visit; all costs over $260** |
| **Vision Hardware** (per calendar year per person) | $0 | 100% up to a total of $75 toward lenses, frames and contacts | **All costs over $75** |

You may use any vision provider for your vision benefits.

## CLAIM SUBMISSION INSTRUCTIONS:

Your vision provider may directly bill WebTPA for payment.

WebTPA
PO Box 1928
Grapevine, TX 76099-1928

The provider's bill should include the description or coding of services provided, name of provider rendering the service, address, phone number and Tax ID number, and address to send the payment.

Provider should also include your name, member number from your medical ID card, and group number 2015ACG.

Your provider may require you to pay for the service up front. If the provider will not bill (WebTPA) for the services rendered, you may submit your claim for reimbursement to WebTPA using the reimbursement form and instructions.

If your provider requires you to pay up front, please complete and return:

1. Vision Reimbursement Form
2. Attach a copy of the itemized statement or bill from your vision provider
3. Attach copy of proof of your payment.

Please return these three items to: WebTPA
PO Box 1928
Grapevine, TX 76099-1928