Texas Annual Conference of the United Methodist Church

HEARING AID BENEFIT REIMBURSEMENT FORM

Active Clergy and Active Lay Employees of the TAC Fiscal Office enrolled in either the TAC Standard or High-deductible Group Health PPO Plan are eligible to obtain a hearing aid once every three (3) years for each ear if required (dependents and retirees are not eligible). There is a $250 co-pay on the first $2,500 of total eligible expenses (including hearing exam and hearing aid(s). For eligible expenses that exceed $2,500, there is 10% co-insurance on the amount above $2,500. Usual, reasonable and customary allowances will apply. The calendar-year deductible applicable to your PPO plan does not apply to the Hearing Aid Benefit described herein.

What is covered: (1) A hearing aid instrument, monaural or binaural, including ear mold(s); (2) visit for fitting, counseling, and adjustments; (3) the initial battery; (4) cords; (5) other ancillary equipment.

What is not covered: (1) Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase; (2) charges for a hearing aid that exceed the specifications prescribed for correction of a hearing loss; (3) replacement parts for hearing aids, repair of a hearing aid after the covered warranty period, and replacement of a hearing aid more than once in any 36 month period; (4) surgically implanted hearing devices.

If you have any questions, please contact our Customer Service Team at (800) 252-9653.

1. Active Clergy or Lay Employee Name: _____

2. Active Clergy or Lay Employee's Social Security Number or Participant I.D.: _____

3. Address: _____
   Street City State Zip

4. Is Hearing Exam included in request for reimbursement? Yes_____ No _____

   If yes, Provider Name: _____ Provider Tax ID: _____

   Procedure Code _____ Diagnosis Code _____
   (An HCFA / CMS 1500 form provided by the Examining Physician may be attached.)

5. Hearing Aid Benefit Reimbursement: (made payable to the eligible Active Clergy or Lay Employee)

   Total reimbursement amount requested:_____

   (If the provider is accepting installment payments, submit an invoice with the total cost of the hearing aid(s), the number of installment payments and the amount of each installment payment, along with a receipt for the current installment payment for which you are requesting reimbursement. Each installment payment can be submitted separately for reimbursement.)

_____ _____
Signature of Participant Date

Submit this form along with invoice and receipt(s) for Hearing Aid(s) and other expenses eligible for reimbursement to:

BOON-CHAPMAN

P.O. Box 9201 / Austin, TX 78766 / (800) 252-9653 / Fax (512) 233-7721