UMWA 1993 Plan Vision Form

A. Health Services Cardholder Section (This is the only section to be filled out by the patient)

Patient's Name (Last, First, Middle Initial)	Unique ID	Member ID	Sex	Date of Birth / /
Home Address				
City	State	Zip		

Patient's signature (parent, if patient is a minor) _____ Date _____

B. Vision Examination Section

Exam Date	Exam Charge	Amount Paid by Patient
1. Does the patient's new prescription differ from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and do the lenses improve visual acuity by at least one line on the standard chart? ☐ Yes ☐ No	2. Primary Diagnosis	
Check applicable box: ☐ 01 Ophthalmologist ☐ 03 Optometrist		
Provider Name (print or type)	TIN or SSN	Phone # (including area code)
Address (Street/City/State/Zip Code)		

I hereby certify that the service(s) listed above have been performed on the patient named above on the date(s) indicted and that I am legally qualified to perform the above service(s).

Signature_____ Date _____

C. Material/Dispensing Section

Date Frames Rec'd	Frame Charge	Frame Amount Paid by Patient	Check applicable box: ☐ 02 Ophthalmologist ☐ 04 Optometrist ☐ 05 Optician (Optical Company)
Date Lens Rec'd	Lens Charge		Lens Amount Paid by Patient
Dispensing Fee	Option Costs		Dispensing Amount Paid by Patient

Options: ☐ 40 oversized ☐ 41 Sunglasses (other than rose tints #1 or 2) ☐ 42 Photosensitive (with light transmittance value less than 85.0)
☐ 43 Anti-Reflective ☐ 44 Frames where cost exceeds plan benefit ☐ 45 Other ☐ 46 Rose Tints #1 or 2

Check only one type of lens:

21 Single Vision ☐ OD ☐ OS	24 Lenticular ☐ OD ☐ OS	28 Aniseikonic ☐ OD ☐ OS
22 Bifocal ☐ OD ☐ OS	25 Contact (hard) ☐ OD ☐ OS	29 Other ☐ OD ☐ OS
23 Trifocal ☐ OD ☐ OS	26 Contact (soft) ☐ OD ☐ OS	

Dispenser's Name (print or type)	TIN or SSN	Phone # (including area code)
Address (Street/City/State/Zip)		

I hereby certify that the service(s) listed above have been performed on the patient named above on the date(s) indicated and that I am legally qualified to perform the above service(s).

Signature_____ Date _____

Benefits

The Vision Care Program provides benefits for routine eye check-ups, and eyeglasses or contact lenses subject to certain limitations. The chart below describes the benefits available, the fee allowances and the frequency allowed for you and your eligible dependents.

Benefit	Actual Charge Up to Maximum Amount	Limit
Vision examination	$30.00 per exam	Once every 12 months
Single vision lens	$20.00 per lens	Once every 12 months
Bifocal lens	$27.50 per lens	Once every 12 months
Trifocal lens	$32.50 per lens	Once every 12 months
Lenticular lens	$65.00 per lens	Once every 12 months
Contact lens	$115.00 per lens	Once every 12 months
Eyeglass frames	$40.00 per set	Once every 24 months

Please note that the Vision Care Program does not cover the cost of new lenses unless there is an axis change of 20 degrees or a .50 diopter sphere or cylinder change in your prescription, and the new prescription improves your vision by a least one line on the standard eye chart. These prescription limitations, as well as the frequency limitations described above, apply even if you lose or break your eyeglasses or contact lenses.

Not Covered Services

If you want sunglasses, anti-reflective lenses, photosensitive lenses, oversized lenses, designer frames, or other optional features, you will be required to pay any extra charges for them yourself. The Vision Care Program will, however, cover the cost of two very light tints which are sometimes prescribed for medical reasons (rose tints #1 and #2).

Benefits are not allowable for any service that is covered by the Funds regular Health Care Program. In order to be eligible under the Vision Care Program all benefits must be prescribed by a licensed physician or optometrist. The Vision Care Program does not cover the cost of treatment for eye diseases and injuries - but the Funds regular Health Care Program does.

Other services not covered include ◆ orthoptics ◆ vision training and tonography ◆ aniseikonic lenses ◆ writing prescriptions or filling out claim forms ◆ services covered by Workers' Compensation ◆ services or supplies that are obtained from a government agency ◆ services or supplies for which no charge would be made.

How to Apply

The first step is to go for a vision examination. Be sure to bring along any eyeglasses or contact lenses you are currently using and remember to mention any particular vision problems. You should also advise the person who performs the examination of any family history of eye problems. You are free to go to any licensed ophthalmologist or optometrist for your examination, and you can have your prescription filled wherever you please.

The second step is to submit your claim or have your claim submitted for you to:

The UMWA H&R Funds
PO Box 211551
Eagan, MN 55121