UMWA H&R Funds Vision Care Program for the **Combined and 1992 Benefit Plans**

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

Patients Name (Last, First, Middle Initial)	Unique ID	Member ID	Sex	Date of Birth / /

Home Address (Street/City/State/Zip Code)

Is your spouse employed? ☐ Yes ☐ No

If yes, where? (Name and address of company)

Is the patient a dependent child, 22 years or older? ☐ Yes ☐ No — If yes, is child mentally retarded or disabled? ☐ Yes ☐ No

Are services for which benefits are being claimed covered under any other group insurance plan, group prepayment arrangement, Medicare, or other Federal, state or government agency? ☐ Yes ☐ No — If yes, indicate insurance company name, address and policy number.

Is claim connected in any way with patient's occupation, auto accident, or other type of accident or eye surgery? ☐ Yes ☐ No — If yes, please give details and dates.

I certify that the above statements are true and correct and I authorize any person or organization rendering care or any person or organization in possession of information concerning coverage or other benefits covering me or my dependents to furnish the UMWA Benefit Fund, or its authorized representative with full information regarding such care or other benefit information.

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

B. Vision Examination Section

Exam Date	Exam Charge	Amount Paid by Patient

This section must be completed or the claim will be returned for completion.
1. Does the patient's new prescription differ from the most recent one by an axis change of 20 degress 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

Are you a member provider under this plan? ☐ Yes ☐ No

Examiner's Name (print or type)	UMWA Examiner #	FEID or SSN	Location #	Phone # (including area code)

Address (Street/City/State/Zip Code)

I hereby certify that the service or services listed above have been performed on the patient named above on the date or dates indicted and that I am legally qualified to perform the above service or services.

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	Are you a member dispensing provider under this plan? ☐ Yes ☐ No
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)	UMWA Dispenser #	FEID or SSN	Location #	Phone # (including area code)

Address (Street/City/State/Zip)

I hereby certify that the service or services listed above have been performed on the patient named above on the date or dates indicated and that I am legally qualified to perform the above service or services.

Signature_____ Date _____

Benefits

The Vision Care Program established by the National Bituminous Coal Wage Agreement of 1978 went into effect on October 1, 1978. The program provides benefits for routine eye check-ups, and eyeglasses or contact lenses subject to certain limitations. The chart below describes the benefits and the frequency allowed for you and your eligible dependents.

Benefit	Actual Charge Up to Maximum Amount	Limit
Vision examination	$20 per exam	Once every 24 months
Single vision lens	$10 per lens	Once every 24 months
Bifocal lens	$15 per lens	Once every 24 months
Trifocal lens	$20 per lens	Once every 24 months
Lenticular lens	$25 per lens	Once every 24 months
Contact lens	$15 per lens	Once every 24 months
Eyeglass frames	$14 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. Certain providers have agreed to participate with the Funds' Vision Care Program. Participating providers sometimes accept the allowances provided under the program as payment in full. In addition, these providers will fill out and submit claim forms for you, so you need not get involved in the process of submitting bills to the Program. If you go to a non-participating provider, you will be required to submit the completed claim form yourself and to pay the provider for services rendered. For a list of participating providers, contact the Funds Call Center at 1-800-291-1425 or a UMWA District office.

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