

UMWA H&R Funds Vision Care Program for the **1993 Benefit Plan - ACNR**

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		2. Primary Diagnosis
Check applicable box: <input type="checkbox"/> 01 Ophthalmologist <input type="checkbox"/> 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) indicated 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: <input type="checkbox"/> 02 Ophthalmologist <input type="checkbox"/> 04 Optometrist <input type="checkbox"/> 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: <input type="checkbox"/> 40 oversized <input type="checkbox"/> 41 Sunglasses (other than rose tints #1 or 2) <input type="checkbox"/> 42 Photosensitive (with light transmittance value less than 85.0) <input type="checkbox"/> 43 Anti-Reflective <input type="checkbox"/> 44 Frames where cost exceeds plan benefit <input type="checkbox"/> 45 Other <input type="checkbox"/> 46 Rose Tints #1 or 2				
Check only one type of lens:				
21 Single Vision <input type="checkbox"/> OD <input type="checkbox"/> OS	24 Lenticular <input type="checkbox"/> OD <input type="checkbox"/> OS	28 Aniseikonic <input type="checkbox"/> OD <input type="checkbox"/> OS		
22 Bifocal <input type="checkbox"/> OD <input type="checkbox"/> OS	25 Contact (hard) <input type="checkbox"/> OD <input type="checkbox"/> OS	29 Other <input type="checkbox"/> OD <input type="checkbox"/> OS		
23 Trifocal <input type="checkbox"/> OD <input type="checkbox"/> OS	26 Contact (soft) <input type="checkbox"/> OD <input type="checkbox"/> 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 established by the National Bituminous Coal Wage Agreement of 2002 went into effect on January 1, 2002. The 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 (effective 01/01/2026) and the frequency allowed for you and your eligible dependents.

Benefit	Actual Charge Up to Maximum Amount	Limit
Vision examination	\$65.48 per exam	Once every 24 months
Single vision lens	\$32.75 per lens	Once every 24 months
Bifocal lens	\$49.13 per lens	Once every 24 months
Trifocal lens	\$65.48 per lens	Once every 24 months
Lenticular lens	\$81.86 per lens	Once every 24 months
Contact lens	\$49.13 per lens	Once every 24 months
Eyeglass frames	\$46.38 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