



Davisvision.com 1(877) 923-2847
Client Code: 2175

Teamsters Local 731 Health and Welfare Funds
Effective October 1, 2021

Your Coverage with a Davis Vision Provider



Exams & Services⁴

Eye Exam Copay: **\$0**

Contacts evaluation, fitting & Follow-up:

| | |
|---|---|
| Conventional Lens Covered in Full | Specialty Lens \$60 allowance + 15% savings² |
|---|---|



Frame⁴

Allowance:

| | |
|---------------------------------|--|
| Other locations \$225 | Visionworks ¹ \$275 |
|---------------------------------|--|

+Additional 20% off any overage²

or

The Exclusive Collection Copay:
Covered in Full



Lenses⁴

Lens Copay: **\$0**



**Contacts³
In lieu of glasses**

Allowance: **\$300**

+Additional 15% off any overage²

Frequencies

Exam: Every Calendar Year
Lenses & Lens Upgrades: Every Other Calendar Year
Frame: Every Other Calendar Year
Contacts, Evaluation and Fitting: Every Other Calendar Year

Options & Upgrades

Lens Options

Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any RX)..... \$0
Polycarbonate Lenses (Children / Adults)..... \$0 or \$30
High-Index Lenses 1.67..... \$55
High-Index Lenses 1.74..... \$120
Polarized Lenses..... \$75
Progressive Lenses..... \$0
Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate)..... \$35 / \$48 / \$60 / \$85
Ultraviolet Coating..... \$12
Tinting of Plastic Lenses (Solid / Gradient)..... \$0
Plastic Photochromic Lenses (Transitions® Signature™)..... \$65
Scratch-Resistant Coating..... \$0
Premium Scratch-Resistant Coating..... \$30
Scratch-Protection Plan (Single-Vision | Multifocal)..... \$20 | \$40
Digital Single Vision Lenses..... \$30
Trivex Lenses..... \$50
Blue Light Filtering..... \$15

Additional Savings

Retinal imaging (Member charge)..... \$39
Additional pairs of eyeglasses..... 30% discount²

Find an In-Network Provider....

Enter Client Code 2175 in the "Member Sign In" section of our website at davisvision.com/member to locate a provider near you, including Visionworks.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the Davis Vision Network.

Eye Examination Allowance: **\$50 Every Calendar Year**

Materials Allowance: **\$250 Every Other Calendar Year**

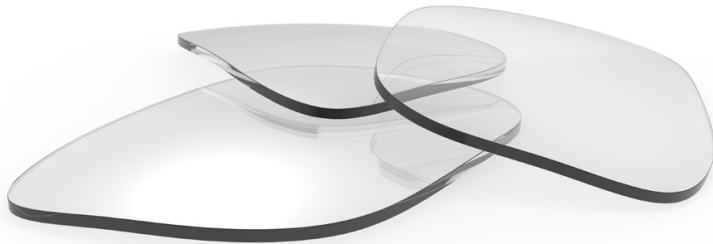
1. Excludes Maui Jim® eyewear. 2. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. 3. Contact lens coverage varies by product selection. 4. Dependent children under age 19 have no limit on eye exams. No prior approval is needed. They are also eligible for frame and lenses annually with an Rx change of at least .50 diopters; prior approval is required. Teamsters Local 731 Health and Welfare Funds has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

Using your Client Code

Log in using **Client Code 2175** at davisvision.com/member to find a list of in-network providers near you and access your benefit information.

The Exclusive Collection

The Exclusive Collection of frames is available at nearly 9,000 locations across the U.S.. Log in to browse frames, and find a Collection near you.



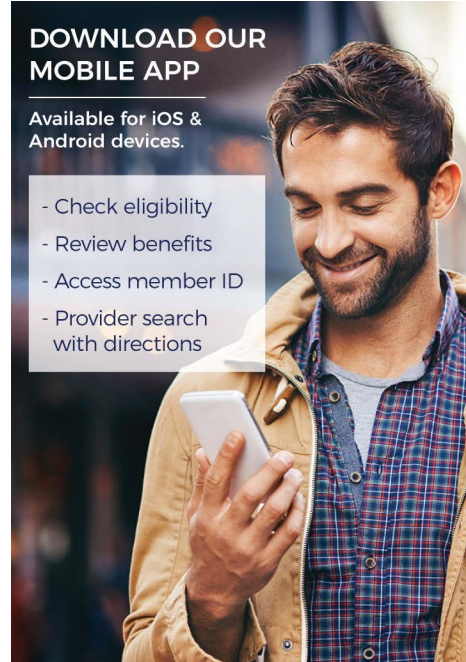
Free Breakage Warranty

Your glasses are covered with our **FREE** one-year breakage warranty. Some limitations apply.

DOWNLOAD OUR MOBILE APP

Available for iOS & Android devices.

- Check eligibility
- Review benefits
- Access member ID
- Provider search with directions



VISION BENEFIT EXCLUSIONS AND LIMITATIONS

Charges made for the following **are not** considered covered vision expenses under the Vision Benefit Program:

1. Vision treatment that is incurred while a person was not covered under the Plan.
2. Services or supplies which are covered in whole or in part under any other benefit provided by this Plan.
3. Services or supplies resulting from any occupational injury or sickness, whether or not covered by a Workers' Compensation Law or similar law.
4. Special procedures, such as orthoptics or vision training; special lens designs or coatings, other than those previously described; vision therapy; safety glasses; non-prescription glasses or non-prescription sunglasses.
5. Contact lenses or eyeglasses which are required after cataract surgery. (One pair is covered under the Comprehensive Major Medical Benefit after cataract surgery.)
6. Medical treatment (including supplies) of eye disease or injury.
7. Services or supplies not listed as covered vision expenses under the Vision Benefit Program.
8. Eye examinations (or lenses or frames required as a result of such examination) which are required by an employer as a condition of employment and for which the employer is required to pay according to the provisions of any labor agreement or statute.
9. Replacement of lost eyewear, services not performed by licensed personnel, two pairs of eyeglasses in lieu of a bifocal, contact lenses and eyeglasses in the same benefit cycle.
10. Services, supplies or types of treatment which are stated as excluded in this benefit explanation or which are stated as excluded in "What the Plan Doesn't Cover" in your SPD provided by the Fund Office.

For more details about the plan, visit davisvision.com/member and enter **Client Code 2175** or call 1(877) 923-2847 and enter **Client Code 2175** when prompted