PriorityVision℠ Grand Valley State University

Summary of benefits: Freestanding, 24 month frequency

PriorityHealth

This is only a summary. If you want more detail about your coverage and costs, contact the PriorityVision customer care center at 877.572.4001 or create a member account at *eyemed.com*.

Vision care services	In-network member cost	Out-of-network reimbursement
Exam with dilation as necessary	$0 copayment	Up to $40

Special pricing available for the following:		
Complete pair eyeglasses purchase discounts: Frame, lenses and lens options must be purchased in same transaction to receive full discount		
Frames		
Any available frame at provider location	40% off retail price	NA
Standard plastic lenses		
Single vision	$50	NA
Bifocal	$70	NA
Trifocal	$105	NA
Standard progressive lens	$135	NA
Lens options (additional copayment)		
UV treatment	$15	NA
Tint (solid and gradient)	$15	NA
Standard plastic scratch coating	$15	NA
Standard polycarbonate	$40	NA
Standard polycarbonate — kids under 19	$40	NA
Standard anti-reflective coating	$45	NA
Polarized	20% off retail price	NA
Other add-ons and services	20% off retail price	NA
Contact lenses (discount applies to materials only)		
Conventional	15% off retail price	NA
Disposable	NA	NA
Laser vision correction		
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% of promotional price	NA
Frequency		
Examination	Once every 24 months	Once every 24 months
Lenses or contact lenses	Unlimited	NA
Frame	Unlimited	NA
Additional discounts		
20% off non-prescription sunglasses		

continued >

Learn more

For a complete list of providers near you, use our online "Find a Doctor" tool at *priorityhealth.com* or call 800.446.5674. For Lasik providers, call 877-5LASER6. If you have questions about your benefits, call 877.572.4001.

Plan exclusions

The following eye care services are not part of your plan:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Any eye or vision examination, or any corrective eyewear as required by an employer as a condition of employment, including safety eyewear.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program.
- Non-prescription lenses and/or contact lenses.
- Non-prescription sunglasses.
- Getting two pair of glasses instead of bifocals.
- Services or materials provided by any other group benefit plan that provides eye care.
- Discounts may not be allowed for some brand name eye care materials in which the manufacturer imposes a no-discount practice.
- Services you receive after your plan ends, except for eye care materials that were ordered before your coverage ended. These eye care materials, and services related to your order, may be covered even if they're delivered after your coverage ends. Eye care services related to your delivery order may also be covered if you receive them within 31 days of placing your delivery order.
- Replacement of lost or broken lenses, frames, glasses or contact lenses. Replacement won't be covered if you've already used your allowed vision benefits for your plan period.