EPC
Benefit Resources, Inc.

2019 VISION PLAN COVERAGE TABLE

2019 EYEMED VISION CARE VISION

Benefit	In-network	Out-of-network
Examination	$10 copay	$40 max reimbursement
Frames	$0 copay $130 retail allowance	$91 max reimbursement
Single vision lenses	$25 copay	$30 max reimbursement
Bifocal lenses	$25 copay	$50 max reimbursement
Trifocal lenses	$25 copay	$70 max reimbursement
Contacts (elective)	$0 copay $130 allowance	$130 max reimbursement
Frequency		
Examination	12 months	12 months
Frames	24 months	Not covered
Eyeglass lenses	12 months	12 months
Contacts (elective)	12 months	12 months
Monthly Cost of Care		
Employee Only	$6.15	
Employee + Spouse	$11.69	
Employee + Children	$12.30	
Employee + Family	$18.09	

Effective January 1, 2019