



**CharterBenefits.com**

# Clear Vision



<b>Vision Service</b>	<b>Participating Provider Benefit</b> <i>Amount Covered by the Plan</i>	<b>Non-Participating Provider Benefit</b> <i>Amount Reimbursed by the Plan<sup>1</sup></i>
<b>Vision Examination</b>	Covered in Full	\$40
<b>Standard Lenses (up to 61mm)</b>	Covered in Full	\$30 Single \$50 Bifocal \$65 Trifocal \$125 Lenticular
<b>Progressive Lenses</b>	Up to \$89.50	\$65
<b>Polycarbonate Lenses<sup>2</sup></b>	Up to \$85.00	\$55
<b>Frame<sup>3</sup></b>	Up to \$130 Retail	\$75
<b>Contact Lenses<sup>4</sup>: Elective</b>	Up to \$130	\$130
<b>Contact Lenses<sup>4</sup>: Non-Elective</b>	Covered in Full With Authorization	\$250

