



# SOLSTICE VISION PLAN

## Clear 10 Benefits Summary

**Member**  
**\$4.44**

**Member + Dependent**  
**\$7.98**

**Member + Family**  
**\$13.78**

In-Network Procedures	Member Co-Payment	Benefit
<b>Eye Exam</b>	\$4.00	One exam every 12 months
<b>Single Lenses</b>	\$10.00	One standard pair (plastic or clear glass) every 12 months
<b>Bifocal Lenses</b>	\$10.00	
<b>Trifocal Lenses</b>	\$10.00	
<b>Lens Options</b> (tint, UV, anti-scratch coat, anti-reflective, progressive, polycarbonate, hi-index, photogray, transitions, polaroid)	20% Discount	None
<b>Frames*</b>	\$79.00 Retail allowance after \$10.00 co-payment	Frames every 12 months
<b>Contact Lenses*</b>	\$85.00 allowance**	Contact lenses every 12 months
<b>Medically Necessary Contact Lenses</b>	Paid in full	

\*Once a year benefit for either frames or contacts.

\*\*Allowance is for exam, fitting, evaluation, follow-up care and materials.

### MORE OPTIONS

- Receive benefits immediately upon the coverage effective date
- Annual deductible—NONE
- Claim forms to submit—NONE
- Waiting periods—NONE
- The member co-payments listed are guaranteed to be a 20-45% discount and are offered by a participating Solstice Provider.
- The patient/member is ultimately responsible for verification as to the accuracy and appropriateness of all fees applicable.
- Benefit for contacts or frames are a once a year benefit (Ex: one year frames the following year contacts).
- You can locate participating vision providers at [www.solsticebenefits.com](http://www.solsticebenefits.com) or via our secure member portal, [www.mysmile365.com/solstice](http://www.mysmile365.com/solstice)

This is a descriptive flyer, not a contract. Please see the complete schedule for a complete description of benefits, limitations, and exclusions. All benefits are subject to the provisions of the Group Employer Contract. *Offered by Solstice Benefits, Inc. a Life and Health Insurer, pursuant to the Florida Insurance Code.*

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