



Florida Community Colleges  
Risk Management Consortium

## Plan C

Hospital  
Indemnity,  
Dental & Vision  
(Employee Only)

### **HOSPITAL INDEMNITY PLAN, DENTAL, AND VISION**

This option is designed as an alternative for employees with other adequate health insurance. The program includes employee only coverage for HOSPITAL INDEMNITY, DENTAL and VISION. To enroll in the vision & HIP portion of this plan, please complete a BCBS Universal Individual Application for Group Insurance/Membership form and mark "Other" in the appropriate box. Indicate "Plan C" on blank line. To enroll in the dental portion of this plan, please complete an FCL Employee Application for Group Dental.

#### **HOSPITAL INDEMNITY PLAN**

Pays you \$100 per day for each day you are hospital-confined as an inpatient for up to 90 days continuous confinement.

#### **DENTAL**

DEDUCTIBLE: \$50 per person per calendar year- Applies to Type II and III services.

MAXIMUM BENEFITS: \$1,000 calendar year maximum.

PREVENTIVE SERVICES: No deductible (Type I). Preventive services provided at 100% of the schedule of allowances. These services include: oral examinations, cleanings and fluoride treatments (services provided once during a 6 month period).

BASIC SERVICES (Type II): Basic services include: x-rays and diagnostic services, periodontics (gum treatment), endodontics (root canals), oral surgery and restorative services (fillings), and are covered at 80% of the schedule of allowances.

MAJOR SERVICES (Type III): Services include crowns, bridges, full dentures, partial dentures and periodontal surgery and are covered at 50% of the schedule of allowances.

PREDETERMINATION: Predetermination by Florida Combined Life will be required for dental services totaling more than \$500 in allowable expenses.

# HOSPITAL INDEMNITY PLAN, DENTAL, AND VISION (continued)

## VISION

### BENEFITS

Benefits are payable at 100%, waiving deductible, for covered expenses incurred while the member is insured for these benefits. These charges must be made by a licensed physician, optometrist or optician.

### LIMITATIONS

The payment for eye examination, frames, lenses (single, bifocal, trifocal) or contact lenses will be limited to one occurrence per 24 month period.

### SCHEDULE OF BENEFITS

Maximum Payment Per Person Per Complete Eye Examination	Maximum Payment Per Person Per Each Lens Single Vision Prescription	Bifocal Prescription	Trifocal Prescription	Maximum Payment Per Person for Frames	Maximum Payment Per Person for Contact Lens
\$20.00	\$20.00	\$30.00	\$40.00	\$20.00	\$75.00 *see note 2 exclusions

### EXCLUSIONS

1. Charges for sunglasses, even if prescribed.
2. Contact lenses, unless the visual acuity cannot be made 20/70 or better with spectacle lenses, but can be improved with contact lenses.
3. Special or unusual vision services or supplies, including orthoptics, vision training, and low vision aids.
4. Replacement of loss or broken lenses or frames.
5. Vision services not determined medically necessary by a physician or optometrist, required by the employer as a condition of employment or rendered through a medical department, clinic or other similar services provided or maintained by the employer.
6. Vision services rendered as a result of sickness or injury arising out of and in the course of employment.
7. Vision services which are rendered, prescribed or dispensed prior to the effective date of coverage.
8. Vision services which are rendered, prescribed or dispense after the termination.
9. Vision services which are covered under or in conjunction with any automobile insurance policy or health insurance policy.
10. Health care services.