FCSRMC
FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM

2017 DV PLAN OPTIONS

Participation in FCSRMC's Employee Benefit Plans Program requires participation of all full-time eligible employees. The DV Plan option was designed as an alternative plan for employees with other adequate health insurance and is an employer paid benefit for employees only. **NEW!** Benefits may be extend the participant's eligible dependents.

DV Plan Option 1

DELTA DENTAL	www.DeltaDental.com
Network	PPO Network
Deductible	$50 per person, not to exceed $150 per family, per calendar year- applies to Basic and Major Services
Maximum Benefits	$1,000 Calendar Year Maximum
Preventive Services	No Deductible - provided at 100% of PPO provider fee schedule for Oral Examinations, Cleanings (two per calendar year) and Bitewings X-rays
Basic Services	Full Mouth X-rays, Periodontics (Gum Treatment), Endodontic (Root Canals), Oral Surgery and Restorative Services (Fillings) are covered at 80% of the PPO provider fee schedule in-network and 50% non-PPO network
Major Services	Crowns, Bridges, Full Dentures, Partial Dentures and Implants are covered at 50% of the PPO provider fee schedule in-network and 40% out-of-network
Missing Tooth Rule	Teeth extracted prior to effective date are covered
Orthodontics	n/a
Delta Dental Premier dentists are paid on a Maximum Plan Allowance. Non-Delta Dental dentist (out-of-network) are paid are paid up to the 80th percentile.	
VSP	www.VSP.com
Network	Choice Network
Well Vision Exam	$10 Co-payment every 12 months
Prescription Glasses	$10 Co-payment for lenses single vision, lined bifocal, and lined trifocal lenses every 12 months
Frames	$115 allowance for a wide selection of frames or 20% off the amount over your allowance
Contacts (instead of glasses)	Every 12 months - up to $60 Co-payment for your contact lens exam (fitting and evaluation) and $120 allowance for contact lens material
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
Monthly Rates	**Two Year Rate Guarantee thru 12/2020**
Spouse (Employee Paid)	$28.13
Child(ren) (Employee Paid)	$28.82
Family (Employee Paid)	$62.43

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DV Plan Option 2

DELTA DENTAL	www.DeltaDental.com
Network	PPO Network/Premier
Deductible	$50 per person, not to exceed $150 per family, per calendar year- applies to Basic and Major Services
Maximum Benefits	$1,000 Calendar Year Maximum
Preventive Services	No Deductible - provided at 100% of PPO provider fee schedule for Oral Examinations, Cleanings (two per calendar year) and Bitewings X-rays
Basic Services	Full Mouth X-rays, Periodontics (Gum Treatment), Endodontic (Root Canals), Oral Surgery and Restorative Services (Fillings) are covered at 80% of the PPO provider fee schedule in-network and 50% non-PPO network
Major Services	Crowns, Bridges, Full Dentures, Partial Dentures and Implants are covered at 50% of the PPO provider fee schedule in-network and 50% out-of-network
Missing Tooth Rule	Teeth extracted prior to effective date are covered
Orthodontics	Child only, $1,000 max.
The out-of-network benefits are increase for those seeking services from a Premier	
VSP	www.VSP.com
Network	Choice Network
Well Vision Exam	$10 Co-payment every 12 months
Prescription Glasses	$10 Co-payment for lenses single vision, lined bifocal, and lined trifocal lenses every 12 months
Frames	$180 allowance for a wide selection of frames or 20% off the amount over your allowance
Contacts (instead of glasses)	Every 12 months - up to $60 Co-payment for your contact lens exam (fitting and evaluation) and $120 allowance for contact lens material
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
Monthly Rates	**Two Year Rate Guarantee thru 12/2020**
Spouse (Employee Paid)	$33.14
Child(ren) (Employee Paid)	$33.95
Family (Employee Paid)	$73.75