ST. CLAIR COUNTY COMMUNITY COLLEGE
VISION & HEARING CARE
REIMBURSEMENT PLAN

Vision & Hearing Care Benefit:
2018 – 2019 Vision Care Benefit Amount $500 (Career Plan, ESP, Leadership, MAHE, & Teamsters).

Who is Eligible: Full-time Career Plan, Leadership, MAHE, Teamster, MEA-ESP, and Executive personnel and their dependents. Dependents will only be covered under this plan through the year in which they turn age 26. **NOTE: If you have elected participation in a high-deductible health plan with an HSA, this claim form is not required, as the contribution has already been made to your HSA account.**

Eligible Vision & Hearing Care Charges: The actual costs charged for service, glasses, lenses, frames and hearing aids, exams and other vision and hearing care expenses. (Include orthodontic expenses ESP only)

How to Use This Plan: Attach the original invoice of your vision, hearing care, or orthodontic bill to this form and complete the bottom section. Submit to Human Resources, Room 206 in the Main Building. Invoices must be submitted prior to June 30th of the fiscal year in which they were incurred. If covered by additional insurance include EOB (Explanation of Benefits) or insurance coverage information.

Plan year is defined as the 12-month period, July 1 through June 30 of the following year.

Vision & Hearing Care Claim Form

I.D. #______________________ PHONE EXT. # ______________________

NAME:____DATE________/________/ ________

ADDRESS: ____

CITY:______________________________STATE:____________ZIP: ____________________

GROUP (Circle one): CP ESP MAHE TEAMSTER LEADERSHIP EXECUTIVE

DO YOU HAVE OTHER VISION INSURANCE COVERAGE? (Circle one): YES NO

PATIENT NAME:____BIRTHDATE:________/________/ ________

RELATIONSHIP:__________________________ACTUAL AMOUNT PAID FOR SERVICES: $ ____________________

For College Use Only

Date Paid: ______________________ **Amount paid: $** ______________________

Cost Center ______________________ **Check Number:** ______________________

ATTACH ORIGINAL VISION OR HEARING CARE BILL OR INVOICE

By submitting this form for payment, the employee certifies that unless indicated above, the attached expenses have not been reimbursed or are not reimbursable under any other vision plan coverage. In addition, the employee understands that these claims cannot be resubmitted for payment under a flexible spending plan.

August 13, 2018