

# PPO DENTAL INSURANCE FOR MEMBERS OF FALSS



## Highlight Sheet

### About the plan

This voluntary group plan is available to members of FALSS. Through this plan, you will enjoy quality coverage at competitive group rates. This plan is a great solution for individual members or small employers that do not have access to group voluntary dental or to members employed by large employers that do not offer a quality dental insurance solution. Dependent coverage is available to lawful spouses, domestic partners, and unmarried dependent children under age 25.

As a dual option plan, you may choose between the lower cost **Network Choice PPO Option**, which is designed for members to receive care through an Ameritas PPO network provider, and the **Freedom Choice PPO Option**, which is an incentive based program that gives you the freedom to visit any licensed dentist.

### PPO Plan Options - Dental Plan Summary

	Network Choice PPO Option		Freedom Choice PPO Option					
	In Network		In Network			Out of Network		
			Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
<b>Coinsurance</b>								
<b>Type 1</b>	100%		100%	100%	100%	90%	90%	90%
<b>Type 2</b>	80%		60%	70%	80%	50%	60%	70%
<b>Type 3</b>	50%		0%	40%	50%	0%	30%	40%
<b>Deductible</b>	Waived Type 1 \$50/Calendar Year		Waived Type 1 \$50/Calendar Year			Waived Type 1 \$50/Calendar Year		
<b>Maximum (per person)</b>	\$1,000 per calendar year No Family Maximum		\$1,000 per calendar year No Family Maximum			\$1,000 per calendar year No Family Maximum		
<b>Allowance</b>	Contracted Fee		Contracted Fee			90 <sup>th</sup> U&C		
<b>Dental Rewards*</b>	Included		Included			Included		
<b>Waiting Period</b>	6 months for Type 3		12 months for Type 3			12 months for Type 3		
			➤ Year 1 benefits begin the 1 <sup>st</sup> day of coverage. ➤ Year 2 benefits begin on the 1 <sup>st</sup> day of the 13 <sup>th</sup> month. ➤ Year 3 benefits begin on the 1 <sup>st</sup> day of the 25 <sup>th</sup> month.					

### Orthodontia Summary – Children under age 19 only

Allowance All Plan Designs: In Network, discounted fee. Out of Network, U&C.

<b>Coinsurance</b>	No ortho coverage	50%
<b>Lifetime Max (per person)</b>	N/A	\$1,000
<b>Waiting Period</b>	N/A	12 months

### Monthly Rates for 01/01/12 – 12/31/12

	Region 1	Region 2	Region 3	Region 1	Region 2	Region 3
Enrollee Only	\$35.64	\$37.88	\$43.72	\$36.72	\$39.04	\$47.08
Enrollee + Spouse	\$68.32	\$70.56	\$83.56	\$69.84	\$72.16	\$88.20
Enrollee + Child(ren)	\$65.16	\$69.32	\$81.48	\$73.92	\$78.52	\$95.60
Enrollee + Spouse & Child(ren)	\$97.84	\$102.00	\$121.32	\$107.04	\$111.64	\$136.72

**Region 1** (ZIP codes 320-326, 344)

**Region 2** (ZIP codes 327-329, 335-342, 346-349)

**Region 3** (Anyone residing outside of ZIP codes of Regions 1 & 2, except in NY)

- Premiums do not include the one-time \$20.00 non-refundable processing fee due at the time of enrollment when selecting the Direct Annual Billing payment method. (Processing fee is waived when selecting Monthly Auto-pay or when enrolling with a business with 5 or more participants). Contact administrator for firm list billing options.
- Premiums are subject to change.
- Plan not available in New York

# PPO DENTAL INSURANCE FOR MEMBERS OF FALSS

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### Sample Procedure Listing (Current Dental Terminology © American Dental Association.)

	Network Choice PPO Option	Freedom Choice PPO Option
<b>Type 1</b> Procedure (Frequency)	<ul style="list-style-type: none"> <li>• Routine Exam (1 in 6 months)</li> <li>• Bitewing X-rays (1 in 12 months)</li> <li>• Full Mouth/Panoramic X-rays (1 in 5 years)</li> <li>• Periapical X-rays</li> <li>• Cleaning (1 in 6 months)</li> <li>• Fluoride for Children 13 and under (1 per benefit period)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Exam (1 in 6 months)</li> <li>• Bitewing X-rays (1 in 12 months)</li> <li>• Full Mouth/Panoramic X-rays (1 in 5 years)</li> <li>• Periapical X-rays</li> <li>• Cleaning (1 in 6 months)</li> <li>• Fluoride for Children 13 and under (1 per benefit period)</li> </ul>
<b>Type 2</b> Procedure (Frequency)	<ul style="list-style-type: none"> <li>• Sealants (age 13 and under)</li> <li>• Restorative Amalgams</li> <li>• Restorative Composites</li> <li>• Endodontics (nonsurgical)</li> <li>• Periodontics (nonsurgical)</li> <li>• Denture Repair</li> <li>• Simple Extractions</li> </ul>	<ul style="list-style-type: none"> <li>• Sealants (age 13 and under)</li> <li>• Restorative Amalgams</li> <li>• Restorative Composites</li> <li>• Endodontics (nonsurgical)</li> <li>• Endodontics (surgical)</li> <li>• Denture Repair</li> <li>• Simple Extractions</li> </ul>
<b>Type 3</b> Procedure (Frequency)	<ul style="list-style-type: none"> <li>• Space Maintainers</li> <li>• Onlays</li> <li>• Crowns (1 per tooth in 10 years)</li> <li>• Crown Repair</li> <li>• Endodontics (surgical)</li> <li>• Periodontics (surgical)</li> <li>• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)</li> <li>• Complex Extractions</li> <li>• Anesthesia</li> <li>• Bleaching (cosmetic)</li> </ul>	<ul style="list-style-type: none"> <li>• Inlays</li> <li>• Onlays</li> <li>• Crowns (1 per tooth in 10 years)</li> <li>• Crown Repair</li> <li>• Periodontics (nonsurgical)</li> <li>• Periodontics (surgical)</li> <li>• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)</li> <li>• Complex Extractions</li> <li>• Anesthesia</li> </ul>

### Dental Rewards®

These plans include a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns Dental Rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning Dental Rewards who submits a claim for services received through the dental PPO network earns an extra reward, called the PPO Bonus. Members and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Plan Threshold	\$500	Dental benefits received for the calendar year cannot exceed this amount
Annual Carryover	\$250	Dental Rewards amount is added to the following year's maximum
PPO Bonus	\$100	Additional amount awarded for seeing a PPO Provider
Maximum Carryover	\$1,000	Maximum possible accumulation for Dental Rewards and PPO bonus combined

# PPO DENTAL INSURANCE FOR MEMBERS OF FALSS

## Highlight Sheet



### In Network vs Out of Network

With this plan, you have the right to receive care from any licensed dentist in the United States. However, your out-of-pocket costs will almost always be lower if you choose an Ameritas PPO dentist. The Ameritas PPO network includes more than 65,000 dentist locations nationwide.

	<b>Network Choice PPO Option</b>	<b>Freedom Choice PPO Option</b>
<b>Visiting an Ameritas PPO network provider</b> (In Network)	<p>Ameritas PPO dentists agree to provide treatment to plan participants at contracted fees prearranged with Ameritas, which means that your out-of-pocket expense will usually be lower. Here's how PPO costs are actively managed:</p> <ul style="list-style-type: none"><li>• True managed care discounts. Our network fees are typically 25% below average charges, or 30-50% below the 90<sup>th</sup> percentile.</li><li>• Discounted fees. Our fees are appropriate for each PPO ZIP code, they're not lumped together in broad ranges. This means reimbursement levels for participants and dentists are appropriate to costs in their area.</li><li>• We offer discounted fees on virtually all covered procedures, not just a few of the more common ones.</li></ul> <p>Ameritas PPO dentists will file claim forms on your behalf and will accept payment directly from Ameritas. This means that you do not need to pay the entire bill and await reimbursement. Instead, you pay only your portion of the coinsurance (including deductible, if necessary) at the time of service.</p> <p>Go online to <a href="http://www.memberbenefits.com/falss">www.memberbenefits.com/falss</a> to find the participating network dentists who are most convenient for you.</p>	<p>Ameritas PPO dentists agree to provide treatment to plan participants at contracted fees prearranged with Ameritas, which means that your out-of-pocket expense will usually be lower. Here's how PPO costs are actively managed:</p> <ul style="list-style-type: none"><li>• True managed care discounts. Our network fees are typically 25% below average charges, or 30-50% below the 90<sup>th</sup> percentile.</li><li>• Discounted fees. Our fees are appropriate for each PPO ZIP code, they're not lumped together in broad ranges. This means reimbursement levels for participants and dentists are appropriate to costs in their area.</li><li>• We offer discounted fees on virtually all covered procedures, not just a few of the more common ones.</li></ul> <p>Ameritas PPO dentists will file claim forms on your behalf and will accept payment directly from Ameritas. This means that you do not need to pay the entire bill and await reimbursement. Instead, you pay only your portion of the coinsurance (including deductible, if necessary) at the time of service.</p> <p>Go online to <a href="http://www.memberbenefits.com/falss">www.memberbenefits.com/falss</a> to find the participating network dentists who are most convenient for you.</p>
<b>Visiting a non-Ameritas PPO network provider</b> (Out of Network)	<p><b>The Network Choice PPO option is not recommended for members electing to receive the majority of their dental care from a non-Ameritas PPO dentist.</b> When receiving treatment from an "out-of-network" dentist, this plan will pay the applicable coinsurance level based on the Maximum Allowable Charge (MAC) in your specific ZIP Code area. The dentist may balance bill you for all charges above the MAC allowance. (For example, if your dentist charges \$140 for a Type 1 procedure that has a coinsurance level of %100 and a MAC of \$100, you would be responsible for paying the additional \$40 to the dentist.)</p>	<p><b>Freedom Choice PPO Option</b></p> <p>When receiving treatment from an out-of-network dentist, this plan will pay the applicable coinsurance level based on the out-of-network plan allowance. The out-of-network plan allowance is 90<sup>th</sup> U&amp;C.</p> <p>90<sup>th</sup> U&amp;C means 9 out of 10 dentists in a specific ZIP Code area charge at or below the plan allowance for a procedure. We determine the Usual and Customary (U&amp;C) allowance using information including data from Ingenix, a multicarrier compilation formerly derived by the Health Insurance Association of America (HIAA). Plan members are reimbursed based on the appropriate charges in the dentist's ZIP Code area. We review our U&amp;C allowances annually.</p>

### Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

### Questions? Contact the administrator of FALSS Member Benefits Insurance Programs at 1-800-282-8626.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact the plan administrator. As a group plan, this plan is subject to changes in carrier, network, plan benefits, and premium rates.

# OPTIONAL VISION INSURANCE FOR MEMBERS OF FALSS



## Highlight Sheet

### About the Optional Focus Vision plan

Like the dental plan, this benefit is available at group rates for members of FALSS. With this plan, you have the right to receive care from any vision care provider in the United States. However, your out-of-pocket costs will almost always be lower if you choose a provider from VSP nationwide network.

### Vision Plan Summary

Focus Benefits	VSP Network	Out of Network
Annual Eye Exam	100% covered	covers up to \$52
Single Vision Lenses	100% covered	covers up to \$55
Bifocal Lenses	100% covered	covers up to \$75
Trifocal Lenses	100% covered	covers up to \$95
Lenticular Lenses	100% covered	covers up to \$125
Frame	covers up to \$105	covers up to \$40
Contact Lenses	covers up to \$105	covers up to \$105

### Monthly Rates for 01/01/12 – 12/31/12

Enrollee Only	\$9.84
Enrollee + Spouse	\$21.24
Enrollee + Child(ren)	\$17.16
Enrollee + Spouse & Child(ren)	\$28.52

Premiums are subject to change. Plan not available in New York, Maine, Maryland, Massachusetts.

### Plan Highlights

- Available to members of FALSS
- Group Rates
- Enjoy 20% off additional non-covered complete pairs of prescription glasses and sunglasses
- For contacts, receive 15% off your contact lens fitting and follow-up
- Get special pricing on lens options such as ultra-violet coating
- For LASIK or PRK, save an average of 15% off the usual and customary price—or 5% off the promotional price—with VSP and a contracted laser surgery center

### Plan Specifics

- VSP provides up to \$105 toward a new frame. If the member chooses a frame exceeding this allowance, he/she will receive a 20% discount off the excess amount
- **Members pay a \$10 annual deductible on exams and \$25 annual deductible on materials**
- Frequency for Exam-Lenses-Frame is 12-12-24 months
- With the 12-12-24 frequency: Contacts are in lieu of eye glasses and normal frequency rules apply, selecting contacts does not reset the frame frequency, contacts and frame frequencies work independently

No benefits are payable for a service which is not listed under the list of eye care services found in the certificate. This form highlights the eye care coverage available through Ameritas Life Insurance Corp. Please refer to the Certificate of Insurance for a complete list of covered procedures. Ameritas Group, a division of Ameritas Life Insurance Corp. (Ameritas Life), a UNIFI Company, offers group dental and eye care products nationwide. Certain plan designs may not be available in all areas. In Arizona, exclusions and limitations must accompany plan highlights. Some states require that producers be appointed with Ameritas Group before soliciting its products. To become appointed with Ameritas Group, call 800.659.2223. Ameritas Group's dental and eye care products (9000 Ed. 01-05) are issued by Ameritas Life. ©2007 Ameritas Life Insurance Corp. Ameritas, the bison symbol, Focus and EyeChoice are registered service marks of Ameritas Life. October 2007

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# ENROLLMENT INSTRUCTIONS

## PPO DENTAL INSURANCE FOR MEMBERS OF FALSS



### 1. COMPLETE ENROLLMENT FORM

Make sure to complete the form in its entirety. Monthly rates for available options are included in kit. Omissions and illegible print may delay issuance of coverage.

### 2. PAYMENT OPTIONS

#### **Payment Option 1 - Monthly Auto Pay**

If you elect to pay by Monthly Bank Draft (ACH), you do not need to send any premium. Upon approval of your enrollment form, we will automatically draft your account on a monthly basis. Make sure to complete the Authorization section and include a VOIDED check.

#### **Payment Option 2 - Direct Annual Billing**

If you elect this method, **please make check or money order written out to BPC Financial**, for the pro-premium required to pay your coverage through the end of the plan year (December 31st).

**For example**, if you are enrolling for the 7/1 enrollment date, you will need to submit 6 months premium plus the one-time \$20.00 Direct Billing fee. You will be invoiced on an annual basis thereafter.

\*The \$20.00 Direct Billing fee is required for each primary enrollee that selects the Direct Billing payment method. The Direct Billing fee is waived when enrolling with a firm of 5 or more primary enrollees or when selecting Monthly Auto Pay. Contact administrator for Firm list billing options.

### 3. FAX OR MAIL FORMS TO:

You may use this form as a FAX COVER

Fax to: (904) 396-2091

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Attn: Enrollment/Processing

Or Mail to:

Program Administrator  
BPC Financial  
7645 Gate Parkway, Suite 101  
Jacksonville, FL 32256

**IMPORTANT:** All requirements must be received by BPC Financial no later than the last day of the month prior to your requested enrollment date. Please note that failure to include all necessary requirements and correct payment amount or voided check could result in a delay of your policy effective date. Upon approval you will receive written notification of your effective date along with your ID cards and instructions on how to view your Certificate of Insurance (COI). Make sure to review the COI carefully. Be sure to understand all of your rights and benefits under the plan. If you are not completely satisfied, please notify us immediately.

**ANY QUESTIONS? CALL TOLL-FREE: 1-800-282-8626**

PPO DENTAL/VISION INSURANCE FOR MEMBERS OF FALSS  
ENROLLMENT FORM

Mail or Fax to Administrator: BPC Financial  
7645 Gate Parkway, Suite 101, Jacksonville, FL 32256  
Toll Free (800) 282-8626 Fax (904) 396-2091

1. INDICATE COVERAGE DESIRED

Desired Quarterly Enrollment Date:  January 1  April 1  July 1  October 1

Plan Options:  Freedom Choice PPO Dental  Network Choice PPO Dental  Focus Vision

2. PRIMARY ENROLLEE INFORMATION

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: \_\_\_\_\_  
(Last, First, Middle)

Mailing Address: \_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)  Male  Female

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Email Address: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

FALSS Member's #: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

3. DEPENDENT ENROLLEE INFORMATION

(To add additional dependents, please attach a separate sheet.)

Spouse: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Dependent: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Dependent: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Dependent: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

4. PLEASE INDICATE YOUR PAYMENT METHOD

**Monthly Auto-Pay.** Include a VOID check and complete the Authorization below.

I hereby authorize BPC Financial to initiate debit entries and to initiate, if necessary, credit entries as adjustments for any debit entries in error to my Checking account and the Financial Institution named below to debit and/or credit the same account. BPC Financial will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This authority is to remain in full force and effective until BPC Financial and the Financial Institution have received written notice from me of its termination in such time and manner as to afford BPC Financial and the Financial Institution a reasonable opportunity to act on it.

**X** \_\_\_\_\_  
Accountholder's Signature:

\_\_\_\_\_  
Date Signed:

\_\_\_\_\_  
Name of Financial Institution:

**Direct Annual Billing.** (Please make check or money order written out to BPC Financial for premium required to pay your coverage through the end of plan year (December 31st) plus the one-time \$20.00, non-refundable Direct Billing fee.)

5. READ CAREFULLY, THEN SIGN AND DATE

As a member of FALSS, and an employee of an attorney or law firm in Florida, I hereby apply for group insurance, for which I am eligible or may become eligible. I understand that I am enrolling as a participant in a group plan. The plan provider, premium rates, and plan benefits may change. I have read and understand the conditions and plan limitations as described in the enrollment kit. I understand that coverage is effective on the next quarterly enrollment date following approval of my enrollment form and receipt of my initial payment. To the best of my knowledge and belief, the information I've provided is complete and correct.

**X** \_\_\_\_\_  
Primary Enrollee's Signature:

\_\_\_\_\_  
Date Signed: