

About the Group plan

This voluntary group plan was designed for members of the **Florida Association of Mortgage Brokers (FAMB)** and their employees. As a member of FAMB, you are part of a large group with buying power. 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. To enroll in this plan, you must be a present member of FAMB, or an employee of a member of FAMB covered in this plan. 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 **Preventive PPO Option**, which is designed to provide limited coverage for routine maintenance dental care needs through Ameritas PPO network providers, and the **Comprehensive PPO Option**, which covers a wider array of procedures including orthodontia for children and also gives you the freedom to visit any licensed dentist.

PPO Plan Options - Dental Plan Summary

	Preventive PPO Option		Comprehensive PPO Option					
	In Network		In Network			Out of Network		
			Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
Coinsurance								
Type 1		100%	100%	100%	100%	90%	90%	90%
Type 2		50%	60%	70%	80%	50%	60%	70%
Type 3		N/A	0%	40%	50%	0%	30%	40%
Deductible		\$50/Calendar Year Type 2&3 Waived Type 1	\$50/Calendar Year Type 2&3 Waived Type 1			\$50/Calendar Year Type 2&3 Waived Type 1		
Maximum (per person)		\$1,000 per calendar year No Family Maximum	\$1,000 per calendar year No Family Maximum			\$1,000 per calendar year No Family Maximum		
Allowance		Contracted Fee	Contracted Fee			90 th U&C		
Dental Rewards*		N/A	Included			Included		
Waiting Period		None	None			None		

- Coinsurance level for Year 1 commences on the effective date of your coverage in the Comprehensive PPO option.
- Coinsurance level for Year 2 commences on the first day of the 13th consecutive month that you are covered in the Comprehensive PPO option.
- Coinsurance level for Year 3 and thereafter commences on the first day of the 25th consecutive month that you are covered in the Comprehensive PPO option.

Orthodontia Summary – Child Only Coverage

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

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

Monthly Rates for 01/01/10 – 12/31/10

	Region 1	Region 2	Region 3	Region 1	Region 2	Region 3
Enrollee Only	\$14.28	\$15.52	\$19.64	\$28.28	\$30.20	\$36.12
Enrollee + Spouse	\$29.80	\$32.48	\$41.08	\$59.56	\$63.60	\$76.16
Enrollee + Child(ren)	\$39.20	\$43.00	\$55.76	\$73.08	\$78.40	\$96.56
Enrollee + Spouse & Child(ren)	\$54.72	\$59.96	\$77.20	\$104.36	\$111.80	\$136.60

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 Billing payment method. (Processing fee is waived when selecting Monthly Auto-pay or when enrolling with a business with 5 or more participants).
- Premiums are subject to change.
- Plan not available in New York

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

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

Dental Rewards® (Comprehensive PPO Option Only)

The Comprehensive PPO option includes 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	The minimum amount of unused maximum in a calendar year in order to qualify for carryover and PPO Bonus.
Annual Carryover Amount	\$250	Amount that is added to the following year's maximum.
PPO Bonus	\$100	Additional amount awarded for seeing a PPO Provider.
Maximum Carryover	\$1,000	The highest possible maximum including carryover and PPO bonus.

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.

	Preventive PPO Option	Comprehensive PPO Option
<p>Visiting an Ameritas PPO network provider</p> <p>(In Network)</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"> • True managed care discounts. Our network fees are typically 25% below average charges, or 30-50% below the 90th percentile. • 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. • We offer discounted fees on virtually all covered procedures, not just a few of the more common ones. <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 www.memberbenefits.com/far 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"> • True managed care discounts. Our network fees are typically 25% below average charges, or 30-50% below the 90th percentile. • 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. • We offer discounted fees on virtually all covered procedures, not just a few of the more common ones. <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 www.memberbenefits.com/far to find the participating network dentists who are most convenient for you.</p>
<p>Visiting an non-Ameritas PPO network provider</p> <p>(Out of Network)</p>	<p style="text-align: center;">Preventive PPO Option</p> <p>The Preventive PPO option is not recommended for members electing to receive the majority of their dental care from a non-Ameritas PPO dentist. 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 style="text-align: center;">Comprehensive PPO Option</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 90th U&C.</p> <p>90th U&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&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&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 the FAMB Insurance Programs at 1-800-282-8626.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your association 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.

FAMB MEMBER GROUP PPO DENTAL PLAN

ENROLLMENT INSTRUCTIONS:

- 1) COMPLETE ENROLLMENT FORM
- 2) COMPLETE PAYMENT METHOD FORM

Monthly Auto Pay

If you elect to pay by Monthly Auto Pay (ACH), you do not need to send any premium. We will automatically draft your account on a monthly basis.

Direct Annual Billing

If you elect the Direct Annual Billing method, **please make check or money order written out to BPC Financial**, for the pro-rated premium required to pay your coverage through December 31st plus the one-time \$20.00 non-refundable processing fee*.

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

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

- 3) MAIL OR FAX FORMS TO ADMINISTRATOR:

BPC Financial
7645 Gate Parkway
Suite 101
Jacksonville, FL 32256

Phone (800) 282-8626
Fax (904) 396-2091

- 4) IMPORTANT:

Your coverage will become effective on the effective date selected on your Enrollment Form upon approval of your Enrollment Form and receipt of your full Initial Premium Payment plus the \$20.00 processing fee (if direct billing method selected). When you receive your ID cards, you will receive 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.

If you have any questions, please call us toll free at **1-800-282-8626**.



**FAMBA Member Group Dental & Eyecare Plan
ENROLLMENT/CHANGE FORM**

Mail or Fax to administrator:
BPC Financial, 7645 Gate Parkway, Suite 101
Jacksonville, FL 32256
Facsimile: (904) 396-2091



Underwritten by:

Please select the plan options you wish to enroll:

- Comprehensive PPO or Preventive PPO and/or Focus Vision

Effective Date

Effective Date:

- January 1
 April 1
 July 1
 October 1

Indicate Qualifying Event and date for changes below after the original enrollment.

Qualifying Event: _____

- (Month) (Day) (Year)
- Add Spouse
 Add Dependent Child
 Delete Spouse
 Delete Dependent Child

Primary Enrollee Information

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

Name: _____ (Last, First, Middle)
Mailing Address: _____ (Street Address)

Social Security # _____ (City) _____ (State) _____ (Zip)
Date of Birth: _____ (Month) _____ (Day) _____ (Year)
Email address: _____ Phone # (____) _____
Member of the FAMBA Employee of FAMBA member FAMBA Member's # _____
Name of Employer: _____

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY: To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

(If enrolling one dependent, ALL must be enrolled.)

	Add		Delete		Male		Female		Date of Birth:		Date of Birth:	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Month)	(Day)	(Year)
Spouse:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

As a member of the FAMBA, or an employee of a member of FAMBA, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I understand that I am enrolling as a participant in a group plan. The plan provider, premium rates, and plan benefits may change. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate. THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS: I am signing up for coverage until the next enrollment period except in the case of a life event.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X Signature of Enrollee _____ Date _____

PLEASE INDICATE YOUR PAYMENT METHOD

- Monthly Auto-Pay.** Attach a VOID check and completed the Authorization below.
- Direct Annual Billing** (If you select this method, please make check or money order written out to BPC Financial, for the pro-rated premium required to pay your coverage through December 31st plus the one-time \$20.00 non-refundable processing fee.

MONTHLY AUTO PAY AUTHORIZATION FORM

You may pay your insurance premiums monthly through monthly pre-authorized debit transactions (ACH) at no additional cost. If you would like to take advantage of this payment option, please complete the form below, attach a voided check, sign and return.

ACCOUNTHOLDER'S NAME: _____

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.

FINANCIAL INSTITUTION: _____

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.

SIGNATURE: _____ DATE: _____

ATTACH VOIDED CHECK BELOW

Attach a voided check here. All total costs will be drawn between the 1st and 10th day of each month.

NOTE: IF THE ACH DEBIT IS RETURNED FOR NONSUFFICIENT FUNDS. A \$25 NONREFUNDABLE SERVICE FEE WILL BE APPLIED WHEN ALLOWED BY LAW.

Important privacy choices

We value your trust. That is why we are committed to protecting your personal information. This Notice explains the way we use and protect your personal information. You do not need to take any action but you do have certain rights that are described in this Notice.

important notice of privacy of information practices

This Notice is provided on behalf of the Group Dental and Eye Care Divisions of Ameritas Life Insurance Corp. and First Ameritas Life Insurance Corp. of New York.

the UNIFI Companies

In addition to Ameritas Life Insurance Corp. and First Ameritas Life Insurance Corp. of New York, the UNIFI Companies consist of the following affiliated companies, all of which offer their own Notice of Privacy Practices:

- The Union Central Life Insurance Company
- PRB Administrators, Inc.
- Summit Investment Partners, Inc.
- Calvert Group, Ltd.
- Ameritas Investment Corp.
- Summit Investment Advisors, Inc.
- Acacia Federal Savings Bank
- Acacia Life Insurance Company

information we collect

We collect information about you for the purpose of conducting routine business functions such as paying your dental and eye care claims. Following are examples of the types of customer information we may collect about you:

Personal identification and contact information such as your:

- Name and address;
- Social Security number; and
- Date of birth.

Enrollment information such as your:

- Employment status; and
- Date of hire.

Health information such as the claims information that you or your dental or eye care provider submit to us so that we can process your claims and assess your benefits.

how we gather your personal information

Most of the information we collect about you comes directly from you. You give us personal information when you enroll in your employer's Dental and/or Eye Care plan. We also may receive information from:

- Your dental or eye care provider;
- Governmental agencies; and
- Independent reporting agencies.

how we use and share your personal information

We do not sell or share your information with outside marketers. However, we may share your information outside of the UNIFI Companies for the following reasons:

• **Service Providers.** We may share information about you with service providers. Service providers are unrelated companies who perform business transactions for us. We require service providers to keep your information confidential. We prohibit them from using your information for their own purposes or re-disclosing it to anyone. Disclosures to service providers are a part of our business operations. You may not opt-out of these disclosures.

• **Required by Law.** Sometimes the law requires us to share customer information such as in response to a valid summons, court order, search warrant or



subpoena. We must comply with the law and therefore you may not opt-out of these disclosures.

- **Agents and Brokers.** We may share your information with your agent or broker so that they may provide you with efficient and superior service. Your agents and brokers understand the importance of your privacy and they are required by law to maintain your privacy and safeguard your information. We require our agents and brokers to follow our policies in order to keep your personal information private and secure. You may not opt-out of these disclosures.

Health or Medical Information

We will not release your medical or health information to anyone unless we are permitted or required by law to do so. When we are not permitted or required by law to disclose your health or medical information, we will not do so without your written authorization.

Examples:

- **Permitted by Law:** The law permits us to exchange information with your health care provider in order to process your claims and facilitate payment.
- **Required by Law:** The law requires us to disclose your information under a valid court order.

your rights

You have the right to receive a copy of this Notice at least once each year while you are our customer. This Notice is also available on our website. You may request an additional copy by writing, e-mailing or calling the UNIFI Companies' Privacy Office as indicated at the end of this Notice.

You have the right to review the information that we have about you. You must make this request in writing and include your full name, address and policy or account number. We may charge you a reasonable fee for the copies you request.

You have the right to request that we make corrections to the information that we maintain about you if you believe that our records are incorrect. All requests must be in writing.

we safeguard your personal information

We maintain physical and electronic safeguards for the protection of your personal information. We restrict access of your information to our employees and agents who need it to perform their jobs. Our

employees and agents understand the importance of these safeguards. We have trained them in the proper handling of your personal information.

former customers' personal information

The policies and practices described in this Notice apply equally to current and former customers. When you are no longer a customer, we will maintain your information for the period of time required by law and then it is destroyed. As a former customer, however, you will not receive our annual Privacy Notice.

our privacy policies

This Privacy Notice summarizes the Official Privacy Policy of the UNIFI Companies identified on the first page of this Notice, which became effective on January 1, 2006. We are required by law to send you our Privacy Notice at least once each year. This Notice complies with all applicable laws and regulations. If your State's privacy law requires more restrictive practices than those described in this Notice, we will apply the more restrictive practices to your information. We may make changes to our Privacy Policies from time to time. However, if we make a change that impacts the accuracy of the sharing practices that are explained in this Notice, we will provide you with a revised Privacy Notice within thirty days.

Special Note to our Group Dental and Eye Care Plan Sponsors and Participants:

Our Group Dental plans and our Group Eye Care plans must also comply with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Protected Health Information Practices more specifically describes our privacy policies with regard to your information. You may contact our Privacy Office to request an additional copy.

You may contact us at:

UNIFI Companies Privacy Office
P.O. Box 81889
Lincoln, NE 68501-1889
888.284.7844
privacy@ameritas.com