

VISION INSURANCE FOR FLORIDA REGISTERED PARALEGALS

Eye Care Highlight Sheet



About the plan

This plan is available at group rates for Florida Registered Paralegals. 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 01/01/10 – 12/31/10

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 Florida Registered Paralegals
- 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
- 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.

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.

our fine print

- Covered Expenses will not include, and no benefits will be payable for, expenses incurred for:
 1. vision examinations more than once in any twelve-month period.
 2. lenses more than once in any twelve-month period, and then only if replacement is deemed necessary by the provider.
 3. frames more than once in any twenty-four month period, and then only if replacement is deemed necessary by the provider.
 4. contact lenses more than once in any twelve-month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the twelve-month period. When lenses and frames are chosen, expenses for contact lenses are not covered expenses during the twelve-month period.
 5. medically necessary contact lenses, except for the first \$105 of expense, when such lenses are purchased for any reason other than for the following conditions:
 - a. following cataract surgery
 - b. to correct extreme visual problems that cannot be corrected with spectacle lenses
 - c. certain conditions of anisometropia
 - d. keratoconusMedically necessary contact lenses are limited to the plan allowance (100% covered in-network, \$210 out-of-network). Such payment is limited to once in any twelve-month period and is in lieu of lenses and frame benefits under this policy.
 6. orthoptics or eye care training and any associated testing.
 7. plano lenses.
 8. two pairs of glasses in lieu of bifocals.
 9. lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
 10. medical or surgical treatment of the eyes.
 11. services for which a claim is filed more than 180 days after completion of the service.
 12. the following materials, over and above the covered expense for the basic material. These materials are cosmetic and the insured will be responsible for the cost of these materials.
 - a. blended lenses
 - b. oversize lenses
 - c. photo chromatic lenses; tinted lenses except pink #1 and #2
 13. progressive multi-focal lenses
 14. the coating of the lens or lenses
 15. the laminating of the lens or lenses
 16. frames exceeding the maximum allowance selected by the policyholder.

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

VISION INSURANCE FOR FLORIDA REGISTERED PARALEGALS



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 premium required to pay your coverage through the end of the plan year (December 31st) plus the one-time \$20.00 Direct Billing fee*.

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 PLAN ENROLLMENT FORM
FOR FLORIDA REGISTERED PARALEGALS

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 Enrollment Date: January 1 July 1 April 1 October 1

Plan Options: Network Choice PPO Dental Freedom 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 #: (_____) _____ - _____

FRP Customer #: _____ 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 Florida Registered Paralegal and an employee of an active member of The Florida Bar, 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: