

# THE FLORIDA BAR MEMBER GROUP VISION PLAN

## Highlight Sheet



### About the plan

Like the dental plan, this benefit is available at group rates for members of The Florida Bar and employees of members. 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 Members, employees of members, and dependents.
- 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 participant chooses a frame exceeding this allowance, he/she will receive a 20% discount off the excess amount.
- **Participants 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.

## 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

**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.**

# ENROLLMENT INSTRUCTIONS

## THE FLORIDA BAR MEMBER GROUP Focus Vision INSURANCE PLAN



### 1. COMPLETE ENROLLMENT FORM

Make sure to complete 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**

# 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)

Member of TFB  
 Employee

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

\_\_\_\_\_  
(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Male  
 Female

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

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

FL Bar 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 The Florida Bar, or an employee of a member, 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:

# 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