



"Just" **FUSION** THE ULTIMATE CHOICESM
an exclusive from

AMERITAS GROUP



Combined Dental & Eye Care Benefits

Benefits for our American Federal Employees Group with increasing maximums to **\$2,000** per year-per family member

We are proud to offer these 3 unique scheduled dental insurance plans that include eye care benefits. Each plan covers all dental procedures with a defined benefit amount - select from a Standard Plan E3, Mid-Level Plan E2 or High Plan E1. All plans also include an eye care benefit that pays \$45 toward an eye exam, \$80 toward frames and a complete schedule for single, bi-focal and tri-focal lenses or \$120 toward contact lenses. We invite you to learn more about the specific benefits included in each plan. The Fusion Product from Ameritas is an Ameritas exclusive - and is now available to you!

**INSURED Scheduled Benefit Plan in all 50 States + DC
FREE TO SELECT YOUR OWN DENTIST**

Go to Any Dentist or Eye Care Provider & Receive Benefits

PPO Network for Added Savings

**Network of over 85,500 Dental Access Points &
over 40,135 Eye Care Providers and Optical Locations**

Open to ALL Federal, Postal Employees and Retirees Regardless of Medical Plan



With Easy Payroll Deduction or Direct Bill

No One Will Be Refused Coverage!

Bi-Weekly Premiums

Standard Plan E3

Various Plans Are Available

\$11.00 Member

\$20.00 Member + 1 Dependent

\$31.00 Member + 2 or more Dependents

Orthodontic Benefit up to \$1,000 per Child

One time only membership enrollment fee of \$20

Pay 2 Months Premiums & Membership Fee with completed forms

by the 25th to be covered the next month for the Plan you have selected.

American Marketing Administrators, Inc.
Insurance Agency & Insurance Administrator Since 1980

23901 Calabasas Road, Suite 2014

Calabasas, California 91302-3307

818-223-9750 Fax 818-223-8147 800-300-PLAN

Email questions to: info@fedvp.com

Website: www.fedvp.com

www.fedvp.com

to view and nominate Providers



PPO Plan



The Dental and Eye Care ExpertsSM

A Division of Ameritas Life Insurance Corp.
A UNIFI Company



The Dental and Eye Care ExpertsSM

A UNIFI Company

The Eagle One Has Landed

American Federal Employees Group

Dental HMO Benefits are also available in limited areas.

This plan is similar to other dental supplements offered, this plan is not guaranteed under the contract with the FEHB Program.

Application for Membership & Enrollment American Federal Employees Group Association (AFEGA) Dental & Eye Care Benefits

Last, First, Middle Initial as it appears on payroll or retired records		Membership Status: New <input type="checkbox"/> Existing <input type="checkbox"/> Retired <input type="checkbox"/>	
Name:	DOB:	SS#:	# of Children
Home Address:		City:	State: Zip:
Home Phone:	Mailing Address (if different):		
Home Fax:			DHMO DDS#
Employer:	Location or Postal Station:		Plan Selected:
Work Address:		City:	State: Zip:
Work Phone:	Ext:	Work Fax:	If a Union Member, name & local #:
Primary Email (never sold or given to others):			
Paid with the application: \$		Spouse:	DOB:
Child(ren) Name & Date of Birth--Ameritas Group Insured Plan Covers to age 19 or to age 24 if a full time student			
I am interested in receiving information on: <input type="checkbox"/> Disability <input type="checkbox"/> Lump Sum Cancer Benefit <input type="checkbox"/> 4 Question Life Insurance			
I hereby authorize any required payroll deductions from my earnings for any required contribution. This authorization remains in effect until revoked by me in writing. I understand that this enrollment is for a minimum of 12 months. If a future increase in premium requires a premium increase and I don't elect to do a premium increase I understand that my plan will change. If coverage is stopped and then I wish to restart I may receive no prior credit and late enrollment reductions in benefits may occur. In several states we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. As a member, I hereby apply for the insurance benefits in the plan's materials which I have read, or have had read to me and understand. I represent that the information I have provided is complete and accurate. Please sign to accept membership and coverage even when no payroll deduction. I hereby apply for coverage as indicated. Fusion PPO <input type="checkbox"/> or DHMO <input type="checkbox"/> Applicant for Membership and coverage <u>Signature X</u> _____ Date: _____ RETURN THIS FORM + payroll deduction form or copy of form clearly indicating that the payroll deduction form is a copy. Do not give to payroll - Mail or Fax with Credit Card/Bank Draft Form to pay \$20 Membership Fee & at least 2 months premium so we may request the next first of the month as a starting date, if received late coverage will start on the first of the next month. Mail to: American Marketing Administrators, Inc., 23901 Calabasas Rd., Suite 2014, Calabasas, CA 91302-3307 Please make checks payable to American Marketing Administrators, Inc. Phone: 818-223-9750 Fax: 818-223-8147 I hereby authorize AMERICAN MARKETING ADMINISTRATORS, INC. to charge my credit card the required premium and/or fees due for the requested coverage and plans. This authority is to remain in effect until revoked by me, in writing, by US Mail. Credit Card Payment Authorization - <u>Mastercard/Visa Only</u> <input type="checkbox"/> Membership Fee <input type="checkbox"/> 2 Months Premiums to Start <input type="checkbox"/> Monthly Please give us billing address if different. Name on Account: _____ Credit Card #: _____ Expiration Date: _____ Security Code #: _____ <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa <u>Signature X:</u> _____ Date: _____			

As a convenience to me, I request and authorize YOU to pay and charge to my account checks drawn on the account by and payable to the order of AMERICAN MARKETING ADMINISTRATORS, INC. (hereafter referred to as AMA) provided there is sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each debit shall be the same as if it were a check drawn by you and signed personally by me. I authorize AMA to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of any required premium and/or fees due for requested coverage and plans. This authority is to remain in effect until revoked by me, in writing, by US Mail and until you actually receive such notice. I agree that you shall be fully protected in honoring such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage and fees for dishonored checks.

Name of Bank or Financial Institution: BANK DRAFT WITHDRAWAL AUTHORIZATION Subscribers Name: _____

Street: _____ Name on Checking Account if different than above: _____

City, State, Zip: _____ ROUTING ABA# (first 9 #s): _____

To Pay Membership Fee 2 Months Continuous Monthly
 NOTE: You will incur a service charge for any withdrawals not honored.
Authorized Signature (As it appears in the Financial Institution's records) _____
 Account # (do not include a check number) _____
 Date: _____
 Voided check is needed-fax, scan or mail

DIRECT DEPOSIT 1199A	SIGN-UP FORM				
EMPLOYEE INFORMATION	Payroll Allotment & Member Info				
Employee Name (Last, First, Middle Initial) as it appears on your paycheck:	<input type="checkbox"/> Start Allotment ASAP				
Employee Address:	<table border="1"> <tr> <td>From:</td> <td></td> </tr> <tr> <td>To:</td> <td></td> </tr> </table>	From:		To:	
From:					
To:					
Employee Payroll ID is your Social Security #:	<input type="checkbox"/> Change Allotment a Federal Employee <input type="checkbox"/> a Postal Employee <input type="checkbox"/> Federal Judges and IRS Employees may have deductions converted to monthly				
Gov't Agency / Postal Installation Name:	Bi-weekly Allotment \$				
Gov't Agency / Postal Installation Address:	Account Number Federal Employee <input type="checkbox"/> Federal 0 9 1 2 0 2 8 8 1 8				
Primary Email:	Account Number Postal Employees add your Social Security # <input type="checkbox"/> Postal C G S 0 2 2 5 _____ (If applying on-line) <input type="checkbox"/> Postal 2 4 7 0 2 2 5 _____ (If applying by telephone)				
Employee Telephone #: Home & Work	Employee Certification: I certify I am entitled to payment identified & that I have read and understand this form. In signing this form, I authorize my payment to be sent to bank named to be deposited to the designated trust account. Employee Signature: X _____				
Postal Employees Only - Financial Number					
FINANCIAL ORGANIZATION INFORMATION					
Financial Inst. (Federal Employees) <input type="checkbox"/> Wells Fargo Routing # 1 2 1 0 4 2 8 8 2	Financial Inst. (Postal Employees) <input type="checkbox"/> Bank of America Routing # 0 1 1 9 0 0 4 4 5				
Authorized By I confirm the identity of the above named payee and the account number. As representative of the above named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and/or 210. X <u>Bruce Begin</u> Bruce Begin, Vice President					

Collection of the information you are requested to provide on this form is authorized under 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment date from the Federal agency to the financial institution.

Allotment Authority for Insurance...Please return a copy of this form even if you have processed with payroll. You are hereby requested to establish an account in my name to designated insurance trust escrow account. I understand that this account will be used solely for the purpose of receiving monies from my employer for the payment of insurance and will be non-interest bearing to me. This will institute an allotment from my pay to bank for deposit to my insurance account. I hereby authorize and empower you for and on my behalf to deposit each month, if available, from insurance/savings/checking trust account. I hereby authorize and empower you for and on my behalf, to deposit each pay period or converted to monthly, if available, from my insurance/savings trust escrow account the funds I have authorized. These instructions and authorizations may be cancelled or amended at anytime upon receipt by the Bank or assignee of either written notice by me or an executed copy of US Treasury allotment form as modified by the US Treasury bearing my signature.
If you turn in to payroll, please return a copy to AMA

X _____
Employee Signature
 *****USPO Employees add \$1.00 for Payroll Deduction Only Premiums.*****
 Date: _____

Look up Providers and Enroll at www.fedvp.com

Ameritas Group, a division of Ameritas Life Insurance Corp. (Ameritas Life), a UNIFI Company with over 25 billion dollars in assets, offers group dental and eye care products nationwide. In New York, insurance products are offered through First Ameritas Life Insurance Corp. of New York (**First Ameritas**).

Ameritas Group and **First Ameritas** offer flexible, affordable dental and eye care for the American Federal Employees Group for Federal & Postal Employees + Retired on **Payroll Deduction** or direct bill from an individuals banking account with American Marketing Administrators, Inc. Insurance Agency & Reg. Insurance Administrators Since 1980.

Ameritas and **First Ameritas** underwrite, reinsure and provide customer relations to more than 34,000 employer groups covering 3 million insured members nationwide, with annualized in-force dental and eye care premiums/premium equivalent over \$605 million. **Ameritas** processes more than 2.5 million claims yearly with **accuracy that exceeds 99%**.

**Claims Hours: Mon. - Thurs. 5:00 a.m. - 10:00 p.m., PST
Friday 5:00 a.m. - 4:30 p.m., PST**

Ameritas is rated **A (Excellent)** by A.M. Best Company and **AA- (Very Strong)** by Standard & Poor's for financial strength.

All **FUSION** Plans include Orthodontics for Children, Eye Care & PPO Providers. *You may go to any Eye Care Provider and receive benefit payments or added benefits at PPO Providers.*

This is NOT a discount plan.

Go to www.fedvp.com for Dental & Eye Care Providers.

FEATURES & BENEFITS - Ameritas Insured Free Choice of Providers or PPO

Coinsurance Plan Pays FUSION Dental & Eye Care Benefits	Plan E1	Plan E2	Plan E3
Type 1 Procedures D0120 Periodic Oral Evaluation (Twice in a Benefit Period). D1110 Prophylaxis - Adult (Twice in a Benefit Period). D1203 Topical Fluoride (separate code) in conjunction w/prophylaxis. (Coverage for fluoride treatment is limited to persons age 18 and under and to one treatment in a Benefit Period.)	\$20.00 \$50.00 \$19.00	\$16.00 \$40.00 \$15.00	\$12.00 \$30.00 \$11.00
Type 2 Procedures D0210 Intraoral - complete series (including bitewings). D0272 Bitewings - two films (Twice in a Benefit Period). D2140 Amalgam restoration - one surface, primary or permanent. D9220 Deep sedation/general anesthesia.	\$60.00 \$22.00 \$53.00 \$175.00	\$48.00 \$18.00 \$42.00 \$140.00	\$36.00 \$13.00 \$32.00 \$105.00
Type 3 Procedures - All insureds are subject to a 12 month elimination period. D3310 Endodontics - root canal, anterior. D4341 Periodontal scaling and root planing, four or more teeth. Each quadrant is eligible for consideration once in a 2 year period. D5211 Maxillary partial denture - resin base D2792 Crown - full cast noble metal. Orthodontia Procedures - Per Child \$1,000 Lifetime There is a 12 month elimination period on Orthodontia procedures.	\$200.00 \$65.00 \$375.00 \$280.00 50%	\$160.00 \$52.00 \$300.00 \$224.00 50%	\$120.00 \$39.00 \$225.00 \$168.00 50%
DEDUCTIBLE AMOUNTS Type 1 Procedures Type 2 and Type 3 Procedures - Calendar Year - Per Person Orthodontia Procedures - Lifetime - Per Child	WAIVED \$50.00* \$0	WAIVED \$50.00* \$0	WAIVED \$50.00* \$0
Maximum Type 1, 2 & 3 Procedures - Calendar Year - Per Person Carry Over Amount - Per Person - Each Benefit Period Benefit Threshold - Per Person - Each Benefit Period Maximum Carry Over Amount	\$1000.00* \$250.00 \$500.00 \$1000.00	\$1000.00* \$250.00 \$500.00 \$1000.00	\$750.00* \$125.00 \$250.00 \$500.00
ORTHODONTIA PROCEDURES Lifetime - Per Child	\$1000.00	\$1000.00	\$750.00
EYE CARE DEDUCTIBLE - CALENDAR YEAR Exams, Lenses (other than contact lenses) or Frames/Contact lenses *Maximum - Exams and Materials - Per Benefit Period	\$25.00* NONE	\$25.00* NONE	\$25.00* NONE
COMBINED EYE CARE and DENTAL Maximum Deductible - Calendar Year Exam Frequency	\$1000.00 \$75.00 NONE	\$1000.00 \$75.00 NONE	\$750.00 \$75.00 NONE

Please note - The patient will be responsible for the difference between the schedule amount and the provider's fee.

DENTAL LIMITATIONS

- Limitations:** Covered expenses will not include and no benefits will be payable for expenses incurred:
- for any procedure except examinations, cleaning and fluoride applications for the 1st 12 months when an employee or dependent becomes classified as a late entrant. If an employee or dependent does not enroll within 31 days from the date the person qualifies for the insurance or who elected to become insured again after canceling a premium contribution agreement will be classified as a late entrant.
 - for any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic.
 - to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the insured person is covered under the dental expense benefit, it will be a covered expense.
 - for initial placement of any prosthetic appliance of the fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed partial denture must include the replacement of the extracted tooth or teeth.
 - for any procedure begun before the insured person was covered under the dental expense benefit.
 - for any procedure begun after the insured's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the insured's insurance under the dental expense benefit terminates.
 - to replace lost or stolen appliances.

- for appliances, restorations or procedures to:
 - alter vertical dimension;
 - restore or maintain occlusion;
 - split or replace tooth structure lost because of abrasion or attrition;
 - for any procedure which is not shown on the master Table of Dental Procedures.
- for which the insured is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
- for charges which the insured is not legally required to pay or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.

ORTHODONTIA LIMITATIONS

- Limitations:** Covered expenses will not include and no benefits will be payable for expenses incurred:
- for a Program which was begun before the insured became covered under the dental expense benefit.
 - before the insured has been insured under the dental expense benefit for at least 12 consecutive months.
 - in any quarter of a Program if the insured was not covered under the dental expense benefit for the entire quarter.
 - after the insured's insurance under the dental expense benefit terminates.

EYE CARE LIMITATIONS

- Limitations:** Covered expenses will not include and no benefits will be payable for expenses incurred for:
- vision examinations more than the frequency as indicated on the plan definition page.
 - lenses more than the frequency as indicated on the plan definition page.
 - frames more than the frequency as indicated on the plan definition page.
 - contact lenses more than once in any 12 month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the 12 month period. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the 12 month period.
 - examinations performed or frames ordered before the insured was covered under the eye care expense benefits.
 - subject to extension benefits, any examination performed or frame or lens ordered after the insured's coverage under the eye care expense benefits ceases.
 - sub-normal eye care aids; orthoptic or eye care training or any associated testing.
 - non-prescription lenses.
 - replacement or repair of lost or broken lenses or frames except at normal intervals.
 - any eye examination or corrective eyewear required by an employer as a condition of employment.
 - medical or surgical treatment of the eyes.
 - any service or supply not shown on the Schedule of Eye Care Procedures.
 - coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
 - lenses and frames during the first 12 months that a person is insured under the eye care expense benefits, when the person is a late entrant, as defined.

FUSION Dental & Eye Care an Ameritas Group Exclusive with ... DENTAL REWARDS SM

Go to ANY PROVIDER YOU WANT or Use the PPO Providers for Additional Savings**Link to Providers www.fedvp.com

<i>Sample Procedure Fees - High Plan E1</i>	MAC*	UCR 90th	Plan Pays	With PPO Your Out of Pocket	Your Choice Out of Pocket
Periodic Oral Evaluation	\$24	\$40	\$20	\$4	\$20
Bitewings - Two Films	\$21	\$38	\$22	ZERO	\$16
Prophylaxis - Adult	\$51	\$75	\$50	\$1	\$25
Amalgam - One Surface - Primary or Permanent	\$67	\$119	\$53	\$14	\$66
Resin - Based Composite - One Surface, Anterior	\$74	\$137	\$53	\$21	\$84
Crown - Porcelain with Gold	\$675	\$991	\$280	\$395	\$711
Crown - Porcelain with Semi-precious Metal	\$634	\$932	\$280	\$354	\$652
Root Canal, Molar, Excluding Final Restoration	\$561	\$1025	\$300	\$261	\$725
Periodontal Scaling & Root Planing - 4 or more Teeth	\$122	\$218	\$65	\$57	\$153
Pontic - Porcelain Fused to High Noble Metal	\$603	\$1051	\$280	\$323	\$771
Pontic - Porcelain Fused to Noble Metal	\$595	\$1031	\$280	\$315	\$751
Crown - Porcelain Fused to High Noble Metal	\$598	\$997	\$280	\$318	\$717
Crown - Porcelain Fused to Noble Metal	\$551	\$996	\$280	\$271	\$716
Extraction, Erupted Tooth or Exposed Root	\$68	\$128	\$60	\$8	\$68
<i>Children's Orthodontic Benefit</i>			\$1000		

*The scheduled amounts represent the Maximum Allowable Charge (MAC) for providers within the Ameritas Managed Network. Allowances and out-of-pocket expenses may vary for providers. The MAC and U&C allowances will vary based on zip code.

Prior authorization is NOT REQUIRED. Private Providers that you select may wait for reimbursement from the plan or may want you to pay in advance or at completion. This is up to the Provider, not the plan. For more information visit our website at www.fedvp.com

A First in the industry....DENTAL REWARDS - Rewards insureds who care for their teeth and use only a portion of their annual maximum benefit during a benefit period. With Dental Rewards, an insured employee or dependent can earn additional benefits toward his/her next year's annual maximum benefit. Benefits could go up to \$2,000 in one year + \$1,000 for a child's braces. *In one year it is possible to have \$3,000 pay out per child.* Insureds qualify by each filing a dental claim during the benefit period and using less than the plan's annual maximum threshold amount. This helps insureds build their annual maximum benefit amount toward future covered dental procedures in a future benefit period.

Eye Care Benefit that Pays \$45 toward an eye exam, \$80 toward frames and reimbursement at \$40 single, \$60 bi-focal or \$75 tri-focal lenses or \$120 annually per family member per year toward contact lenses. **Subscribers using contracted Eye Med offices have a maximum fee that may be charged.** Examples: Single Vision Lenses \$50, Bi-focal Lenses \$70, Tri-focal Lenses \$105. Any Frame 35% off retail price, **plus the \$80 reimbursement.**

Please Note - The patient will be responsible for the difference between the schedule amount and the provider's fee when using a participating PPO provider or a non-participating provider.

Please Note - We do not require the filing of a pre-authorization form. However, we recommend that as smart, aware consumers, you request your provider file **a pretreatment estimate** with the claim's office for any suggested work of \$200 or more, **before the work is done.** The paperwork will be processed and a copy returned to you and the provider so that both parties will know the exact amount of benefits payable and any remaining financial obligation.

This brochure highlights the features of our Plans. A complete description is in the Certificate of Insurance issued to each insured member. All benefits are subject to provisions in the group policy issued for the American Federal Employees Group.

FUSION Combined Dental/Eye Care PREMIUM RATES

STANDARD PLAN E3	Bi-Weekly Payroll Deduction	Monthly Bank Draft Only	Monthly Credit Card Only*	Quarterly Direct Bill
Member Only	\$11.00	\$23.65	\$26.65	\$71.95
Member + 1 Dependent	\$20.00	\$43.25	\$46.25	\$130.75
Member + 2 or more Dependents	\$31.00	\$67.69	\$70.69	\$204.07

MID-LEVEL PLAN E2	Bi-Weekly Payroll Deduction	Monthly Bank Draft Only	Monthly Credit Card Only*	Quarterly Direct Bill
Member Only	\$15.00	\$33.40	\$36.40	\$101.20
Member + 1 Dependent	\$28.00	\$60.65	\$63.65	\$182.95
Member + 2 or more Dependents	\$44.00	\$96.25	\$99.25	\$289.75

HIGH PLAN E1	Bi-Weekly Payroll Deduction	Monthly Bank Draft Only	Monthly Credit Card Only*	Quarterly Direct Bill
Member Only	\$18.00	\$39.35	\$42.25	\$119.05
Member + 1 Dependent	\$33.00	\$71.64	\$74.64	\$215.92
Member + 2 or more Dependents	\$53.00	\$113.95	\$116.95	\$342.85

*Credit card premium includes special handling fees.

No Enrollment Fee for ICE Immigration Customs Enforcement & participating locals
*****USPO Employees add \$1.00 for Payroll Deduction Only Premiums*****

To Expedite Enrollment - Even if by Payroll Deduction
Mail or Fax Application with Check or Bank Draft/Credit Card authorization form for paying the **\$20 Membership Fee** & a minimum of **2 months "Bank Draft" Premiums** - see above. (or send/fax Quarterly payment with \$20 Membership Fee) (Checks made payable to American Marketing Admin.)
Don't forget the payroll deduction form if desired.

Eligibility is first of the month after the second payroll deduction and the premiums are received by the administrator and approved by Ameritas.

Go to www.fedvp.com (Questions > info@fedvp.com) to look up dental and eye care providers on page 2.

American Federal Employees Group Association Benefits for all
Federal & Postal Employees
American Marketing Administrators, Inc.

Insurance Agency & Licensed Administrator Since 1980
23901 Calabasas Rd. #2014, Calabasas, CA 91302
818-223-9750 Fax 818-223-8147 800-300-PLAN

© 2006 All rights reserved & pending American Marketing Administrators, Inc.