No Waiting Periods | Choose Your Own Dentist Option | Three Cleanings Per Year
For Employers 2-149 | Up to $5,000 Calendar Year Maximum Plans Available

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ABOUT THE PLANS

The Spirit Group Dental Plans allow you to choose your own dentist however you can save on out-of-pocket costs when you utilize the Ameritas Classic or Value Networks. The Classic Network is one of the largest in the nation with more than 100,000 unique providers at more than 400,000 access points.

You save when you use a network provider as these providers have agreed to discounted fees through their network agreement with Ameritas. When you use a network provider typical discounted fees can be 30% below the average for your area. That's savings you and your employees can take to the bank.

The Spirit Group Dental Plan allows you to choose from a single network option or purchase a plan that covers both networks for a Dual Option plan. With the Dual Option there is no price differential and you and your employees benefit from the higher benefit levels of the Value plan as well as the broader Classic provider network.

To find an Ameritas Classic or Value network provider near you, visit star.ameritas.com/findadentist.

Option 1 - Ameritas Classic Network
This option includes coverage for both in and out-of-network services, however you will see your greatest savings when using one of the 100,000 unique providers contracted with the Ameritas Classic Network. In-network benefits include 100% for Preventive Services, 90% for Basic Services and 60% for Major Services. Out-of-network covers Preventive Services at 100% as well, however Basic Services are covered at 80% and Major at 50%.

Option 2 - Ameritas Value Network
The Value Network plan also provides for in and out-of-network benefits. Coverage includes 100% for Preventive and Basic Services and 65% for Major if choosing one of the Value Network dental offices. Out of network benefits include 100% for Preventive, 80% for Basic and 50% for Major.

Option 3 - Dual Choice
Choose both the Value and Classic network plans together with no rate differential. You will be able to utilize the larger Classic provider network and at the same time enjoy the higher co-insurance options of the Value network plan.

This information is provided by Ameritas Life Insurance Corp. of New York (Ameritas of New York). In New York, group dental, vision and hearing care products (9000 Rev. 03-16) and individual dental and vision products (Indiv. 9000 NY Ed. 09-15) are issued by Ameritas of New York. Some plan designs are not available in all areas. To be appointed with Ameritas of New York, please call 800-201-8562.

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$100 lifetime deductible
Applies to preventive, basic and major services per person, to a maximum of 3 Individual deductibles per family.

Participation Requirements
Not less than two unrelated employees (75% of the employers eligible employees - the greater number after waivers) must be enrolled in the plan. For the Voluntary plan, not less than two unrelated employees. 100% family-related employees may apply for a 15% rate increase. You may choose to waive the voluntary participation requirement for a 5% increase in premium.

DENTAL REWARDS®
Seeing your dentist regularly is a great dental health habit. The Dental Rewards program helps reinforce that good habit by rewarding you when you visit the dentist yearly but don't use all of your annual maximum.

If you use less than $750 of your annual maximum, the unused portion will "carry over" to the next year. You can continue to carry over and build on your rewards dollars until you reach the maximum accumulation of $1,000.

How it works:
1. Submit at least one dental claim a year.
2. Keep your total benefits received for that year at or below the annual threshold amount of $750.
3. Earn rewards to use the following year.

Optional $1,500, $2,000, $3,000 or $5,000 Maximum Benefit
You may choose to increase the calendar year maximum benefit for this plan to $1,500, $2,000, $3,000 or $5,000. There is a 14% increase to the base rate for $1,500, 20% for $2,000, 30% for $3,000 and 50% for $5,000.

Optional $50/$150 Calendar Year Deductible
You may choose to replace the $100 lifetime deductible with a $50 per person/$150 per family calendar year deductible that applies to Class B and C services for a 5% rate increase.

Optional $25/$75 Calendar Year Deductible
You may choose to replace the $100 lifetime deductible with a $25 per person/$75 per family calendar year deductible that applies to Class B and C services for a 12% rate increase.

We also offer an additional PPO Bonus of $150 when you utilize an Ameritas Dental Network provider.

Dental Rewards Program Example
Annual Maximum for Preventive, Basic and Major Services... $1,500
Total services used in the plan year............................... $600
Annual Dental Reward...................................................... $250
Bonus for using an in-network provider........................... $150
Next year's annual maximum.......................... $1,500
PLUS Dental Rewards dollars.................. $400
Total available next year................................. $1,900

Please note: The Dental Rewards program is available with a 2% increase in rates on annual maximum plans of $1,000, $1,500 and $2,000. Dental Rewards option is not available when group selects an annual maximum plan of $3,000 or $5,000.

Optional $0/$0 Calendar Year Deductible
You may choose to replace the $100 lifetime deductible with a $0 per person/ $0 per family calendar year deductible that applies to Class B and C services for a 20% rate increase.

Optional Endo/Perio to Class B
You may choose to have Endodontics and Periodontics covered under Class B services for a 12% rate increase.

Optional Teeth Bleaching Benefit
A group may elect to include teeth bleaching with a 50% coinsurance benefit and up to a lifetime maximum benefit of $150 for a 3% rate increase.

For Groups Without Prior Coverage
Groups without prior or comparable dental coverage may purchase this plan, however there will be a 25% increase in the base rates.

No employer contribution required.

MEMBER SAVINGS
You may receive additional savings that can reduce out of pocket expenses:
- Save up to 15% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide (savings does not include contact lenses or vision care materials).
- Save on prescription medications through any Walmart or Sam's Club pharmacy (membership at Sam's Club not required).
- Access to emergency provider referrals when traveling outside the U.S. through AXA Assistance.

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ELIGIBILITY: An individual employed by a participating employer working 20 hours or more per week and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

ELIGIBLE DEPENDENTS: Spouse or domestic partner and/or unmarried dependent children up to age 26.

DEDUCTIBLE AMOUNT: The lifetime and calendar year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured Dependent before We start paying benefits.

CALENDAR YEAR MAXIMUM: Calendar year maximums are shown on the Coverage Schedule and are calculated for each certificate (person covered) yearly from January 1st.

OUT-OF-NETWORK BENEFITS: Out-of-network benefits are based upon the 90th percentile usual and customary fees charged in the area where service is rendered (percentile may be higher according to state requirements).

PRETREATMENT REVIEW: If the Course of Treatment will exceed $300, We will request prior review. We must be given the dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally satisfactory results. If You do not request a pretreatment review, We will pay for the least expensive method of treatment regardless of the method actually used.

COORDINATION OF BENEFITS: This Plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. This helps keep the cost of the Plan reasonable.

TERMINATION OF COVERAGE: Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage; the last day of the month in which Your dependent is no longer a dependent, as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by You or on your behalf; or the date the policy ends.

EFFECTIVE DATE: Plan effective dates are always the First of the month. Enrollment cards received by Direct Benefits after the First of the month will become effective on the First of the following month. Incomplete enrollment cards or failure to submit the required initial premium amount may cause an initial delay in Issuance of insurance. Do not cancel any other Insurance or assume you are insured under the Plan until you receive written confirmation from Direct Benefits.

ALTERNATE BENEFIT: If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate procedure is available. Accordingly, the plan member may choose to apply the alternate benefit amount determined under this provision toward payment to the submitted treatment.

MISSING TOOTH: When covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.
ELIGIBLE EXPENSES: Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To become an Eligible Expense, the dental services must be performed by: a licensed Dentist/Physician performing dental services within the scope of his license; or a licensed dental hygienist acting under the supervision and direction of a Dentist/Physician.

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates: for full and partial dentures - on the date the final impression is taken; for fixed bridges, crowns, inlays and onlays - on the date the teeth are first prepared; for root canal therapy - on the date the pulp chamber is opened; for periodontal surgery - on the date surgery is performed; for all other services - on the date the service is performed.

EXPENSES NOT COVERED: No coverage is available under the policy for the following:

• Medically Necessary. In general, we will not cover any dental service, procedure, treatment, test or device that we determine is not medically necessary. However, if an external appeal agent certified by the state overturns our denial, we will cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that it is otherwise covered under the terms of this policy.

• Aviation. We do not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

• Convalescent and Custodial Care. We do not cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.

• Cosmetic Services. We do not cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the utilization review process in the Utilization Review and External Appeals sections of this policy unless medical information is submitted.

• Experimental or Investigational Treatment. We do not cover any health care service, procedure, treatment, or device that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when our denial of services is overturned by an external appeal agent certified by the state. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this policy for a further explanation of your appeal rights.

• Felony Participation. We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.

• Foot Care. We do not cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

• Government Facility. We do not cover care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

• Medical Services. We do not cover medical services or dental services that are medical in nature, including any hospital charges or prescription drug charges.

• Medicare or Other Governmental Program. We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

• Military Service. We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

• No-Fault Automobile Insurance. We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

• Services Not Listed. We do not cover services that are not listed in this policy as being covered.

• Services Provided by a Family Member. We do not cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.

• Services Separately Billed by Hospital Employees. We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.

• Services with No Charge. We do not cover services for which no charge is normally made.

• War. We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

• Workers’ Compensation. We do not cover services if benefits for such services are provided under any state or federal Workers’ Compensation, employers’ liability or occupational disease law.
**2 - 4 LIVES**

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**5 - 9 LIVES**

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**10 - 149 LIVES**

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## PLAN OPTIONS

- **$1,500 MAX BENEFIT**
  - Multiply rates by 1.14
- **$2,000 MAX BENEFIT**
  - Multiply rates by 1.20
- **$3,000 MAX BENEFIT**
  - Multiply rates by 1.30
- **$5,000 MAX BENEFIT**
  - Multiply rates by 1.50
- **ENDO/PERIO TO CLASS B**
  - Multiply rates by 1.12
- **100% VOLUNTARY**
  - Multiply rates by 1.05
- **DENTAL REWARDS**
  - Multiply rates by 1.02
- **OPTIONAL TEETH BLEACHING**
  - Multiply rates by 1.03

- **OPTIONAL $50/$150, $25/$75, $0/$0 CALENDAR YEAR DEDUCTIBLES**
  - $50/$150 Deductible — Multiply rates by 1.05
  - $25/$75 Deductible — Multiply rates by 1.12
  - $0/$0 Deductible — Multiply rates by 1.20

- **OPTIONAL 100% FAMILY-RELATED EMPLOYEES**
  - Multiply rates by 1.15

- **FOR GROUPS WITHOUT PRIOR COVERAGE**
  - Multiply rates by 1.25

- **DECREASE FROM 90TH TO 80TH PERCENTILE OF USUAL & CUSTOMARY**
  - Multiply rates by .96

- **FOR RESTRICTED INDUSTRIES**
  - Multiply rates by 1.20

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## NEW YORK AREA (STATE) DEFINITIONS

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<td>All Other</td>
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* Restricted Industries include: Schools/Educational Groups, City, County, State and Federal Government Agencies, Interior Decorating or Design, Religious, Charitable, Political, Membership, or Fundraising Organization Administrative Staffs, Insurance Agents, Brokers, Carriers, Title Insurance Offices, Banks, Law Firms and Law Offices, Jewelry Stores and Real Estate Sales
Why Should You Choose a Network Dental Plan?

Network dental plans help reduce your out-of-pocket costs as the dentists have agreed to accept a set contracted amount for each service rendered as the basis for payment under the Spirit Dental Plan. This amount is typically significantly less than the amount which could be charged by an out-of-network dentist. These network dentists are prohibited (by contract) from charging you the difference between their typical fee and the amount negotiated with the network.

Dentists not participating in the network are not subject to the negotiated amounts and are permitted to charge any fee for services they provide. This may lead to greater out-of-pocket costs for you and your family members. The sample comparison chart below will give you an idea of how you can save money by visiting an in-network dentist for services.

**Network Savings Example**

This hypothetical example shows how receiving services from a network provider could lower your out-of-pockets costs.*

<table>
<thead>
<tr>
<th><strong>IN-NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When you receive care from a</strong></td>
<td><strong>When you receive care from a</strong></td>
</tr>
<tr>
<td><strong>participating dentist</strong></td>
<td><strong>non-participating dentist</strong></td>
</tr>
<tr>
<td>Dentist’s Usual Fee is:</td>
<td>$985.00</td>
</tr>
<tr>
<td>The Reduced Network Fee is:</td>
<td>$685.00</td>
</tr>
<tr>
<td>Your Plan Pays:</td>
<td></td>
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<tr>
<td>50% x $685 Fee</td>
<td>- $342.50</td>
</tr>
<tr>
<td>Your Out-of-Pocket Cost:</td>
<td>$342.50</td>
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<tr>
<td>Dentist’s Usual Fee is:</td>
<td>$985.00</td>
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<tr>
<td>Usual &amp; Customary (U&amp;C) Fee is:</td>
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<td>Your Plan Pays:</td>
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<tr>
<td>50% x $750 U&amp;C</td>
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<tr>
<td>Your Out-of-Pocket Cost:</td>
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*In this example, you save $267.50 ($610.00 minus $342.50) by using a participating dentist.*

* Savings from using a network provider will vary depending on factors including how often you see the dentist and costs for services rendered. The above example assumes deductible, if any, has been met.