

PrimeStar[®] Advantage Plus

Individual Dental Insurance – New York

Research shows that good dental health is essential to your overall health. Protecting your smile starts with regular visits to the dentist, and a good dental plan.

- No waiting periods on preventive and basic services
- No enrollment fees
- Ameritas dental network savings

Dental network plan options

The Ameritas Dental Network is one of the nation's largest. Network providers have agreed to charge 25-50% less than their regular rates which can lower your out-of-pocket costs.

You can visit any dentist, in- or out-of-network. And family members do not need to visit the same provider.

Find a dental provider near you at ameritas.com—**Find a Provider**. Simply enter your ZIP Code and choose the Classic Network to start your search.

PrimeStar Advantage Plus Network plans are designed for those who will visit an Ameritas Dental Network provider. The Maximum Allowable Charge (MAC) claim allowance is the maximum amount a network provider may charge. If you select a network provider, you may have lower out-of-pocket costs. If you visit an out-of-network dentist, the claim allowance is considered at the Maximum Allowable Benefit (MAB), which is equal to the lowest contracted fee in your ZIP Code. Any difference between the plan allowance and the dentist's charge will be an out-of-pocket expense for you.

All PrimeStar plans allow you to choose any dentist, but if you plan to visit an out-of-network dentist Advantage Plus offers the best benefits for you. If you visit a network provider, payments are based on the dentist's contracted fees (MAC/maximum allowable charge), which may result in lower out-of-pocket costs. If you visit an out-of-network dentist, covered benefits are paid at the 80th percentile of usual and customary (80th U&C) charges. This means we expect 8 out of 10 charges from dental providers to be within the amount we'll pay for a covered procedure. You pay the difference between what the plan pays and the dentist's actual charge.

Plan details

| | Plan benefit |
|--|-----------------------------------|
| Preventive (Type 1) <ul style="list-style-type: none"> • Exams (2 per year) • Cleanings (2 per year) • Bitewing X-rays • Fluoride (under age 16) • Sealants (under age 16) | 100% |
| Basic (Type 2) <ul style="list-style-type: none"> • Fillings • Simple Extractions | 50% day one 80% after year one |
| Major (Type 3) <ul style="list-style-type: none"> • Implants • Oral Surgery • Root Canals • Periodontics • Crowns • Bridges • Dentures • Panoramic X-rays | 50% after 9 months |
| Orthodontics <ul style="list-style-type: none"> • Straightening of teeth (under age 19) • Lifetime Maximum \$1,000 per child | 50% after year one |
| Calendar year deductible Per person for preventive, basic and major services combined, with a maximum of three deductibles per family | \$50 |
| Calendar year maximum benefit Per person for preventive, basic and major services combined | \$1,000 or \$2,000 |

Additional information

Individuals 18+ and their dependents are eligible for coverage. Coverage can begin as soon as tomorrow. Once enrolled, you will receive your full policy and ID cards within 10 days.

This document is a plan highlight only. Your actual policy will include the full legal description of your benefits. Certain plans and plan options may not be available in all areas.

Limitations and exclusions

No coverage is available under this Policy for the following:

- A. 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.
- B. 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.
- C. 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.
- D. Elimination Period.** We do not cover Dental Expenses in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. There will be no longer than a 12 month wait for benefits.
- E. 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.
- F. Felony Participation.** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.
- G. 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.
- H. 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.
- I. Medical Services.** We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.
- J. Medically Necessary.** In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Policy.
- K. 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).
- L. Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
- M. 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.
- N. Pre-Existing Conditions.** For a period of 12 months from the enrollment date, we do not Cover any conditions for which medical advice was given, treatment was recommended by or received from a Physician within six (6) months before the effective date of Your coverage. The 12-month exclusionary period may be shortened by crediting the time You were covered under creditable coverage. We will credit the time You were covered under another dental plan, if You were enrolled in the prior coverage within 63 days before enrolling in this Policy. We will not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information. There will be no longer than a 12 month wait for benefits.
- O. Services Not Listed.** We do not Cover services that are not listed in this Policy as being Covered.
- P. 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.
- Q. Services Separately Billed by Hospital Employees.** We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.
- R. Services with No Charge.** We do not Cover services for which no charge is normally made.
- S. War.** We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.
- T. 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.

PrimeStar[®] Advantage Plus

Dental Rates - New York

Use the following to find your dental rates by area and network coverage. Visit star.ameritas.com to receive a final quote. Find your area by locating the first 3 digits of your ZIP Code.

| State | ZIP Code | Area |
|----------|--------------------|------|
| New York | 063, 100-119 | 7 |
| | 120-126, 130-132 | 5 |
| | 127, 129, 136, 147 | 3 |
| | All Others | 4 |

Find your dental rate using your state, area, plan type & coverage:

| Advantage Plus Network 1000 Rates | | | |
|-----------------------------------|--------------|---------------------------------|--|
| Area | Policyholder | Policyholder plus One Dependent | Policyholder plus Two or More Dependents |
| 3 | \$33.16 | \$68.12 | \$113.70 |
| 4 | \$36.44 | \$74.86 | \$124.94 |
| 5 | \$40.08 | \$82.35 | \$137.43 |
| 7 | \$48.47 | \$99.56 | \$166.17 |

| Advantage Plus Network 2000 Rates | | | |
|-----------------------------------|--------------|---------------------------------|--|
| Area | Policyholder | Policyholder plus One Dependent | Policyholder plus Two or More Dependents |
| 3 | \$40.02 | \$81.85 | \$135.65 |
| 4 | \$43.98 | \$89.94 | \$149.07 |
| 5 | \$48.38 | \$98.93 | \$163.98 |
| 7 | \$58.49 | \$119.62 | \$198.26 |

| Advantage Plus 1000 Rates | | | |
|---------------------------|--------------|---------------------------------|--|
| Area | Policyholder | Policyholder plus One Dependent | Policyholder plus Two or More Dependents |
| 3 | \$44.73 | \$91.25 | \$150.71 |
| 4 | \$49.15 | \$100.28 | \$165.61 |
| 5 | \$54.07 | \$110.31 | \$182.17 |
| 7 | \$65.37 | \$133.37 | \$220.26 |

| Advantage Plus 2000 Rates | | | |
|---------------------------|--------------|---------------------------------|--|
| Area | Policyholder | Policyholder plus One Dependent | Policyholder plus Two or More Dependents |
| 3 | \$55.99 | \$113.79 | \$186.76 |
| 4 | \$61.53 | \$125.04 | \$205.23 |
| 5 | \$67.68 | \$137.54 | \$225.75 |
| 7 | \$81.83 | \$166.30 | \$272.96 |

The monthly premium is guaranteed for the initial 12 months of coverage. After 12 months, premiums may increase.



Ameritas Life Insurance Corp. of New York

Underwritten by Ameritas Life Insurance Corp. of New York | 1350 Broadway Suite 2201 New York, NY 10018

This highlight is not a certificate of insurance or guarantee of coverage. Plan designs may not be available in all areas and are subject to individual state regulations. Rates are subject to change at any time.

This information is provided by Ameritas Life Insurance Corp. of New York (Ameritas of New York). Individual dental and vision products 9000 NY Rev. 03-18 are issued by Ameritas of New York.

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