



# Individual & Family Dental Insurance

Pennsylvania

No Waiting Periods | Choose Your Own Dentist | Up to Three Cleanings Per Benefit Year  
Lifetime Deductible | Up to \$5,000 Maximum Benefit | Implant Coverage










For more information, contact:

# Spirit Preventive Plus PPO

The Spirit Preventive Plus PPO plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own Ameritas Dental network provider and a plan that best fits the needs for you and your family. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25–50% below the average for your area. Visit [ameritas.com](https://www.ameritas.com) and select [Find a Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Preventive Plus PPO |** This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 50% for Basic, and 20% for Major. Your benefit year maximum amount starts in year one at \$750, increases to \$1,000 in year two and subsequent years remains at \$1,000.

	Preventive	Basic	Major	Max Benefit
Year One				\$750
Year Two				\$1,000
Year Three				\$1,000

## Preventive | Type One

- | Two exams per benefit year
- | Two cleanings per benefit year
- | One series of bitewing X-rays per benefit year

## Basic | Type Two

- | Space maintainers
- | Sealants under age 16
- | One topical fluoride per benefit year under age 16

## Major | Type Three













- | Basic fillings
- | Simple extractions
- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Restoration services; inlays, onlays and crowns
- | Prosthetic services; bridges and dentures

# Spirit Core PPO

The Spirit Core PPO plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own Ameritas Classic network provider and a plan that best fits the needs for you and your family. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25–50% below the average for your area. Visit [ameritas.com](https://www.ameritas.com) and select [Find a Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Core PPO |** This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 50% for Basic, 25% for Major and 10% for Ortho Services in year one. In year two, Basic Services increase to 65%, 50% for Major and 25% for Ortho Services. In year three, Basic Services increase to 80% and Ortho Services increase to 50%. Your calendar year maximum benefit amount is \$1,200 each year.

	Preventive	Basic	Major	Ortho	Max Benefit
Year One	 100%	 50%	 25%	 10%	\$1,200
Year Two	 100%	 65%	 50%	 25%	\$1,200
Year Three	 100%	 80%	 50%	 50%	\$1,200

## Preventive | Type One

- | Two exams per benefit year
- | Three cleanings per benefit year

## Basic | Type Two

- | Space maintainers
- | One series of bitewing X-rays per year
- | Sealants under age 16
- | One topical fluoride per year under age 16

## Major | Type Three

- | Simple extractions
- | Implants
- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Restoration services; inlays, onlays and crowns
- | Prosthetic services; bridges and dentures
- | Basic fillings

## Orthodontia

- | Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- | Coverage is 10% in benefit year one, 25% in benefit year two and 50% in benefit year three with a \$1,200 lifetime maximum per child

# Spirit Senior Preferred PPO













The Spirit Senior Preferred PPO plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own Ameritas Dental network provider and a plan that best fits the needs for you and your family. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit [ameritas.com](https://www.ameritas.com) and select [Find a Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Senior Preferred PPO |** This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 65% for Basic and 20% for Major Services in year one. In year two and subsequent years, Basic Services increase to 100% and 50% for Major Services. Your benefit year maximum amount is \$1,500 in year one and increases to \$3,000 in year two and thereafter.

## Hearing Benefit

Benefits are available for hearing exams and hearing aids. Each benefit period you receive up to \$75 for eligible hearing exams. The plan pays 50% of the hearing aid cost up to the maximum benefit. The maximum benefit is \$200 year one, \$300 year two, and \$400 year three. Five years after using your hearing aid coverage, you are re-eligible for the benefit at the top level. A reduced benefit is available after three years if your current hearing aids can no longer correct your hearing. All benefits assume no break in coverage.

	Preventive	Basic	Major	Max Benefit		Hearing Aids	Max Benefit
Year One				\$1,500	Year One		\$200
Year Two				\$3,000	Year Two		\$300
Year Three				\$3,000	Year Three		\$400

### Preventive | Type One

- | Two exams per benefit year
- | Three cleanings per benefit year

### Basic | Type Two

- | One series of bitewing X-rays per benefit year

### Major | Type Three

- | Basic fillings
- | Simple extractions
- | Implants
- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Restoration services; inlays, onlays and crowns
- | Prosthetic services; bridges and dentures















# Spirit Pinnacle PPO

The Spirit Pinnacle PPO plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own Ameritas Dental Network provider and a plan that best fits the needs for you and your family. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit [ameritas.com](https://www.ameritas.com) and select [Find a Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Pinnacle PPO** | This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 50% for Basic, 25% for Major and 10% for Ortho Services in year one. In year two, Basic Services increase to 60%, 30% for Major and 25% for Ortho Services. In year three, Basic Services increase to 80%, 60% for Major and Ortho Services increase to 50%. Additionally, your benefit year maximum amount will automatically increase in your second and third years of coverage. Your maximum benefit amount starts in year one at \$1,200, increases to \$2,500 in year two and in year three and subsequent years remains at \$5,000.

	Preventive	Basic	Major	Ortho	Max Benefit
Year One	 100%	 50%	 25%	 10%	\$1,200
Year Two	 100%	 60%	 30%	 25%	\$2,500
Year Three	 100%	 80%	 60%	 50%	\$5,000

## Preventive | Type One

- | Two exams per benefit year
- | Three cleanings per benefit year

## Basic | Type Two

- | Basic fillings
- | Space maintainers
- | One series of bitewing X-rays per year
- | Sealants under age 16
- | One topical fluoride per year under age 16

## Major | Type Three

- | Simple extractions
- | Implants
- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Restoration services; inlays, onlays and crowns
- | Prosthetic services; bridges and dentures

## Orthodontia

- | Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- | Coverage is 10% in benefit year one, 25% in benefit year two and 50% in benefit year three with a \$1,200 lifetime maximum per child










# Spirit Flex

The Spirit Flex plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. This Spirit plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as the providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25–50% below the average for your area. Visit [ameritas.com](http://ameritas.com) and select [Find a Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the dentists have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges\*.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Flex |** This policy pays for dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the \$100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are : 100% for Preventive Services, 50% for Basic and 15% for Major. In year two, Basic services increase to 70% and 30% for Major Services. In year three, Basic Services increase to 80% and 40% for Major Services. Your benefit year maximum amount starts in year one at \$1,000 and increases to \$2,000 year two and thereafter.

	Preventive	Basic	Major	Max Benefit
Year One				\$1,000
Year Two				\$2,000
Year Three				\$2,000

## Preventive | Type One

- | Two exams per benefit year
- | Two cleanings per benefit year

## Basic | Type Two

- | One series bitewing X-rays per year
- | One topical fluoride per year under age 16
- | Sealants under age 16
- | Space maintainers

## Major | Type Three

- | Basic fillings
- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Simple extractions
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Prosthetic services; bridges and dentures
- | Restoration services; bridges and dentures

\*Usual and Customary – means the usual and customary charges for the area where such expenses are incurred.










# Spirit Flex Plus

The Spirit Flex Plus plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. This Spirit plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as the providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25–50% below the average for your area. Visit [ameritas.com](http://ameritas.com) and select [Find a Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the dentists have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges\*.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Flex Plus |** This policy pays for dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the \$100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are : 100% for Preventive Services, 50% for Basic and 20% for Major. In year two, Basic services increase to 70% and 40% for Major Services. In year three, Basic Services increase to 80% and 50% for Major Services. Your benefit year maximum amount starts in year one at \$1,500 and increases to \$2,500 year two and thereafter.

	Preventive	Basic	Major	Max Benefit
Year One	 100%	 50%	 20%	\$1,500
Year Two	 100%	 70%	 40%	\$2,500
Year Three	 100%	 80%	 50%	\$2,500

## Preventive | Type One

- | Two exams per benefit year
- | Three cleanings per benefit year

## Basic | Type Two

- | Basic fillings
- | One series bitewing X-rays per year
- | One topical fluoride per year under age 16
- | Sealants under age 16
- | Space maintainers

## Major | Type Three

- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Simple extractions
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Prosthetic services; bridges and dentures
- | Restoration services; bridges and dentures

\*Usual and Customary - means the usual and customary charges for the area where such expenses are incurred.










# Spirit Flex (Forest & Potter Counties)

The Spirit Flex plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own dentist, and a plan that best fits the needs for you and your family.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Flex |** This policy pays for covered dental expenses based upon a percentage of the Usual and Customary (U&C)\* fees for covered expenses after the \$100 lifetime deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic and 15% for Major Services. In year two, Basic Services increase to 70% and 30% for Major Services. In year three Basic Services increase to 80% and 40% for Major Services.

Your benefit year maximum is \$1,000 in year one and increases to \$2,000 in year two and each subsequent year.

	Preventive	Basic	Major	Max Benefit
Year One				\$1,000
Year Two				\$2,000
Year Three				\$2,000

## Preventive | Type One

- | Two exams per benefit year
- | Two cleanings per benefit year

## Basic | Type Two

- | One series bitewing X-rays per year
- | One topical fluoride per year under age 16
- | Sealants under age 16
- | Space maintainers

## Major | Type Three

- | Basic fillings
- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Simple extractions
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Prosthetic services; bridges and dentures
- | Restoration services; bridges and dentures

\*Usual and Customary - means the usual and customary charges for the area where such expenses are incurred.












# Spirit Flex Plus (Forest & Potter Counties)

The Spirit Flex Plus plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own dentist, and a plan that best fits the needs for you and your family.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

**Spirit Flex Plus |** This policy pays for covered dental expenses based upon a percentage of the Usual and Customary (U&C)\* fees for covered expenses after the \$100 lifetime deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic and 20% for Major Services. In year two, Basic Services increase to 70% and 40% for Major Services. In year three Basic Services increase to 80% and 50% for Major Services.

Your benefit year maximum is \$1,500 in year one and increases to \$2,500 in year two and each subsequent year.

	Preventive	Basic	Major	Max Benefit
Year One				\$1,500
Year Two				\$2,500
Year Three				\$2,500

## Preventive | Type One

- | Two exams per benefit year
- | Three cleanings per benefit year

## Basic | Type Two

- | Basic fillings
- | One series bitewing X-rays per year
- | One topical fluoride per year under age 16
- | Sealants under age 16
- | Space maintainers

## Major | Type Three

- | One diagnostic X-ray, full or panoramic in any 3 year period
- | Simple extractions
- | Oral surgery
- | Endodontic treatment
- | Periodontic services
- | Prosthetic services; bridges and dentures
- | Restoration services; bridges and dentures

\*Usual and Customary - means the usual and customary charges for the area where such expenses are incurred.

# Rates and Area Definitions

## Rates for: PA

Spirit Preventive Plus PPO		
	AREA 1	AREA 3
Applicant	\$15.08	\$18.30
Applicant + 1	\$30.17	\$36.60
Applicant + Family	\$48.26	\$58.56

Spirit Core PPO		
	AREA 1	AREA 3
Applicant	\$25.88	\$31.40
Applicant + 1	\$53.15	\$64.48
Applicant + Family	\$88.69	\$107.61

Spirit Senior Preferred PPO		
	AREA 1	AREA 3
Applicant	\$32.66	\$39.30
Applicant + 1	\$65.00	\$78.29
Applicant + Family	\$103.14	\$124.41

Spirit Pinnacle PPO		
	AREA 1	AREA 3
Applicant	\$34.82	\$42.25
Applicant + 1	\$71.04	\$86.20
Applicant + Family	\$117.32	\$142.35

Flex		
	AREA 1	AREA 3
Applicant	\$29.49	\$35.78
Applicant + 1	\$58.98	\$71.56
Applicant + Family	\$94.37	\$114.50

Flex Plus		
	AREA 1	AREA 3
Applicant	\$41.03	\$49.79
Applicant + 1	\$82.07	\$99.57
Applicant + Family	\$131.30	\$159.31

## Area Definitions for: PA

### PENNSYLVANIA

183, 189-194	3
All Others	1

The Spirit PPO plans are not available in Forest and Potter counties.

### Flex – (Forest & Potter Counties)

	AREA 1	AREA 3
Applicant	\$33.35	\$40.46
Applicant + 1	\$66.69	\$80.92
Applicant + Family	\$106.70	\$129.47

### Flex Plus – (Forest & Potter Counties)

	AREA 1	AREA 3
Applicant	\$46.40	\$56.29
Applicant + 1	\$92.79	\$112.59
Applicant + Family	\$148.46	\$180.13



12 MONTH RATE GUARANTEE | Rates illustrated are guaranteed for initial 12 months and may change annually thereafter.

# Why should you choose the Spirit PPO Plan?

In addition to paying lower monthly premiums, the Spirit PPO plan can help reduce your out-of-pocket costs. Network providers have contracted fees (MAC/maximum allowable charge) 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 providers are prohibited (by contract with the network) from charging you the difference between their typical fee and the amount contracted with the network.

Dentists not participating in the network are not subject to the contracted 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 selecting one of Spirit Dental's network plans and visiting an in-network provider for services. It compares the charges between visiting in-network and out-of-network dentists.

## NETWORK SAVINGS EXAMPLE

### Your Dentist says you need a Crown, which is a Major Service...

Network Fee **\$685.00** | Usual & Customary Fee **\$750.00** | Dentist's Usual Fee **\$985.00**

#### Spirit PPO

When you receive care from a participating network dentist

Dentist's Usual Fee	<b>\$985.00</b>
Network Fee	<b>\$685.00</b>
<b>Your Plan Pays</b>	
50% x \$685 Network Fee	<b>– \$342.50</b>
Your Out-of-Pocket Cost	<b>\$342.50</b>

#### Spirit Flex

When you receive care from an out-of-network dentist

Dentist's Usual Fee	<b>\$985.00</b>
UCR Reduced Fee	<b>\$750.00</b>
<b>Your Plan Pays</b>	
50% x \$750 UCR Fee	<b>– \$375.00</b>
Your Out-of-Pocket Cost	<b>\$610.00</b>

**In this example,**  
**you save \$267.50 (\$610.00 minus \$342.50) by using a participating network provider.**

Savings from enrolling in the Spirit Network plan depend on various factors, including how often participants visit the dentist and the cost for services rendered.

\*Please note: These examples assume that your deductible has been met.

**ELIGIBILITY |** The insurance coverage is available in states where it's approved to anyone age 18 and older who does not have coverage through another Ameritas dental plan. You can request coverage for your dependents; dependent eligibility varies based on state law.

**DEDUCTIBLE AMOUNT |** The deductible is shown in the coverage schedule. The deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

**PREDETERMINATION OF BENEFITS |** It is recommended that a treatment plan/course of treatment be submitted when the total cost of eligible expenses for any insured is expected to exceed the amount shown on the coverage schedule. This should be submitted to us before the work is started. If actual services submitted do not agree with the treatment plan, or if a treatment plan is not sent in, we will base our payment on treatment consistent with reasonable and customary charges. Predetermination of benefits is not a guarantee of what we will pay. The estimated benefit payment is based on your current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or this policy may alter final payment.

**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 |** When you enroll online your coverage can start as soon as the next day. Do not cancel any other insurance or assume you are insured under this plan until you receive written confirmation. Please note your enrollment may take 4 business days to be processed and accessible through any network providers.

**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 provider performing dental services within the scope of their license; or a licensed dental hygienist acting under the supervision and direction of a dentist.

**MISSING TOOTH |** If an insured has lost one or more teeth prior to this policy effective date, we will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under this policy. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits.

\*Plan includes a one-time non-refundable enrollment fee of \$25. This charge will be made at the time of purchase and may appear as a separate transaction from your dental insurance.

## Limitations & Exclusions

### Dental

Covered expenses will not include and benefits will not be payable for expenses incurred:

- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- to replace any crowns, inlays, onlays, veneers, complete or partial dentures within five years of the date of the last placement of these items. But if a replacement is required because of an accidental bodily injury sustained while the insured person is covered under this contract, it will be a covered expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But 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 policy.
- for any procedure begun after the insured person's insurance under the policy terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the insured's insurance under the policy terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion; or
  - splint or replace tooth structure lost as a result of abrasion or attrition.
- for any procedure which is not shown on the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures in the policy.)
- for orthodontic treatment under the following provisions:
  - for treatment begun on or after the insured's 19th birthday;
  - for treatment begun before the insured became covered under this section;
- for which the insured person is entitled to benefits under any workmen's 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 (except in CA & KY).
- for charges for which the insured person is not liable 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.
- 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.

### Orthodontia

Covered Expenses will not include and no benefits will be payable for expenses incurred:

- for a Program begun on or after the Insured's 19th birthday.
- for a Program which uses a material other than metal brackets for treatment. The benefit will be considered as though metal brackets were applied.
- for a Program begun before the Insured became covered under this section,
- in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
- for a Program more than once in a lifetime.
- if the Insured's insurance under this section terminates.
- for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for 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 the Insured is not legally required to pay or would not have been made had no insurance been in force.
- for services not required for necessary care and treatment or not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- to fix or repair broken or damaged orthodontic appliances.
- to replace lost, missing or stolen orthodontic appliances.
- for expenses incurred as a result of the Insured not being compliant with the Treatment Program.
- for services to alter vertical dimension and/or restore or maintain the occlusion due to, but not limited to the following: equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

### Hearing

Covered Expenses will not include and no benefits will be payable for expenses incurred:

- examinations performed before the Insured was covered under this section.
- any examination performed after the Insured's coverage under this section ceases.
- any hearing examination required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.
- medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.
- which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.
- charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
- any procedure not shown in the Schedule of Hearing Care Services.
- any treatment which is for cosmetic purposes.
- assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.
- charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.
- services which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.
- charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.
- because of war or any act of war, declared or not.

\*Plan includes a one-time non-refundable enrollment fee of \$25. This charge will be made at the time of purchase and may appear as a separate transaction from your dental insurance.





# Optional Vision Coverage

## Indemnity Vision Rider

Monthly Premium	
Applicant	\$7.00
Applicant + 1	\$14.00
Applicant + Family	\$20.00

**SERVICES OFFERED** | \$50 eyeglass lenses or frames deductible per person per lifetime. A maximum of 3 individual deductibles per family will apply.

**EXAMINATION** \_\_\_\_\_ **\$50.00**  
Once every 12 months with \$10 deductible

A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the member

**FRAMES** \_\_\_\_\_ **\$65.00**  
Once every 24 months

**LENSES**  
Once Every 12 Months

Single	_____	<b>\$40.00</b>
Bifocal	_____	<b>\$60.00</b>
Trifocal	_____	<b>\$70.00</b>
No line bifocal or progressive power	_____	<b>\$100.00</b>
Lenticular	_____	<b>\$100.00</b>

**CONTACT LENSES** \_\_\_\_\_ **\$100.00**  
In lieu of lenses and frames

### Limitations and Exclusions

What is not covered? Covered expenses will not include and no benefits will be payable for:

- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- Examinations performed or frames or lenses ordered before the Insured was covered under this section.
- Any examination performed or frame or lens ordered after the Insured's coverage under this section ceases, subject to Extension of Benefits.
- Sub-normal vision aids; orthoptic or vision 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 Services.
- 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 twelve months that a person is insured under this section, when the person is a Late Entrant, as defined.

**NOTICE:** Underwritten by Ameritas Life Insurance Corp. | 5900 O Street Lincoln, NE 68510 This 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. This piece is not for use in New Mexico. This information is provided by Ameritas Life Insurance Corp. (Ameritas Life). Dental, vision and hearing care products (9000 Rev. 03-16 for Group and 9000 Rev. 10-22 for Individual, dates may vary by state) are issued by Ameritas Life. The Dental and Vision Networks are not available in RI. In Texas, our dental network and plans are referred to as the Ameritas Dental Network. Ameritas, the bison design and "fulfilling life" are service marks or registered service marks of Ameritas Life, affiliate Ameritas Holding Company or Ameritas Mutual Holding Company. © 2023 Ameritas Mutual Holding Company.



## Frequently Asked Questions

### for Members of Spirit Dental and Vision Plans

#### Where can I locate my member identification (ID) number?

The number will be located on the front of your ID card.

#### Who should I contact with questions?

- | For dental questions contact Ameritas at 866-619-6095.
- | For EyeMed Vision Care contact EyeMed at 866-289-0614 to speak to a customer service representative.

#### How should a claim be submitted?

- | You or your provider should submit an ADA dental claim form or an itemized billing statement which provides the following information:
  - | Member's name, address and member ID number
  - | Date of service
  - | Current ADA procedure code(s)
  - | Procedure fee(s)
  - | Provider name, address and tax ID number

The claims mailing address is located on the back of your ID card.

#### Can I see the dentist I have now?

- | Yes, you are always free to visit the dentist of your choice.
- | Visit [ameritas.com](https://www.ameritas.com) and select [Find a Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

#### What can you tell me about Ameritas, the insurance company underwriting this plan?

- | Ameritas Life Insurance Corp. offers a wide range of insurance and financial products and services to individuals, families and businesses. Ameritas has been offering dental insurance since 1959 and vision insurance since 1984. Claims service associates have earned BenchmarkPortal's Center of Excellence award. since 2006

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#### About Spirit Dental & Vision | Spirit Dental & Vision is available exclusively through Direct Benefits, Inc.

Direct Benefits, Inc. is a managing general agency that provides one-stop employee benefits brokerage to over 15,000 agents who provide coverage to over 150,000 Americans.

We're in it for the little people of America. Our mission is to provide individuals and small businesses with the same or better quality insurance products as Fortune 500 employers. By partnering with financially strong insurance carriers like Ameritas we are able to create exclusive niche products like Spirit Dental & Vision.





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