Spirit DENTAL
New York

Individual & Family Dental Insurance

For more information, contact:

Agent Name
Phone
Email

(S12040 rev. 4.2020)

No Waiting Periods
Choose Your Own Dentist
Three Cleanings Per Calendar Year
Lifetime Deductible
Up to $2,000 Calendar Maximum
Implant Coverage

Ameritas
fulfilling life.
Ameritas Life Insurance Corp. of New York

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

Spirit DENTAL

Spirit Network 2000

The Spirit Network 2000 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** and select **Find a 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 Network 2000

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 Major Services in year one. In year two, Basic Services increase to 80%, and Ortho Services are covered at 50%. Your annual policy maximum benefit amount is $2,000 with a maximum of $1,000 on Major Services.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	50%	50%	0%	$2,000
Year 2	100%	80%	50%	50%	$2,000

Preventive (Type 1)

- Two exams per calendar year
- Three cleanings per calendar year

Basic (Type 2)

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

Major (Type 3)

- 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
- Coverage for Major Services on an annual basis cannot exceed 50% of the total calendar year maximum

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage begins in year two at 50% with a $1,200 lifetime maximum per child

Spirit DENTAL

The Spirit Network 1200 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** and select **Find a 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 Network 1200

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 Major Services in year one. In year two, Basic Services increase to 80%, and Ortho Services are covered at 50%. Your annual policy maximum benefit amount is $1,200 with a maximum of $600 on Major Services.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	50%	50%	0%	$1,200
Year 2	100%	80%	50%	50%	$1,200

Preventive (Type 1)

- Two exams per calendar year
- Three cleanings per calendar year

Basic (Type 2)

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

Major (Type 3)

- 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
- Coverage for Major Services on an annual basis cannot exceed 50% of the total calendar year maximum

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage begins in year two at 50% with a $1,200 lifetime maximum per child

Spirit Network - Rates & Area Definitions

New York

Spirit Network 1200				
	AREA 3	AREA 4	AREA 5	AREA 7
Applicant	$37.48	$41.19	$45.31	$54.78
Applicant + 1	$77.12	$84.75	$93.23	$112.72
Applicant + Family	$129.05	$141.81	$155.99	$188.61

Spirit Network 2000				
	AREA 3	AREA 4	AREA 5	AREA 7
Applicant	$43.55	$47.86	$52.65	$63.65
Applicant + 1	$89.26	$98.09	$107.90	$130.46
Applicant + Family	$148.47	$163.15	$179.47	$216.99

Area (State) Definitions	
063, 100-119	7
120-126, 130-132	5
127, 129, 136, 147	3
All Others	4

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

Spirit DENTAL & VISION

Why should you choose the Spirit Network Plan?

In addition to paying lower monthly premiums, the Spirit Network 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
– Dentist's Usual Fee:	$985.00

When you receive care from a participating network dentist	
Dentist's Usual Fee:	$985.00
Network Fee:	$685.00
Your Plan Pays:	
50% x $685 Network Fee:	– $342.50
Your Out-of-Pocket Cost:	$342.50

When you receive care from an out-of-network dentist.	
Dentist's Usual Fee:	$985.00
Network Fee:	$685.00
Your Plan Pays:	
50% x $685 Network Fee:	– $342.50
Your Out-of-Pocket Cost:	$642.50

In this example, you save $300.00 ($642.50 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.

General Information

ELIGIBILITY: Who is eligible to purchase the plan? 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.

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 the surgery is performed; for all other services - on the date the service is performed.

ALTERNATE BENEFIT: If we determine that a less expensive procedure, service, treatment plan/course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice, then the maximum we will allow will be the charge for the less expensive treatment.

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 vision provider referrals when traveling outside the U.S. through AXA Assistance.

WORLDWIDE SUPPORT

AXA Assistance USA is part of a global organiztion with offices in more than 30 countries, where AXA Assistance professionals answer calls 24 hours a day to assist members traveling abroad.

Immediately after a call comes in, an assistance coordinator assesses the situation, provides credible provider referrals and can even help with making the appointment.

Dental or vision provider referral assistance services are independently offered and administered by AXA Assistance USA, Inc. (AXA). Providers referred by AXA are not members of the Ameritas network. Ameritas does not guarantee or make any representation as to the quality of the services provided by AXA or any provider referred by AXA. Referral to an AXA provider is not a guarantee of benefits, and all policy revisions and limitations would apply.

**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.*

Dental Exclusions & Limitations

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 farepaying 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
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).

Dental Exclusions & Limitations (continued)

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.

Frequently Asked Questions for Members of Spirit Dental 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.

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** and select **Find a Provider** to find a provider near you. Simply enter your ZIP Code and select the Classic (PPO) Network to start your search.

About Spirit Dental

Spirit Dental is available exclusively through Direct Benefits, Inc.

Direct Benefits, Inc. is a managing general agency that provides one-stop employee benefits brokerage to over 13,000 agents who provide coverage to over 125,000 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.

DirectBenefits

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8 Reasons

for Dental Insurance

1. Protect your smile. Dental insurance exists just like any other insurance. It helps you protect your assets and manage your risks. If something were to happen, insurance is there to help control the costs.

2. Dental health is linked to overall health. That's kind of a big deal! Many systemic diseases such as diabetes, leukemia, cancer, heart disease, and kidney disease have oral characteristics that can be detected by the dentist with just an oral exam.

3. You'll be more likely to go to the dentist when you have insurance. This alone may help motivate you to take control of you and your family's dental health!

4. It helps you keep your teeth! Gum disease and tooth decay lead to tooth loss. These issues are most effectively treated by a dental professional.

5. Enjoy a little peace of mind. Let's say you or your child has a dental emergency like a chipped tooth, tooth pain or a lost tooth. You may be less worried about the financial burden of fixing the problem knowing you have dental insurance.

6. Minimize your dental out-of-pocket expenses. Bridges, crowns, implants, root canals, and other major issues are spendy. Finding a plan that will help minimize the costs can be very beneficial to your wallet!

7. A boost of confidence! A healthier, whiter smile and better breath may help you and your loved ones feel a little more confident.

8. YOU AND YOUR FAMILY ARE WORTH IT!

Spirit DENTAL

Spirit DENTAL

Reach out to review product details, get a free quote & enroll today:

Agent Name
Phone
Email

DirectBenefits

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