



75% PARTICIPATION AND VOLUNTARY GROUP DENTAL INSURANCE PLAN

Underwritten by:



Ameritas Life Insurance Corp.
5900 O Street
Lincoln NE 68510

Distributed by:



Plan Coordinator:

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Choose Your Own Dentist

No Waiting Periods

3 Cleanings Per Year

For Employers 2-149

\$1,000, \$1,500, \$2,000, \$3,000 or \$5,000
Annual Maximums



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 111,500 providers at more than 428,000 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 ameritas-dental.prismisp.com.

Option 1 - Ameritas Classic Network

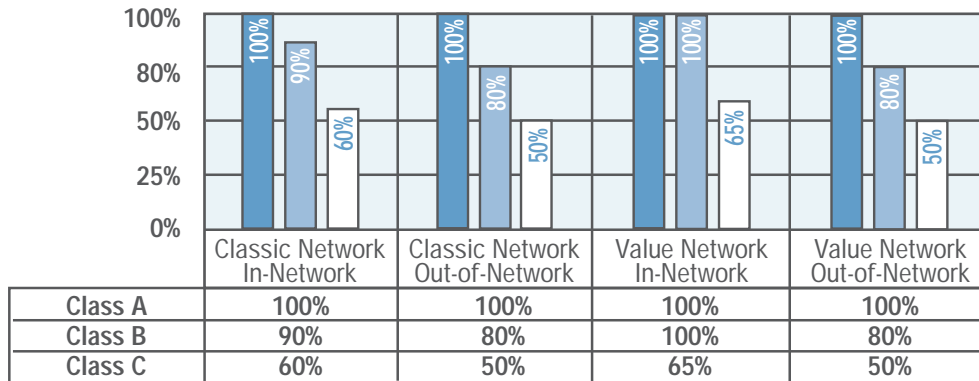
This option includes coverage for both in and out-of-network services, however you will see your greatest savings when using one of the 111,500 providers contracted with the Ameritas Classic Network. In-network benefits include 100% for Preventive Services, 90% for Basic Services and 60% for Major Services. 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.



Class A - Preventive Services

- Two exams per year
- Three cleanings per year
- One topical fluoride per year *to age 16*
- One set of bitewing x-rays per year

Class B - Basic Services

- Fillings (amalgam and composite)
- Space maintainers
- Sealants (*to age 16*)

Class C - Major Services

- One diagnostic x-ray, full or panoramic in any 5 year period
- Oral surgery
- Simple extractions
- Endodontic treatment
- Periodontic services
- Crowns, inlays and onlays
- Bridges and dentures
- Implants (implant maximum on \$3,000 and \$5,000 annual limit plans is \$2,500 annually)

\$100 lifetime deductible

Applies to preventive, basic or 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.

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 \$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 Orthodontic Services are available for an additional premium. Orthodontic care for the proper alignment of teeth is provided to children and adults. Coverage is 10% reimbursement for the first year, 25% reimbursement for the second year and 50% reimbursement for the third year, with a lifetime maximum of \$1,500 per person. Orthodontic Services are not available in CT, IL, NJ and NY.

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.

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.

Underwritten by Ameritas Life Insurance Corp. Group dental, vision and hearing care products (9000 Rev. 03-08, dates may vary by state) are issued by Ameritas Life. Some plan designs are not available in all areas. Ameritas, the bison design, "fulfilling life" and product names designated with SM or ® are service marks or registered service marks of Ameritas Life, affiliate Ameritas Holding Company or Ameritas Mutual Holding Company. All other brands are property of their respective owners.

GENERAL INFORMATION

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.

BENEFIT YEAR MAXIMUM: Benefit year maximums are shown on the Coverage Schedule and are calculated for each certificate (person covered) yearly from certificate effective date.

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.

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

- For any procedure except exams, cleaning and fluoride applications for the first 12 months when an employee or dependent becomes classified as a late entrant. An employee or dependent who does not enroll within 31 days from the date the person qualifies for the insurance or who elects to become covered again after canceling a premium contribution agreement will be classified as a late entrant.
- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic.
- To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within eight years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the person is covered, it will be a Covered Expense.
- For any procedure begun before the plan member was covered under the dental expense benefit.
- For any procedure begun after the member's insurance under the dental expense benefit terminates; or for any prosthetic dental appliance installed or delivered more than 90 days after the member's insurance under the dental expense benefit terminates.
- To replace lost or stolen appliances.
- For appliances, restorations, or procedures to: alter vertical dimension; restore or maintain occlusion; splint or replace tooth structure lost because of abrasion or attrition.
- For any procedure not shown on the Table of Dental Procedures.
- For which the plan member is entitled to benefits under any workers' compensation or similar law, or charges or 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 or wage of profit.
- For charges for which the plan member is not liable or which would not have been made had insurance been in force.
- For services that are 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.
- Applies to non-takeover business: in the first 12 months that a plan member is covered 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 plan member is covered under the dental expense benefit.

The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

- For an orthodontic program which was begun on or after the member's 19th birthday, if orthodontia was elected.
- Before the plan member has been covered under the orthodontic expenses benefits for at least 12 consecutive months, however, this is waived for initials who were previously covered by the prior plan's dental and orthodontia plan and have at least 5 enrolled lives on the initial effective date otherwise a 12 month waiting period applies.
- In any quarter of a Program if the member was not covered under the orthodontic expense benefits for entire quarter
- After the member's insurance under the orthodontic expense benefits terminate.

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.



2 - 4 LIVES								
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	29.23	30.51	32.12	33.73	35.33	39.19	43.04	47.54
Employee + 1	54.86	57.28	60.29	63.30	66.32	73.55	80.79	89.23
Family	89.39	93.32	98.23	103.14	108.05	119.84	131.63	145.38
5 - 9 LIVES								
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	25.42	26.53	27.93	29.33	30.72	34.07	37.43	41.34
Employee + 1	47.71	49.81	52.43	55.05	57.67	63.96	70.26	77.60
Family	77.73	81.15	85.42	89.69	93.96	104.21	114.46	126.42
10 - 149 LIVES								
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee Only	24.14	25.20	26.53	27.86	29.18	32.37	35.55	39.26
Employee + 1	45.33	47.32	49.81	52.30	54.79	60.77	66.75	73.72
Family	73.85	77.09	81.15	85.21	89.27	99.00	108.74	120.10

Rates effective 11/01/2016

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 \$50/\$150 CALENDAR YEAR DEDUCTIBLE

Multiply rates by 1.05

OPTIONAL \$25/\$75 CALENDAR YEAR DEDUCTIBLE

Multiply rates by 1.12

OPTIONAL \$0/\$0 CALENDAR YEAR DEDUCTIBLE

Multiply rates by 1.20

OPTIONAL TEETH BLEACHING

Multiply rates by 1.03

OPTIONAL 100% FAMILY-RELATED EMPLOYEES

Multiply rates by 1.15

FOR GROUPS WITHOUT PRIOR COVERAGE

Multiply rates by 1.25

ORTHODONTIA RATES

(\$1500 lifetime maximum for adults and children)

Orthodontia can be added to any of the above plans by adding these premiums to the selected rate above. Orthodontia is covered at 10% for the first year, 25% for the second year and 50% reimbursement for the third year. Lifetime maximum for orthodontia coverage is \$1,500 per person.

	Employee	Employee +1	Family
2-4 lives	\$0.94	\$9.73	\$16.13
5-9 lives	\$0.89	\$9.20	\$15.26
10-149 lives	\$0.84	\$ 8.71	\$14.46

NOTE: Rates do not include a \$15 monthly administrative fee. Fee will be waived if group pays by ACH or purchases a vision plan along with the dental plan.

AREA (STATE) DEFINITIONS

Alabama		Dist Columbia		Kansas		Minnesota		New Mexico		South Carolina	
358	2	200, 202-205	4	662	4	555	6	882	4	295, 298	1
All Other	1	569	5	660	3	550-551, 556,	3	873-875, 877	2	292	3
Alaska		Florida		664-666, 669-679	2	559-560, 562-563,	3	All Other	1	All Other	2
996	8	323-326, 344	1	All Other	1	565-567	3	North Carolina	3	South Dakota	
All Other	7	320-321, 335, 337-338	2	Kentucky	2	553-554, 558, 561	4	278-279, 283	2	570, 573, 575	2
Arizona		322, 327-328, 336,	3	400-404, 407-418,	1	All Other	5	271-273, 277	4	571	6
850-852, 860, 863, 865	2	346-347, 349	3	420-427	1	Missouri	1	274, 288	5	577	4
All Other	1	329, 339, 341-342	4	All Other	2	635-636, 638-639,	2	All Other	3	All Other	3
Arkansas		330, 333-334	5	Maine	5	644-646, 653-655	1	North Dakota	1	Tennessee	
All Areas	1	331-332	6	047	2	631, 651-652	3	583-584	3	370, 372, 374	2
California		Hawaii		043, 046, 049	3	640-641	4	581	5	All Other	1
936	5	All Areas	6	044-045	4	All Other	2	All Other	2	Utah	
935, 937-938, 952,	6	Idaho		All Other	5	Nebraska		Ohio		840-841, 844-845, 847	3
955-956, 959-960	6	6 832, 834	2	Maryland	2	680, 683, 686, 692-693	1	437, 439, 444-445,	1	All Other	5
902-906, 908, 910-912,	7	All Other	3	216-217	5	685, 691	3	453-455, 457	3	Vermont	
917-928, 932-934, 939,	7	Illinois		219	6	All Other	6	452, 459	2	All Areas	3
942, 945-946, 949, 953,	7	609, 619, 622,	1	207	6	Nevada		All Other	2	Virginia	
957-958, 961	7	624, 628-629	1	206, 211	2	893	3	Oklahoma	3	243	1
900-901, 907, 913-916,	8	612-615, 620, 623,	2	208, 218	2	890-891	4	All Areas	1	224-225, 242	2
930-931, 940-941,	8	625-626	2	All Others	4	889	4	Oregon	5	220-221	5
943-944, 947-948,	8	604, 610, 616-618	3	Massachusetts	3	894	6	976, 978-979	6	226-228, 233-237	4
950-951, 954	8	600-602, 605, 611, 627	4	012-014, 016, 023	5	All Other	7	977	7	201, 222-223	6
Colorado		608	5	010-011, 015, 020-022,	6	New Jersey		All Other	4	All Other	3
810, 812-813	2	All Other	4	024, 027, 055	6	081, 083	3	Pennsylvania*	3	West Virginia	
803	6	Indiana		All Other	7	073, 080	7	168-176, 180-185,	4	253-254, 266	2
801, 804, 807, 815	4	4 461, 469-472,	2	Michigan	2	075, 082, 084, 087, 089	5	192, 196	5	255-257, 265	3
816	7	474, 478-479	2	485	2	070-072, 077-078,	6	193, 194	3	All Others	1
All Other	3	All Other	3	498	5	085-086, 088	6	189	4	Wisconsin	
Connecticut		Iowa		480-483, 489, 496-497	4	All Other	7	191	5	532, 535, 538-540,	
060, 062-067	6	515	1	All Other	3	New Hampshire		190	6	543, 545, 548	4
All Other	7	500-502, 508	2			032, 035-036	5	All Other	1	All Other	5
Delaware		503-507, 509, 511,	3			All Other	6	Wyoming		All Areas	3
198-199	4	513, 516, 521, 528	3								
197	5	All Other	4								

* The Spirit Group Dental plan is not available in PA counties of: Cameron, Forest, Fulton, Mifflin and Potter. See MT/RI/PA Restricted County brochure for plan options if group is domiciled in one of these PA counties.)



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.*

Your Dentist says you need a Crown, a Type C service –

- Network Fee: \$685.00
- Usual & Customary Fee: \$750.00
- Dentist's Usual Fee: \$985.00

IN-NETWORK When you receive care from a participating dentist		OUT-OF-NETWORK When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	\$985.00	Dentist's Usual Fee is:	\$985.00
The Reduced Network Fee is:	\$685.00	Usual & Customary (U&C) Fee is:	\$750.00
Your Plan Pays:		Your Plan Pays:	
50% x \$685 Fee	- \$342.50	50% x \$750 U&C	- \$375.00
Your Out-of-Pocket Cost:	\$342.50	Your Out-of-Pocket Cost:	\$610.00

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.



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