For more information, contact:

Agent Name

(123) 456-7890

Agent@email.com

MAGNUM DENTAL

Individual & Family Dental Insurance

Connecticut | Illinois

Choose Your Own Dentist | Two Cleanings Per Year | Up to $1,250 Annual Benefit

Ameritas

Plan Underwritten by Ameritas Life Insurance Corp. 5900 O Street, Lincoln, NE 68510

Magnum PPO 750

The Magnum PPO 750 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. Magnum 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 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 $50 deductible per person for Preventive, Basic and Major services combined, with a maximum of three deductibles per family.

This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the 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.

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$750	$750	$750
PREVENTIVE SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	100%	100%	100%
Out-of-network	90%	90%	90%
BASIC SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	50%	50%	50%
Out-of-network	50%	50%	50%
MAJOR SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	0%	50%	50%
Out-of-network	0%	50%	50%

Preventive | Type One

| Two exams per benefit year
| Two cleanings per benefit year
| One series of bitewing X-rays per benefit year
| One topical fluoride per benefit year age 15 and under

Basic | Type Two

| 6 month waiting period
| Basic fillings
| Space maintainers
| Sealants age 15 and under
| One diagnostic X-ray, full or panoramic in any 5 year period

Major | Type Three

| 12 month waiting period
| Simple extractions
| Oral surgery
| Endodontic treatment
| Periodontic services
| Restoration services; inlays, onlays and crowns
| Prosthetic services; bridges and dentures

Magnum PPO 1000

The Magnum PPO 1000 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. Magnum 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 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 $50 deductible per person for Preventive, Basic and Major services combined, with a maximum of three deductibles per family.

This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the 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.

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$1000	$1000	$1000
PREVENTIVE SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	100%	100%	100%
Out-of-network	90%	90%	90%
BASIC SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	70%	70%	70%
Out-of-network	60%	60%	60%
MAJOR SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	0%	50%	50%
Out-of-network	0%	50%	50%

Preventive | Type One

| Two exams per benefit year
| Two cleanings per benefit year
| One series of bitewing X-rays per benefit year
| One topical fluoride per benefit year age 15 and under

Basic | Type Two

| 6 month waiting period
| Basic fillings
| Space maintainers
| Sealants age 15 and under
| One diagnostic X-ray, full or panoramic in any 5 year period

Major | Type Three

| 12 month waiting period
| Simple extractions
| Oral surgery
| Endodontic treatment
| Periodontic services
| Restoration services; inlays, onlays and crowns
| Prosthetic services; bridges and dentures

Magnum PPO 1250

The Magnum PPO 1250 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. Magnum 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 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 $50 deductible per person for Preventive, Basic and Major services combined, with a maximum of three deductibles per family.

This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the 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.

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$1250	$1250	$1250
PREVENTIVE SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	100%	100%	100%
Out-of-network	90%	90%	90%
BASIC SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	80%	80%	80%
Out-of-network	70%	70%	70%
MAJOR SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
In-network	0%	50%	50%
Out-of-network	0%	50%	50%

Preventive | Type One

| Two exams per benefit year
| Two cleanings per benefit year
| One series of bitewing X-rays per benefit year
| One topical fluoride per benefit year age 15 and under

Basic | Type Two

| 6 month waiting period
| Basic fillings
| Space maintainers
| Sealants age 15 and under
| One diagnostic X-ray, full or panoramic in any 5 year period
| Simple extractions

Major | Type Three

| 12 month waiting period
| Oral surgery
| Endodontic treatment
| Periodontic services
| Restoration services; inlays, onlays and crowns
| Prosthetic services; bridges and dentures

Plan Rates

Rates for: Connecticut, Illinois

Magnum PPO 750

	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Applicant	$23.20	$25.67	$28.15	$30.93	$34.02	$37.43	$41.14
Applicant + 1	$46.40	$51.34	$56.29	$61.86	$68.05	$74.85	$82.27
Applicant + Family	$74.24	$82.15	$90.07	$98.98	$108.88	$119.77	$131.64

Magnum PPO 1000

	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Applicant	$26.87	$29.74	$32.61	$35.83	$39.41	$43.35	$47.65
Applicant + 1	$53.75	$59.48	$65.21	$71.66	$78.83	$86.71	$95.31
Applicant + Family	$86.00	$95.17	$104.34	$114.66	$126.13	$138.74	$152.50

Magnum PPO 1250

	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Applicant	$30.72	$34.00	$37.27	$40.96	$45.06	$49.56	$54.48
Applicant + 1	$61.44	$67.99	$74.55	$81.92	$90.11	$99.12	$108.95
Applicant + Family	$98.30	$108.79	$119.27	$131.07	$144.18	$158.59	$174.32

Area Definitions for:

Connecticut

061, 069	5
063-064	7
All Others	6

Illinois

619, 624, 628	1
614, 625-626, 629	2
613, 616-618, 623, 627	3
601, 603, 606-607	5
611-612	
605	6
All Others	4

General Information

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 Ameritas 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, Ameritas will base our payment on treatment consistent with usual and customary charges. Predetermination of benefits is not a guarantee of what Ameritas 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.

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.

***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.**

Frequently Asked Questions

for Members of Magnum Dental

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 dental 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 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.

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. 07-23 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. © 2026 Ameritas Mutual Holding Company.

MAGNUM DENTAL

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