



Individual & Family Dental Insurance

Ohio










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

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 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. The coinsurance 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	 100%	 50%	 20%	\$750
Year Two	 100%	 50%	 20%	\$1,000
Year Three	 100%	 50%	 20%	\$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 | Senior Preferred Network 3500

The Spirit Senior Preferred Network 3500 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 Health Provider](#) to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

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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	100%	65%	10%	\$3,500	Year One	50%	\$200
Year Two	100%	80%	50%	\$3,500	Year Two	50%	\$300
Year Three	100%	90%	65%	\$3,500	Year Three	50%	\$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 Network 1200/2500/5000

The Spirit Pinnacle Network 1200/2500/5000 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 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 Network 1200/2500/5000 | 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%, 50% 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%	 50%	 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 | Core Network 1200

The Spirit Core 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 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 \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Core 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

	Preventive	Basic	Major	Ortho	Max Benefit
Year One					\$1,200
Year Two					\$1,200
Year Three					\$1,200

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 benefit year maximum benefit amount is \$1,200 each year.

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

Network Plan Rates

Network Plan Rates for: Ohio

Spirit Preventive Plus PPO			
	AREA 1	AREA 2	AREA 3
Applicant	\$13.74	\$15.21	\$16.67
Applicant + 1	\$27.47	\$30.40	\$33.33
Applicant + Family	\$43.96	\$48.65	\$53.34

Spirit Core Network 1200			
	AREA 1	AREA 2	AREA 3
Applicant	\$23.81	\$26.35	\$28.89
Applicant + 1	\$48.91	\$54.12	\$59.34
Applicant + Family	\$81.62	\$90.32	\$99.03

Spirit Pinnacle Network 1200/2500/5000			
	AREA 1	AREA 2	AREA 3
Applicant	\$29.96	\$33.15	\$36.35
Applicant + 1	\$61.19	\$67.72	\$74.25
Applicant + Family	\$101.27	\$112.07	\$122.87

Spirit Senior Preferred Network 3500			
	AREA 1	AREA 2	AREA 3
Applicant	\$36.22	\$39.92	\$43.62
Applicant + 1	\$72.12	\$79.52	\$86.93
Applicant + Family	\$114.52	\$126.37	\$138.22

Area Charts for: Ohio

439, 454-455, 457	1
430, 434-435, 440-442	3
447, 450, 452, 458	
All Others	2



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

Spirit Network

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

Spirit Choice

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

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

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.

Spirit | Senior Preferred Choice 3500

The Spirit Senior Preferred Choice 3500 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 dental 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 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.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the providers 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. Covered benefits are paid at the 90th percentile of usual and customary (90th U&C). This means we expect 9 out of 10 charges from dental providers to be within the amount we pay for a covered procedure. You pay the difference between what the plan pays and the dentist's actual charge.

Spirit Senior Preferred Choice 3500 | This policy pays for covered dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network 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, 65% for Basic and 10% for Major Services in year one. In year two, Basic Services increase to 80% and 50% for Major Services. In year three, Basic Services increase to 90% and 65% for Major Services. Your benefit year maximum amount is \$3,500 each year.

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	100%	65%	10%	\$3,500	Year One	50%	\$200
Year Two	100%	80%	50%	\$3,500	Year Two	50%	\$300
Year Three	100%	90%	65%	\$3,500	Year Three	50%	\$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 Choice 1200/2500/5000

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Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the providers 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. Covered benefits are paid at the 90th percentile of usual and customary (90th U&C) This means we expect 9 out of 10 charges from dental providers to be within the amount we pay for a covered procedure. You pay the difference between what the plan pays and the dentist's actual charge.

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	Preventive	Basic	Major	Ortho	Max Benefit
Year One					\$1,200
Year Two					\$2,500
Year Three					\$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 | Core Choice 1200

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Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the providers 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. Covered benefits are paid at the 90th percentile of usual and customary (90th U&C). This means we expect 9 out of 10 charges from dental providers to be within the amount we pay for a covered procedure. You pay the difference between what the plan pays and the dentist’s actual charge.

Spirit Core Choice 1200 | This policy pays for covered 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, 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 benefit year maximum 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 benefit year
- | Sealants under age 16
- | One topical fluoride per benefit year under age 16

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

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

Choice Plan Rates

Choice Plan Rates for: Ohio

Spirit Core Choice 1200			
	AREA 1	AREA 2	AREA 3
Applicant	\$36.76	\$40.68	\$44.60
Applicant + 1	\$74.80	\$82.78	\$90.75
Applicant + Family	\$123.04	\$136.16	\$149.29

Spirit Pinnacle Choice 1200/2500/5000			
	AREA 1	AREA 2	AREA 3
Applicant	\$48.93	\$54.15	\$59.37
Applicant + 1	\$99.14	\$109.72	\$120.29
Applicant + Family	\$161.99	\$179.26	\$196.54

Spirit Senior Preferred Choice 3500			
	AREA 1	AREA 2	AREA 3
Applicant	\$58.04	\$64.07	\$70.10
Applicant + 1	\$115.78	\$127.85	\$139.91
Applicant + Family	\$184.39	\$203.69	\$222.99

Area Charts for: Ohio

439, 454-455, 457	1
430, 434-435, 440-442	3
447, 450, 452, 458	
All Others	2



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. We will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of this policy effective date if this policy immediately replaces a prior plan. 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.

Dental

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

- for any treatment which is for cosmetic purposes.
- 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.



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.

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](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?

| Backed by a foundation of financial strength, Ameritas offers a competitive array of employee benefits. And Ameritas services them in a highly welcoming, ethical and professional manner that builds lasting trust and enduring relationships.

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. (AmeritasLife). Dental, vision and hearing care products (9000 Rev. 03-16 for Group and 9000 Rev. 02-19 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. © 2024 Ameritas Mutual Holding Company.



Plan Distributed by Direct Benefits
7900 International Drive, Suite 1040
Bloomington, MN 55425
info@directbenefits.com | 800.620.5010
www.directbenefits.com/agents



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