My Dental Plan® - plan details

Plan 7

Preventive (type 1) • exams/cleanings (twice per plan year) • fluoride treatment under age 14 (once per plan year) • bitewing films (once per plan year) • full mouth series or panoramic x-ray (once every 5 years)	Plan Benefit* **100%**	Member Coinsurance **0%**
Basic (type 2)	Plan Benefit 100% of Schedule **Sample Schedule Amounts:** Filling – One Surface **$60** Filling – Multi Surface **$85** Extraction **$80**	
Major (type 3)	Plan Benefit 100% of Schedule **Sample Schedule Amounts:** Crown **$350** Root Canal **$335**	
Per Visit Deductible (per person)	**$25**	
Waiting Periods	**6 Months for Type 3 Benefits**	
Annual Maximum Benefit (per person)	**$2000**	
Dental Rewards® with PPO bonus — Threshold Amount	**$500**	
Dental Rewards® with PPO bonus — Annual Reward	**$250**	
Dental Rewards® with PPO bonus — Maximum Reward (including PPO bonus)	**$1000**	
In areas where PPO is approved, if you qualify for your Annual Reward by seeing an Ameritas Dental Network Provider, we'll add a $50 PPO bonus amount to your Annual Reward. Not available in MT and RI.	Boost your annual maximum benefit by submitting at least one dental claim each year and keeping your total benefits received for the year at or below the **Threshold Amount**. You will "earn" an **Annual Reward** that you carry over to increase your annual maximum benefit available the next year. Accumulate rewards up to the total **Maximum Reward** amount. If no dental claims are submitted during a year, no rewards are earned and accumulated rewards are lost. But you can begin building rewards again the next year.	
Orthodontia	Ortho Coinsurance **50%** Ortho Lifetime Deductible **$0** Ortho Lifetime Maximum **$500** Ortho Waiting Period **12 Months**	
LASIK Advantage	Lifetime Maximum Benefit per eye Benefit Year 1 & 2 **$125** Benefit Year 3+ **$250** LASIK Advantage provides coverage for LASIK and related procedures, including standard LASIK, Custom LASIK, LASIK with Wavefront Technology, CustomVue LASIK, LASIK with IntraLase technology and Photorefractive Keratectomy (PRK). Members earn a lifetime benefit per eye over time, with the highest coverage provided at year two. Members earn benefits for each eye and may not combine benefits earned for each eye to pay for a covered procedure for a single eye.	
Vision Benefit	There is a $100 benefit that you can use for exams, frames, lenses or contact lenses. It comes with a vision ID card that explains how to access discounts on eye exams and products. If you choose to use the vision benefit, it is deducted from the total annual maximum allowed for dental benefits. If you use the plan's entire annual maximum benefit for dental care, no vision benefit will be available that year.	

* When you visit an Ameritas Dental Network provider, Ameritas sends payment directly to the dentist. There is no balance billing, meaning you won't pay the difference between the dentist's contracted fee and what the plan allows, subject to contractual limitations. When you visit an out-of network dentist, you must pay the difference between what the plan pays and the dentist's actual charge and may have to submit your own claim.

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This Plan Details document is a highlight sheet only. Please review the Outline of Coverage along with the Application Form or send an email to sales@hpsameritas.com to request a sample policy. Your actual policy will be the full legal description of your benefits.

Certain plans and plan options may not be available in all areas.

The plan described in this document is marketed and insured by Ameritas Life Insurance Corp. and administered by HealthPlan Services.

Limitations and Exclusions

Dental Expenses will not include, and benefits will not be payable, for any of the following.

1. Covered Dental Expenses for Type 3 Procedures in the first 6 months the person is covered under this contract.
2. Covered Dental Expenses for initial placement of any prosthetic crown, appliance, or fixed partial denture 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 prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.
3. Covered Dental Expenses for appliances, restorations, or procedures to do any of the following.
    a. Alter vertical dimension.
    b. Restore or maintain occlusion.
    c. Splint or replace tooth structure lost as a result of abrasion or attrition.
4. Covered Dental Expenses for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.
5. Covered Dental Expenses to replace lost or stolen appliances.
6. Covered Dental Expenses for any treatment which is for cosmetic purposes.
7. Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)
8. Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision.
9. Covered Dental Expenses for 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 dental condition caused or contributed to by an injury or sickness arising out of or in the course of employment.
10. Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.
11. Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. Covered Dental Expenses because of war or any act of war, declared or not.
13. Alternative Procedures – Occasionally two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care. In this case, 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. This provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. You may choose to apply the alternate benefit amount determined under this provision toward payment of the received treatment.

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