DENTAL INSURANCE
Ameritas Life Insurance Corp.
PO Box 81889
Lincoln, NE 68501-1889
1-800-487-5533

Outline of Coverage

THIS POLICY PROVIDES DENTAL BENEFITS
THIS IS NOT A MEDICARE SUPPLEMENT POLICY

1. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance policy and only the actual policy provisions will control benefit administration. The policy sets forth the definitions of the capitalized terms referred to below.

The policy itself sets forth in detail the rights and obligations of both you and Ameritas Life Insurance Corp. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. **DENTAL COVERAGE.** This policy is designed to provide coverage for certain dental services. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

3. **BENEFITS.** We will review benefits subject to the limitations and exclusions described here and more specifically in the policy. When you visit a Participating Provider, a discounted fee is charged for covered services. This is intended to reduce your out-of-pocket costs. The Provider may bill you the difference between the plan payment and the discounted fee amount. If you visit a non-Participating Provider, the Provider may bill you the difference between the plan payment and the dentist's actual charge. Plan payment may be based on usual and customary charges or a set scheduled allowance as described in your policy.

DENTAL

Deductible Amount

When a Non-Participating Provider is used:	
Type 1 Procedures	$0
Combined Type 2 Procedures - Each Benefit Period	$50
When a Participating Provider is used:	
Type 1 Procedures	$0
Combined Type 2 Procedures - Each Benefit Period	$50
Maximum Deductible per Benefit Period	$50

Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible. Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required.

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

	Participating Provider	Non-Participating Provider
Coinsurance Percentages		
Type 1 Procedures	100%	80%
Type 2 Procedures		
Step 1	15%	10%
Step 2	50%	30%
When a Non-Participating Provider is used:		
Maximum Amount - Each Benefit Period		$1,000
When a Participating Provider is used:		
Maximum Amount - Each Benefit Period		$1,000

4. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE POLICY:

YOUR POLICY CONTAINS A COMPLETE LISTING OF PROCEDURES COVERED AND ANY FREQUENCY OR OTHER LIMITATIONS ON SPECIFIC PROCEDURES. Certain Covered Expenses may be subject to a Waiting Period (an Elimination Period). Please refer to your policy for details.

Alternate Benefit Provision – At times, two or more procedures are considered adequate and appropriate treatment. In this case, the benefit paid will be based on the charge for the least expensive procedure.

Certain expenses are not covered. For instance, procedures begun prior to your Effective Date are not covered. This policy does not provide benefits for lost or stolen appliances or cosmetic procedures. It also does not cover hospitalization or prescription drugs. This is not a complete list of exclusions. A full list is in your policy.

5. RENEWABILITY. The policy is renewable by payment of the premium in effect at the beginning of each renewal period. Policy termination is governed by the termination provisions in the policy.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY.

THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

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DENTAL

Deductible Amount	
Type 1 Procedures	$0
Type 2 Procedures - Each Benefit Period	$50

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentages	
Type 1 Procedures	100%

Type 2 Procedures	
Step 1	15%
Step 2	50%

Step 1 applies during the first Benefit Period the person becomes insured.
Step 2 will apply during the second Benefit Period.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Step 2 as if he or she were newly insured.

Maximum Amount	
Each Benefit Period	$1,000

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