

# dental plan 1000

our promise: dependable, affordable dental insurance backed by an industry leader.

## Long-Standing Customer Focus

Ameritas Group is a division of Ameritas Life Insurance Corp. Established in 1887, Ameritas offers more than a century of insurance industry expertise and superior customer service.

**Rated A (Excellent)** for financial strength and operating performance by A.M. Best Company (the third highest of Best's 15 ratings) and **AA- (Very Strong)** for insurer financial strength by Standard & Poor's (the fourth highest of S&P's 21 ratings), Ameritas is a company you can trust.

Once you become a member, customer service representatives are available to answer any claim or eligibility questions you may have. We also provide online access to useful information such as benefit summaries, Participating Provider Organization (PPO) lists, claim forms and claim status.

It's all available at [ameritasgroup.com](http://ameritasgroup.com).

## See Any Dentist!

This plan offers you complete freedom to select any dentist and still receive the same dollar amount of coverage for each dental procedure.

You are not required to see a network dentist. But remember, as an added benefit, you have access to our nationwide PPO network. These participating providers have agreed to charge contracted fees for covered procedures, which are generally lower than the going rate. Your dental benefits usually go much farther with an Ameritas PPO provider.

To see if your dentist is in the PPO network, visit our web site at [ameritasgroup.com](http://ameritasgroup.com) and select "Find a Provider." Select the "Dental" link. Under Step 3, select the network: "PPO-Nationwide."

## Fixed Benefit Dental Plan

This dental plan has a benefit schedule that clearly lists all covered dental procedures and the dollar amount of coverage for each. This way, there are no insurance coverage surprises, because you'll know what a procedure is going to cost ahead of time.

The plan provides comprehensive coverage for all members. Please note, on Type 3 procedures, there's a 6-month waiting period.

**Annual Maximum . . . . . \$1,000**

**Deductible . . . . . \$50**

(waived for Type 1 procedures such as exams, cleanings and x-rays)

Family Deductible Maximum included. When three family members satisfy their annual deductible amounts in the same benefit year, they have reached the Family Deductible Maximum, so no more family member deductibles are required in that benefit year.

Dental Rewards®

An industry first! With Dental Rewards, you have the ability to increase your annual maximum each year by \$250 at no additional cost.

If you keep your claims below \$500 per year, you will carry over \$250 dollars toward your next year's annual maximum. Earn an additional \$100 carry over by making your dental visits to one of our PPO providers. Maximum reward accumulation is \$1,000.

Over time, your annual maximum benefit can be built up to provide that extra coverage when you really need it!

**Please don't miss this opportunity...**

**Sign up today!**

These rates are valid until 6/30/2012.

Rates renew each year on July 1.

Employee Only . . . . . \$27.44

Employee + One Dependent . . . . . \$50.36

Employee + Two or More . . . . . \$78.24

Monthly Administrative Fee: \$10 Groups 3-4, \$20 Groups 5+  
CARA Annual Association Dues are \$15. Please make check payable to CARA.

Optional bank draft payment mode = \$3.50 monthly

For questions, contact AIS 800-788-6524 or [www.ais-insurance.com](http://www.ais-insurance.com)

## TYPE 1 DENTAL PROCEDURES

The following is a FULL list of Type 1 (Preventive) dental procedures payable under this dental plan. Please see the Dental Limitations for additional coverage information. *Current Dental Terminology* ©2004 American Dental Association. All rights reserved.

<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION OF SERVICE</u>	<u>MAXIMUM COVERED EXPENSE PLAN PAYS</u>
<b>ROUTINE ORAL EVALUATION</b>		
D0120.....	Periodic oral evaluation..... <i>One per 6 months.</i>	\$18.00
D0150.....	Comprehensive oral evaluation - new or established patient.....	\$27.00
D0180.....	Comprehensive periodontal evaluation - new or established patient.....	\$27.00
<b>COMPLETE SERIES OR PANORAMIC FILM</b>		
D0210.....	Intraoral - complete series (including bitewings).....	\$57.00
D0330.....	Panoramic film..... <i>One per 5 years.</i>	\$46.00
<b>OTHER X-RAYS</b>		
D0220.....	Intraoral - periapical first film.....	\$11.00
D0230.....	Intraoral - periapical each additional film.....	\$8.00
D0240.....	Intraoral - occlusal film.....	\$15.00
D0250.....	Extraoral - first film.....	\$19.00
D0260.....	Extraoral - each additional film.....	\$15.00
<b>BITEWING FILMS</b>		
D0270.....	Bitewing - single film.....	\$9.00
D0272.....	Bitewings - two films.....	\$16.00
D0274.....	Bitewings - four films.....	\$25.00
D0277.....	Vertical bitewings - 7 to 8 films..... <i>One per 12 months.</i>	\$38.00
<b>PROPHYLAXIS (CLEANING) AND FLUORIDE</b>		
D1110.....	Prophylaxis - adult.....	\$38.00
D1120.....	Prophylaxis - child..... <i>One per 6 months. A child is defined as age 13 and under.</i>	\$27.00
D1201.....	Topical application of fluoride (including prophylaxis) - child.....	\$41.00
D1203.....	Topical application of fluoride (prophylaxis not included) - child.....	\$15.00
D1204.....	Topical application of fluoride (prophylaxis not included) - adult.....	\$15.00
D1205.....	Topical application of fluoride (including prophylaxis) - adult..... <i>One per 12 months.</i>	\$53.00

## TYPE 2 DENTAL PROCEDURES

The following is a PARTIAL list of Type 2 (Basic) dental procedures payable under this dental plan. A complete list of procedures can be obtained by contacting your company's benefits administrator. Please see the Dental Limitations for additional coverage information. *Current Dental Terminology* © 2004 American Dental Association. All rights reserved.

<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION OF SERVICE</u>	<u>MAXIMUM COVERED EXPENSE PLAN PAYS</u>
<b>AMALGAM RESTORATIONS (FILLINGS)</b>		
D2140.....	Amalgam - one surface, primary or permanent.....	\$46.00
D2150.....	Amalgam - two surfaces, primary or permanent.....	\$58.00
D2160.....	Amalgam - three surfaces, primary or permanent.....	\$71.00
D2161.....	Amalgam - four or more surfaces, primary or permanent..... <i>One per 6 months.</i>	\$84.00
<b>RESIN RESTORATIONS (FILLINGS)</b>		
D2330.....	Resin-based composite - one surface, anterior.....	\$56.00
D2331.....	Resin-based composite - two surfaces, anterior.....	\$71.00
D2332.....	Resin-based composite - three surfaces, anterior.....	\$88.00
D2335.....	Resin-based composite - four or more surfaces or involving incisal angle (anterior).....	\$97.00
D2391.....	Resin-based composite - one surface, posterior.....	\$61.00
D2392.....	Resin-based composite - two surfaces, posterior.....	\$77.00
D2393.....	Resin-based composite - three surfaces, posterior.....	\$97.00
D2394.....	Resin-based composite - four or more surfaces, posterior..... <i>One per 6 months. Porcelain and resin benefits are considered for anterior and bicuspid teeth only.</i>	\$107.00

## TYPE 2 DENTAL PROCEDURES (continued)

PROCEDURE NUMBER	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE PLAN PAYS
<b>STAINLESS STEEL CROWN (PREFABRICATED CROWN)</b>		
D2390	Resin-based composite crown, anterior.	\$119.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$100.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$106.00
D2932	Prefabricated resin crown.	\$119.00
D2933	Prefabricated stainless steel crown with resin window.	\$119.00
<i>One per 12 months.</i>		
<b>ENDODONTIC THERAPY (ROOT CANALS)</b>		
D3310	Anterior (excluding final restoration).	\$284.00
D3320	Bicuspid (excluding final restoration).	\$334.00
D3330	Molar (excluding final restoration).	\$438.00
<i>On permanent teeth only. Allowances include intraoperative films and cultures.</i>		
D3346	Retreatment of previous root canal therapy - anterior.	\$353.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$407.00
D3348	Retreatment of previous root canal therapy - molar.	\$505.00
<i>One per 12 months. Allowances include intraoperative films and cultures.</i>		
<b>DENTURE RELINES</b>		
D5730	Reline complete maxillary denture (chairside).	\$107.00
D5731	Reline complete mandibular denture (chairside).	\$107.00
D5740	Reline maxillary partial denture (chairside).	\$96.00
D5741	Reline mandibular partial denture (chairside).	\$97.00
D5750	Reline complete maxillary denture (laboratory).	\$159.00
D5751	Reline complete mandibular denture (laboratory).	\$156.00
D5760	Reline maxillary partial denture (laboratory).	\$159.00
D5761	Reline mandibular partial denture (laboratory).	\$160.00

## TYPE 3 DENTAL PROCEDURES (6-month waiting period)

The following is a PARTIAL list of Type 3 (Major) dental procedures payable under this dental plan. A complete list of procedures can be obtained by contacting your company's benefits administrator. Please see the Dental Limitations for additional coverage information. *Current Dental Terminology* © 2004 American Dental Association. All rights reserved.

PROCEDURE NUMBER	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE PLAN PAYS
<b>CROWNS SINGLE RESTORATIONS</b>		
D2710	Crown - resin-based composite (indirect).	\$160.00
D2720	Crown - resin with high noble metal.	\$408.00
D2740	Crown - porcelain/ceramic substrate.	\$441.00
D2750	Crown - porcelain fused to high noble metal.	\$428.00
D2780	Crown - 3/4 cast high noble metal.	\$407.00
D2783	Crown - 3/4 porcelain/ceramic.	\$441.00
D2790	Crown - full cast high noble metal.	\$407.00
<i>One per 10 years. Frequency is waived for accidental injury. Porcelain and resin benefits are considered for anterior and bicuspid teeth only.</i>		
<b>FIXED CROWN AND PARTIAL DENTURE REPAIR</b>		
D2980	Crown repair, by report.	\$71.00
D6980	Fixed partial denture repair, by report.	\$80.00
<b>SURGICAL ENDODONTICS</b>		
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$304.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$329.00
<b>SURGICAL PERIODONTICS</b>		
D4211	Gingivectomy or gingivoplasty - one to three contiguous/bounded teeth spaces per quadrant.	\$84.00
D4263	Bone replacement graft - first site in quadrant.	\$137.00
<b>PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)</b>		
D5110	Complete denture - maxillary.	\$456.00
D5120	Complete denture - mandibular.	\$442.00
D5130	Immediate denture - maxillary.	\$494.00
D5140	Immediate denture - mandibular.	\$478.00
<i>One per 10 years. Frequency is waived for accidental injury. Allowances include adjustments within 6 months after placement date.</i>		

## General Information

**Participation is Voluntary** — This policy is provided as part of AIS's Section 125 Plan. Each person has the option of participating or not participating.

**Enrollment** — If a person does not elect to participate when initially eligible, the person may elect to participate at AIS's next annual election period. Enrollment changes are accepted only during an annual election period, unless there's a change in family status (qualifying event). Qualifying events are marriage, divorce, birth of a child, spouse or child's death, or termination of spouse's employment.

**Late Enrollment** — A person who elects to participate at an election period other than the initial election period will be a late

entrant and subject to Limitation #2 below. There are no open enrollment periods for this plan.

**Six-month Elimination Period** — On Type 3 procedures, there's a 6-month waiting period. See Limitation #1 below. It may be waived for groups with proof of at least six months' prior group dental coverage.

**Pretreatment Estimates** — We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered expensive. A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility, but an estimate of benefits available if the described procedure(s) were performed.

**This form is a benefit highlight, not a certificate of insurance. The coverage outlined here highlights the dental benefits available through Ameritas Life Insurance Corp. and AIS.**

## Dental Limitations

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

1. for Type 3 procedures in the first six months that the insured person is covered under the dental expense benefit.
2. 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. If an employee or dependent does not enroll within 31 days from the date the person qualifies for the insurance, or elects to become insured again after canceling a premium contribution agreement, he/she will be classified as a late entrant.
3. for any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic.
4. to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five 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 insured person is covered under the dental expense benefit, it will be considered covered.
5. for initial placement of any prosthetic 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 the dental expense benefit. 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.
6. for any procedure begun before the insured person is covered under the dental expense benefit.
7. for any procedure begun after the insured's insurance under the dental expense benefit terminates, or for any prosthetic dental appliances installed or delivered more than 90 days after the insured's insurance under the dental expense benefit terminates.
8. to replace lost or stolen appliances.
9. for appliances, restorations or procedures to:
  - a. alter vertical dimension,
  - b. restore or maintain occlusion,
  - c. splint or replace tooth structure lost because of abrasion or attrition
10. for any procedure which is not shown on the Table of Dental Procedures.
11. for orthodontic treatment.
12. 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.
13. for charges which the insured person is not liable or which would not have been made had no insurance been in force.
14. for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
15. because of war or any act of war, declared or not.

5/16/11  
Cathy Hiemer

PROOF DATE: \_\_\_\_\_  
RETURN PROOF TO \_\_\_\_\_

OK TO PRINT  
 REVISE & PRINT  
 REVISE & SEND PROOF

CLIENT SIGNATURE \_\_\_\_\_  
DATE \_\_\_\_\_

