

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Ameritas Life Insurance Corp. **Plan Name:** Traditional
Policy Type: Freedom of Choice **Insurer Phone #:** 1-877-667-6127
Effective Date: Beginning on or after 01/01/2022 **Insurer Website:** ameritas.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT AMERITAS.COM OR CALL 1-877-667-6127.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

PART II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	\$50 per benefit period per individual, 3 members per family.	\$50 per benefit period per individual, 3 members per family.

The combined deductible applies to all services, except Preventive & Diagnostic procedures.

A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.

In-network services are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.

Out-of-network services are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual maximum	1st Ben Period: \$1000, 2nd+ Ben Period: \$2000	1st Ben Period: \$1000, 2nd+ Ben Period: \$2000
Lifetime Maximum for Orthodontia	\$1000	\$1000

Annual maximum is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.

Lifetime maximum means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments. There is no waiting period.

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions, for a full listing refer to the 9232 Table of Dental Procedures in your Certificate of Insurance.
<i>Oral Exam</i>	Preventive & Diagnostic	0%, deductible does not apply.	20%, deductible does not apply.	2 of any of these procedures per benefit period
<i>Bitewing X-ray</i>	Preventive & Diagnostic	0%, deductible does not apply.	20%, deductible does not apply.	1 of any of these procedures per benefit period
<i>Cleaning</i>	Preventive & Diagnostic	0%, deductible does not apply.	20%, deductible does not apply.	2 of any of these procedures per benefit period
Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions, for a full listing refer to the 9232 Table of Dental Procedures in your Certificate of Insurance.
<i>Filling</i>	Basic	Year 1: 35%, Year 2: 20%	Year 1: 55%, Year 2: 40%	1 of any of these procedures per 2 years
<i>Extraction, Erupted Tooth or Expose Root</i>	Basic	Year 1: 35%, Year 2: 20%	Year 1: 55%, Year 2: 40%	

<i>Root Canal</i>	Major	Year 1: 80%, Year 2: 50%	Year 1: 90%, Year 2: 70%	Benefits are considered on permanent teeth only.
<i>Scaling and Root Planing</i>	Major	Year 1: 80%, Year 2: 50%	Year 1: 90%, Year 2: 70%	Each quadrant is limited to 1 of each of these procedures per 2 years
<i>Ceramic Crown</i>	Major	Year 1: 80%, Year 2: 50%	Year 1: 90%, Year 2: 70%	Replacement is limited to 1 of any of these procedures per 5 years
<i>Removable Partial Denture</i>	Major	Year 1: 80%, Year 2: 50%	Year 1: 90%, Year 2: 70%	Replacement is limited to 1 of any of these procedures per 5 years
<i>Extraction, Erupted Tooth with Bone Removal</i>	Major	Year 1: 80%, Year 2: 50%	Year 1: 90%, Year 2: 70%	
<i>Orthodontia</i>	Orthodontia	Year 1: 85%, Year 2: 50%	Year 1: 85%, Year 2: 50%	Child only Ortho up to age 19.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist

New patient exam, x-rays (FMX) and cleaning

Sam Needs a Tooth Filled

Resin-based composite - one surface, posterior

Maria Needs a Crown

Crown - porcelain/ceramic substrate

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: \$400 Out-of-network: \$550	Total Cost of Care	In-network: \$150 Out-of-network: \$200	Total Cost of Care	In-network: \$1,300 Out-of-network: \$1,750

Deductible	In-network: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: \$50 Out-of-network: \$50	Deductible	In-network: \$50 Out-of-network: \$50
Annual Maximum (Plan Will Pay)	\$1000	Annual Maximum (Plan Will Pay)	\$1000	Annual Maximum (Plan Will Pay)	\$1000

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: Year 1: 35%, Year 2: 20% Out-of-network: Year 1: 55%, Year 2: 40%	Patient Cost (copayment or coinsurance)	In-network: Year 1: 80%, Year 2: 50% Out-of-network: Year 1: 90%, Year 2: 70%
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$400 Out-of-network: \$110	In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$150 Out-of-network: \$132.5	In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: \$1300 Out-of-network: \$1580
Summary of what is not covered or subject to a limitation:	Exams: 2 of any of these procedures per benefit period X-Rays (FMX): 1 of any of these procedures per 5 years Cleanings: 2 of any of these procedures per benefit period	Summary of what is not covered or subject to a limitation:	1 of any of these procedures per 2 years	Summary of what is not covered or subject to a limitation:	Replacement is limited to 1 of any of these procedures per 5 years