Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Ameritas Life Insurance Corp.
Plan Name: Traditional
Policy Type: PPO
Insurer Phone #: 1-800-487-5553
Effective Date: Beginning on or after 05/01/2022
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 1-800-487-5553.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

PART II: DEDUCTIBLES

Deductible	All Providers
Dental	$50 combined per benefit period per individual, $150 per benefit period per family.

- **The $50 per benefit period 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	All Providers
Annual Maximum	$1,500
Lifetime Maximum for Orthodontia	$1,000

- **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**	**All Providers**	**Benefit Limitations and Exclusions, for a full listing refer to the 9232 Table of Dental Procedures in your Certificate of Insurance.**
Oral Exam	Preventive & Diagnostic	0%, deductible does not apply.	2 of any of these procedures per benefit period.
Bitewing X-ray	Basic	20%	2 of any of these procedures per benefit period.
Cleaning	Preventive & Diagnostic	0%, deductible does not apply.	2 of any of these procedures per benefit period.
Common Dental Procedures	**Category**	**All Providers**	**Benefit Limitations and Exclusions, for a full listing refer to the 9232 Table of Dental Procedures in your Certificate of Insurance.**
Filling	Basic	20%	
Extraction, Erupted Tooth or Expose Root	Basic	20%	
Root Canal	Major	50%	
Scaling and Root Planing	Major	50%	
Ceramic Crown	Major	50%	1 of any of these procedures per 96 months.
Removable Partial Denture	Major	50%	1 of any of these procedures per 96 months.

Extraction, Erupted Tooth with Bone Removal	Major	50%
Orthodontia	Orthodontia	50%

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	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (FMX) and cleaning	Resin-based composite - one surface, posterior	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: Not Applicable Out-of-network: $50.00	Deductible	In-network: $50.00 Out-of-network: $50.00
Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500

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: 0%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	**In-network:** $0.00 **Out-of-network:** $0.00	**In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $30.00 **Out-of-network:** $40.00	**In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $675.00 **Out-of-network:** $900.00
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 36 months. Cleanings: 2 of any of these procedures per benefit period.	Summary of what is not covered or subject to a limitation:		Summary of what is not covered or subject to a limitation:	1 of any of these procedures per 96 months.