Ameritas Dental Plan - PPO

Effective Date: September 1, 2013

To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan or your Out-of-Network benefits will be significantly reduced.

CALENDAR YEAR DEDUCTIBLE

$50.00 per individual for Type II (Basic) and Type III (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

TYPE I - PREVENTIVE AND DIAGNOSTIC

- Type I benefits are payable at 100% MAC*. **No deductible applies.**

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Once a year) (Under age 19)
- Space Maintainers
- Bitewing x-rays (Two per calendar year)

TYPE II - BASIC PROCEDURES

Type II benefits are payable at 80-90-100% MAC*. $50.00 deductible applies.

- Fillings
- Simple Extractions
- Sealants
- Oral Surgery
- Denture Repair

TYPE III - MAJOR PROCEDURES

Type III benefits are payable at 50% MAC*. $50.00 deductible applies.

- Crown-Precious Metal
- Prosthodontics- (Removable Dentures, Partials)
- Crown Repair
- Periodontics (Gum Disease)
- Complex Extractions
- Endodontics (Root Canal)
- Anesthesia

ORTHODONTIA

Paid at 50% MAC* with a $1,000 lifetime maximum per person. No deductible applies. (Includes Children and Adults)

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

*Percentage Paid based on Maximum Allowable Charge

ANNUAL MAXIMUM BENEFIT

- Type I, II, and III Procedures - $1,000 per calendar year per person.
- Orthodontia Procedures - $1,000 Lifetime per person (carryover does not apply)

*This plan includes a **maximum carryover** for dental. Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $500.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than $500, additional amounts of $250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is $1,000. Therefore, the maximum annual benefit may never exceed $2,000 in any one year.

ELIGIBLE EMPLOYEES

You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.). A child must be added within thirty-one (31) days of turning age 2 not to be considered a late entrant.

DENTAL EXCLUSIONS (DEFERMENT PERIOD*)*

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, dentures, partial dentures, inlays or crowns is excluded.

Exceptions to this exclusion will be made if the replacement is made necessary by:

a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or

b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

PRE-DETERMINATION OF BENEFITS

A treatment plan MAY be filed if a proposed course of treatment will exceed $300.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

COORDINATION OF BENEFITS

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

LATE ENTRANT

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant.** For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

CERTIFICATE OF INSURANCE

This is a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

SECTION 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

ORTHODONTIA LIMITATIONS (NOT A COMPLETE LIST)

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

LIMITATIONS/EXCLUSIONS (NOT A COMPLETE LIST)

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.

• Services which are not recommended by a dentist or which are not required for necessary care and treatment.

• Expenses incurred to replace lost or stolen appliances.

• Expenses incurred by an insured because of a sickness for which he/she is eligible for benefits under Worker's Compensation Act or similar.

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

This information is not a guarantee of eligibility or benefits. The benefits shown are subject to policy provisions and the patient's eligibility at the time services are rendered.

AMERITAS MANAGED CARE PRODUCTS

• Employers achieve a balance between cost efficiency and employee choice.

• Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.

• Over 70,000 PPO provider access points are available nationwide.

• PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

Commonly Asked PPO Questions

Your employer is proud to provide their employees with a new dental program administered by Ameritas Group. The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our plan includes access to Ameritas' Participating Provider Organization (PPO).

Do I have to use an Ameritas PPO provider?

Davidson County Schools has provided members an option of choosing between three dental plans. If you elect to enroll in the PPO plan, you and your covered dependents should utilize a participating network provider in order to see the full benefits of the PPO plan option

Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

What happens if I don't use an Ameritas PPO provider?

A member covered under the PPO option should use a panel provider whenever possible. If a member in the PPO option visits a non-panel provider, covered services will be reimbursed based on MAC (Maximum Allowable Charge) of an Ameritas network provider. Dentists not participating in the Ameritas network can charge any price for services but Ameritas will only reimburse based on the MAC if the member is enrolled in the PPO option. If this occurs, the member is responsible for any charges above our MAC reimbursement

Filing A Claim

Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that

includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on Ameritas web site (this will be available via our Intranet in the near future), OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about PPO or the plan, please call:
Ameritas Group Claims Department at 800-487-5553

Or, visit the Ameritas website at:
www.AmeritasGroup.com

MONTHLY DENTAL RATES

Employee Only	**$25.61**
Employee & Spouse	**$74.17**
Employee & Child(ren)	**$76.36**
Employee & Family	**$124.92**

This insurance is underwritten by Ameritas Life Insurance Corp.