Ameritas Dental Plan

Effective Date: August 1, 2010

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% U&C*. No deductible applies.

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

TYPE II- BASIC PROCEDURES
Type II benefits are payable at 80-90-100% U&C*. $50.00 deductible applies.

- Sealants (Under age 17)
- Limited Exams (Problem Focused)
- Denture Repair
- Restorative Amalgam & Resin (excluding inlays & crowns)
- Anesthesia
- Oral Surgery -Complex Extractions
- Oral Surgery - Simple Extractions
- Crowns - Stainless Steel (Age 18 and under)

TYPE III - MAJOR PROCEDURES
Type III Benefits are payable at 50% U&C*. $50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns - Stainless Steel (Age 19 & Over)
- Prosthodontics - Fixed Pontics or Abutments
- Restorative - Inlays and Crown
- Crown Repair
- Prosthodontics - Removable Dentures, Partials

ORTHODONTIA (For Children & Adults)
Paid at 50% U&C*. No deductible applies.

LATE ENTRANT PROVISION
There is a 12 month waiting period on **all services** except for cleanings, exams, and fluoride applications for employees who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible.

***Usual & Customary**

ANNUAL MAXIMUM BENEFIT
- **Type I, Type II and Type III Procedures**: $1,200 per calendar year per person.
- **Orthodontia Procedures:** $1,200 Lifetime per person.

100% PREVENTIVE, 80-90-100% INCENTIVE
Everyone insured on the effective date of the Company's policy begins with 100% coinsurance for Type I (Preventive) and 80% coinsurance level for Type II (Basic) procedures and will remain at that level until the next January 1.

If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Type II (Basic) procedures will advance to the 90% level on the following January 1 and to 100% on the next January 1. Your Type II (Basic) procedures will remain at 100% each year as long as you visit a dentist during each subsequent calendar year and have at least one covered dental procedure performed while insured under the Company's policy.

If you do not have at least one covered dental procedure performed during any calendar year while insured under the Company's policy, you will revert back to 80% coinsurance level during the next calendar year and must begin to progressively advance to the next levels as described above.

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, partial dentures, 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.

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 24 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

PREDETERMINATION OF BENEFITS

A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. 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.

CERTIFICATE OF INSURANCE

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

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. 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.

LIMITATIONS/EXCLUSIONS

(This is 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 laws.

ORTHODONTIA LIMITATIONS

(This is 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.

This is only a partial description of the dental benefits available under this policy. Consult your certificate booklet for details.

MONTHLY RATES

Employee	$29.22
Employee and Spouse	$55.72
Employee and Child(ren)	$71.42
Employee and Family	$97.92

NOTE: You are required to pay for the dental plan with pre-tax dollars. No changes are allowed during the 12 month plan year unless there is a change in family status.

For Claims/Customer Service Questions
call Ameritas at 1.800.487.5553

This plan is underwritten by Ameritas Life Insurance Corporation

Superior Vision Plan

Effective Date: August 1, 2010

Co-Payments- None
Contact Lens Fitting Fee- $0
Vision Plan - Preferred Provider (PPO / Indemnity)

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam *(by an Ophthalmologist)*	12 Months	Covered in Full	Up to $44.00
Comprehensive Exam *(by an Optometrist)*	12 Months	Covered in Full	Up to $39.00
Standard Lenses (Standard) per Pair			
Single Vision	12 Months	Covered in Full	Up to $34.00
Bifocal	12 Months	Covered in Full	Up to $48.00
Trifocal	12 Months	Covered in Full	Up to $64.00
Lenticular	12 Months	Covered in Full	Up to $88.00
Contact Lenses (Per Pair) [2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective) [3]	12 Months	Up to $200.00	Up to $100.00
Contact Lens Fitting [4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames-Standard [3]	12 Months	Up to $150.00	Up to $77.00

[1] All in-network and out-of-network allowances are at the retail value.
[2] Contact lenses are in lieu of eyeglass lenses and frames benefits.
[3] The insured is responsible for paying any charges in excess of this allowance.
[4] Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses

Items or Services Not Covered
While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. YOUR specific Superior Vision Plan may differ, so confirm the details of your employer's plan prior to seeking services.

Items or Services Not Covered or Have Limited Coverage*
• non-prescription (plano) lenses of any kind, sunglasses, or contact lenses
• any coating applied to lenses such as anti-reflective, scratch, UV, lamination, tints (except pink tint #1 and #2), and sunglass coloring
• any lens materials other than standard plastic or glass such as polycarbonate,