



Spirit
DENTAL & VISION
Montana | Rhode Island

Individual & Family Dental Insurance

(S12040 rev. 9.2018)

No Waiting Periods
Choose Your Own Dentist
Three Cleanings Per Year
Lifetime Deductible
Up to \$5,000 Calendar Maximum
Implant Coverage
Optional Vision Coverage

Ameritas 
fulfilling life

Plan Underwritten by:
Ameritas Life Insurance Corp.
5900 O Street, Lincoln NE 68510

The Spirit Max 3500 plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges, and dentures. Spirit Dental allows you to select your own dentist, and a plan that best fits the needs for you and your family.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Max 3500

This policy pays for covered dental expenses based upon a percentage of the Usual and Customary (U&C)* fees for those covered expenses after the \$100 lifetime deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 65% for Basic, 25% for Major Services and 10% for Ortho Services in year one. In year two, Basic Services increase to 80%, 50% for Major, and 25% for Ortho Services. In year three, Basic Services increase to 90%, 65% for Major and Ortho Services increase to 50%. Your calendar year maximum benefit amount is \$3,500 each year.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	65%	25%	10%	\$3,500
Year 2	100%	80%	50%	25%	\$3,500
Year 3	100%	90%	65%	50%	\$3,500

Preventive (Type 1)

- Two exams per calendar year
- Three cleanings per calendar year

Basic (Type 2)

- Space maintainers
- One series of bitewing x-rays per year
- Sealants under age 16
- One topical fluoride per year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Basic fillings

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% year one, 25% year two and 50% year three with a \$1200 lifetime maximum per child

*Usual and Customary - means the usual and customary charges for the area where such expenses are incurred.

NOTICE: This provides a very brief description of some of the important features of this insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Individual Dental Policy Form Indiv. 9000 Rev. 07-16 and/or Vision Policy Form Indiv. 9000 Ed. 07-16-V. Premium rates may change upon renewal. This policy is renewable at the option of the insured. This product may not be available in all states and is subject to individual state regulations.

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The Spirit Max 1200/2500/5000 plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own dentist, and a plan that best fits the needs for you and your family.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Max 1200/2500/5000

This policy pays for covered dental expenses based upon a percentage of the Usual and Customary (U&C)* fees for those covered expenses after the \$100 lifetime deductible (combined for Preventive, Basic, and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic, 10% for Major, and 10% for Ortho Services in year one. In year two, Basic Services increase to 60%, 30% for Major and 25% for Ortho Services. In year three, Basic Services increase to 80%, 50% for Major and Ortho Services increase to 50%. Additionally, your calendar year maximum benefit amount will automatically increase in your second and third years of coverage. Your maximum benefit amount starts in year one at \$1,200, increases to \$2,500 in year two and in year three and subsequent years remains at \$5,000.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	50%	10%	10%	\$1,200
Year 2	100%	60%	30%	25%	\$2,500
Year 3	100%	80%	50%	50%	\$5,000

Preventive (Type 1)

- Two exams per calendar year
- Three cleanings per calendar year

Basic (Type 2)

- Basic fillings
- Space maintainers
- One series of bitewing x-rays per year
- Sealants under age 16
- One topical fluoride per year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% year one, 25% year two and 50% year three with a \$1200 lifetime maximum per child

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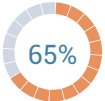






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The Spirit Max 1200 plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges, and dentures. Spirit Dental allows you to select your own dentist, and a plan that best fits the needs for you and your family.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Network 1200

This policy pays for covered dental expenses based upon a percentage of the Usual and Customary (U&C)* fees for those covered expenses after the \$100 lifetime deductible (combined for Preventive, Basic, and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic, 25% for Major and 10% for Ortho Services in year one. In year two, Basic Services increase to 65%, 50% for Major and 25% for Ortho Services. In year three, Basic Services increase to 80% and Ortho Services increase to 50%. Your calendar year maximum benefit amount is \$1,200 each year.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	 100%	 50%	 25%	 10%	\$1,200
Year 2	 100%	 65%	 50%	 25%	\$1,200
Year 3	 100%	 80%	 50%	 50%	\$1,200

Preventive (Type 1)

- Two exams per calendar year
- Three cleanings per calendar year

Basic (Type 2)

- Space maintainers
- One series of bitewing x-rays per year
- Sealants under age 16
- One topical fluoride per year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Basic fillings

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% year one, 25% year two and 50% year three with a \$1200 lifetime maximum per child

*Usual and Customary - means the usual, customary and regular charges for the area where such expenses are incurred.

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The Spirit Max 750/1000/1250 plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges, and dentures. Spirit Dental allows you to select your own dentist, and a plan that best fits the needs for you and your family.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Network 750/1000/1250

This policy pays for covered dental expenses based upon a percentage of the Usual and Customary (U&C)* fees for those covered expenses after the \$100 lifetime deductible (combined for Preventive, Basic, and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic, 10% for Major Services in year one. In year two, Basic Services increase to 60%, and 30% for Major Services. In year three, Basic Services increase to 80% and Major Services increase to 50%. Your calendar year maximum benefit amount starts in year one at \$750, increases to \$1,000 in year two and in year three and subsequent years remains at \$1,250.

	Preventive	Basic	Major	Max Benefit
Year 1	 100%	 50%	 10%	\$750
Year 2	 100%	 60%	 30%	\$1,000
Year 3	 100%	 80%	 50%	\$1,250

Preventive (Type 1)

- Two exams per calendar year
- Three cleanings per calendar year

Basic (Type 2)

- Basic fillings
- Space maintainers
- One series of bitewing x-rays per year
- Sealants under age 16
- One topical fluoride per year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% year one, 25% year two and 50% year three with a \$1200 lifetime maximum per child

*Usual and Customary - means the usual and customary charges for the area where such expenses are incurred.

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Montana & Rhode Island

Spirit Max 3500		
	Area 3	Area 4
Applicant	\$86.35	\$94.89
Applicant + 1	\$174.61	\$191.88
Applicant + Family	\$284.38	\$312.50

Spirit Max 1200/2500/5000		
	Area 3	Area 4
Applicant	\$69.63	\$76.52
Applicant + 1	\$141.18	\$155.14
Applicant + Family	\$230.88	\$253.71

Spirit Max 1200		
	Area 3	Area 4
Applicant	\$54.03	\$59.37
Applicant + 1	\$109.96	\$120.84
Applicant + Family	\$180.94	\$198.83

Spirit Max 750/1000/1250		
	Area 3	Area 4
Applicant	\$48.99	\$53.83
Applicant + 1	\$97.97	\$107.66
Applicant + Family	\$156.76	\$172.26

Area (State) Definitions			
Montana		Rhode Island	
590-591, 598	4	All Areas	4
All Others	3		

12 MONTH RATE GUARANTEE - Rates illustrated are guaranteed for initial 12 months and may change annually thereafter.

General Information

ELIGIBILITY: The insurance coverage is available in states where it's approved to anyone age 18 and older who does not have coverage through another Ameritas dental plan. You can request coverage for your dependents; dependent eligibility varies based on state law.

DEDUCTIBLE AMOUNT: The deductible is shown in the coverage schedule. The deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

PREDETERMINATION OF BENEFITS: It is recommended that a treatment plan/course of treatment be submitted when the total cost of eligible expenses for any insured is expected to exceed the amount shown on the coverage schedule. This should be submitted to us before the work is started. If actual services submitted do not agree with the treatment plan, or if a treatment plan is not sent in, we will base our payment on treatment consistent with reasonable and customary charges. Predetermination of benefits is not a guarantee of what we will pay. The estimated benefit payment is based on your current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or this policy may alter final payment.

TERMINATION OF COVERAGE: Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage; the last day of the month in which Your dependent is no longer a dependent, as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by You or on your behalf; or the date the policy ends.

EFFECTIVE DATE: When you enroll on-line your coverage may start as soon as 4-5 business days. Do not cancel any other insurance or assume you are insured under this plan until you receive written confirmation. Please note your enrollment may take 4 business days to be processed and accessible through any network providers.

ELIGIBLE EXPENSES: Expenses must be incurred while the policy is in force and the person is covered by the policy. To become an eligible expense, the dental services must be performed by: a licensed physician performing dental services within the scope of his license; or a licensed dental hygienist acting under the supervision and direction of a dentist.

MISSING TOOTH: If an insured has lost one or more teeth prior to this policy effective date, we will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under this policy. We will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of this policy effective date if this policy immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits.

Dental Limitations & Exclusions

Dental Expenses will not include, and benefits will not be payable, for any of the following:

- Covered Dental Expenses for appliances, restorations, or procedures to do any of the following:
 - Alter vertical dimension.
 - Restore or maintain occlusion.
 - Splint or replace tooth structure lost as a result of abrasion or attrition.
- Covered Dental Expenses for any procedure begun after the insured person's insurance under this contract terminates.
- Covered Dental Expenses to replace lost or stolen appliances.
- Covered Dental Expenses for any treatment which is for cosmetic purposes.
- Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)
- Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision.
- Covered Dental Expenses for which the Insured person is entitled to benefits under any workers' 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 employment (unless prohibited by state regulations).
- Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.
- Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- Covered Dental Expenses because of war or any act of war, declared or not.
- Alternative Procedures – Occasionally two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care. In this case, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. This provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. You may choose to apply the alternate benefit amount determined under this provision toward payment of the received treatment.

**Plan includes a one-time non-refundable enrollment fee of \$25. This charge will be made at the time of purchase and may appear as a separate transaction from your dental insurance.*

Services Offered

Lifetime per person Deductible of \$50.00 on Lenses and Frames

Examination \$50.00
(once every 12 months with \$10 copay)

A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the member.

Frames (once every 24 months) \$65.00

Lenses (once every 12 months)

Single \$40.00
Bifocal \$60.00
Trifocal \$70.00
No line bifocal or progressive power
OR Lenticular \$100.00

Contact Lenses (in lieu of lenses and frames) \$100.00

Monthly Premium

Applicant Only	\$7.00
Applicant + 1	\$14.00
Applicant + Family	\$20.00



For more information, call Direct Benefits, Inc. at (800) 620-5010

LIMITATIONS & EXCLUSIONS

Please check for availability in your state. Covered expenses will not include and no benefits will be payable for:

- Vision examinations, lenses and frames exceeding the set annual benefit amount.
- Examinations performed or frames or lenses ordered before the member was covered under the plan.
- Subject to extension of benefits, any examination performed or frame or lens ordered after the coverage under the plan ceases.
- Sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- Non-prescription lenses.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Medical or surgical treatment of the eyes.
- Any service or supply not shown on the Schedule of Eye Care Procedures.
- Coated lenses; oversize lenses (exceeding 71 mm); photogray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
- Claims filed more than 90 days after completion of the service (or longer than 90 days in certain states).
An exception is if the Insured shows it was not possible to submit the proof of loss within that period.

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Frequently Asked Questions for Members of Spirit Dental and Vision Plans

Where can I locate my member identification (ID) number?

- The number will be located on the front of your ID card.

Who should I contact with questions?

- For dental questions
 - Contact Ameritas at 866-619-6095.
- For EyeMed Vision Care
 - Contact EyeMed at 800-521-3605 to speak to a customer service representative.

How should a claim be submitted?

- You or your provider should submit an ADA dental claim form or an itemized billing statement which provides the following information:
 - Member's name, address and member ID number
 - Date of service
 - Current ADA procedure code(s)
 - Procedure fee(s)
 - Provider name, address and tax ID number

The claims mailing address is located on the back of your ID card.

Can I see the dentist I have now?

- Yes, you are always free to visit the dentist of your choice. The Ameritas Dental Network offers more than 400,000 access points nationwide for dental care, which means you benefit from credentialed dentists who offer a discount on services provided.
- Find a Provider at: star.ameritas.com/findadentist (choose the Classic Network after inputting zip code).

What can you tell me about Ameritas, the insurance company underwriting this plan?

- Ameritas Life Insurance Corp. and its affiliated companies have a proud and rich heritage dating back to the late 1880s. This tradition is deeply rooted in our commitment to our customers, a foundation of integrity and trust and a legacy of financial strength to deliver on our promises.
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About Spirit Dental & Vision

Spirit Dental & Vision is available exclusively through Direct Benefits, Inc.

Direct Benefits, Inc. is a managing general agency that provides one-stop employee benefits brokerage to over 12,000 agents who provide coverage to over 125,000 Americans.

We're in it for the little people of America. Our mission is to provide individuals and small businesses with the same or better quality insurance products as Fortune 500 employers. By partnering with financially strong insurance carriers like Ameritas we are able to create exclusive niche products like Spirit Dental & Vision.





Spirit
DENTAL & VISION

Enroll online today at
www.spiritdental.com



DirectBenefits | **Trusted Coverage. One Place.**

55 E 5th Street, Suite 500 Saint Paul, MN 55101
info@directbenefits.com 800.620.5010
www.directbenefits.com