Spirit DENTAL & VISION

Individual & Family Dental Insurance

No Waiting Periods | Choose Your Own Dentist | Up to Three Cleanings Per Benefit Year Lifetime Deductible | Up to $5,000 Maximum Benefit

Alaska | Georgia | Louisiana | Mississippi | Missouri

Ameritas

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

Spirit Preventive Plus 1500

The Spirit Preventive Plus 1500 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. This Spirit dental plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit **ameritas.com** and select **Find a Health Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the dentists have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges*.

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

Spirit Preventive Plus 1500 | This policy pays for covered dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the $100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic, and 20% for Major. Your benefit year maximum amount starts in year one at $1000, increases to $1,500 in year two and subsequent years remains at $1,500.

Preventive | Type One

- Two exams per benefit year
- Two cleanings per benefit year
- One series of bitewing X-rays per benefit year

Basic | Type Two

- Space maintainers
- Sealants age 15 and under
- One topical fluoride per benefit year age 15 and under

Major | Type Three

- Basic fillings
- Simple extractions
- 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

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$1000	$1500	$1500
PREVENTIVE SERVICE	YEAR 1	YEAR 2	YEAR 3
	100%	100%	100%
BASIC SERVICE	YEAR 1	YEAR 2	YEAR 3
	50%	50%	50%
MAJOR SERVICE	YEAR 1	YEAR 2	YEAR 3
	20%	20%	20%

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

Spirit Core 1200

The Spirit Core 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. This Spirit dental plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit **ameritas.com** and select **Find a Health Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the providers have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges*.

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

Spirit Core 1200 | This policy pays for covered dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the $100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic, 25% for Major, 10% for Implants and 10% for Ortho Services in year one. In year two, Basic Services increase to 65%, 50% for Major, 25% for Implants and 25% for Ortho Services. In year three, Basic Services increase to 80% and Ortho Services increase to 50%. Your benefit year maximum amount is $1,200 each year for in-network providers and $1,000 each year if you use an out-of-network provider.

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
In-network	$1200	$1200	$1200
Out-of-network	$1000	$1000	$1000
PREVENTIVE SERVICE	YEAR 1	YEAR 2	YEAR 3
	100%	100%	100%
BASIC SERVICE	YEAR 1	YEAR 2	YEAR 3
	50%	65%	80%
MAJOR SERVICE	YEAR 1	YEAR 2	YEAR 3
	25%	50%	50%
IMPLANTS	YEAR 1	YEAR 2	YEAR 3
	10%	25%	25%
ORTHODONTIA	YEAR 1	YEAR 2	YEAR 3
	10%	25%	50%

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% in benefit year one, 25% in benefit year two and 50% in benefit year three with a $1,200 lifetime maximum per child

Preventive | Type One

- Two exams per benefit year
- Three cleanings per benefit year

Basic | Type Two

- Space maintainers
- One series of bitewing X-rays per benefit year
- Sealants age 15 and under
- One topical fluoride per benefit year age 15 and under

Major | Type Three

- Basic fillings
- 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

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

Spirit Preferred 3500

The Spirit Preferred ūǧěě 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. This Spirit dental plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit **ameritas.com** and select **Find a Health Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the providers have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges*.

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

Spirit Preferred ū500 | This policy pays for covered dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the $100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 65% for Basic, 20% for Major Services and 10% for Implants in year one. In year two and subsequent years, Basic Services increase to 100%, 50% for Major Services and 20% for Implants. Your benefit year maximum is $1,500 in year one and increases to $3,500 in year two and thereafter.

Hearing Benefit | Benefits are available for hearing exams and hearing aids. Each benefit period you receive up to $75 for eligible hearing exams. The plan pays 50% of the hearing aid cost up to the maximum benefit per ear with the increased benefits after year one. The maximum benefit is $200 day 1 and $400 after year 1. The hearing aid maximum benefit is separate from the dental maximum benefit. Five years after using your hearing aid coverage, you are re-eligible for the benefit at the top level. A reduced benefit is available after three years if your current hearing aids can no longer correct your hearing. All benefits assume no break in coverage.

Preventive | Type One

- Two exams per benefit year
- Three cleanings per benefit year

Basic | Type Two

- One series of bitewing X-rays per benefit year

Major | Type Three

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

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$1500	$3500	$3500
PREVENTIVE SERVICE	YEAR 1	YEAR 2	YEAR 3
	100%	100%	100%
BASIC SERVICE	YEAR 1	YEAR 2	YEAR 3
	65%	100%	100%
MAJOR SERVICE	YEAR 1	YEAR 2	YEAR 3
	20%	50%	50%
IMPLANTS	YEAR 1	YEAR 2	YEAR 3
	10%	20%	20%

HEARING MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$200	$400	$400
PREVENTIVE SERVICE	YEAR 1	YEAR 2	YEAR 3
	50%	50%	50%

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

Spirit Pinnacle 5000

The Spirit Pinnacle 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. This Spirit dental plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit **ameritas.com** and select **Find a Health Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.
Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the providers have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges*.

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

Spirit Pinnacle 5000 | This policy pays for covered dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the $100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic, 25% for Major, 10% for Implants 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%, 60% for Major, 20% for Implants and Ortho Services increase to 50%. Additionally, your benefit year maximum amount will automatically increase in your second and third years of coverage. Your maximum benefit amount for in-network providers 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. Your maximum benefit amount for out-of-network providers starts in year one at $1,000, increases to $2,000 in year two and in year three and subsequent years remains at $3,000.

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
In-network	$1200	$2500	$5000
Out-of-network	$1000	$2000	$3000
PREVENTIVE SERVICE	YEAR 1	YEAR 2	YEAR 3
	100%	100%	100%
BASIC SERVICE	YEAR 1	YEAR 2	YEAR 3
	50%	60%	80%
MAJOR SERVICE	YEAR 1	YEAR 2	YEAR 3
	25%	30%	60%
IMPLANTS	YEAR 1	YEAR 2	YEAR 3
	10%	10%	20%
ORTHODONTIA	YEAR 1	YEAR 2	YEAR 3
	10%	25%	50%

Orthodontia

- Orthodontic care forthe proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% in benefit year one, 25% in benefit year two and 50% in benefit year three with a $1,200 lifetime maximum per child

Preventive | Type One

- Two exams per benefit year
- Three cleanings per benefit year

Basic | Type Two

- Basic fillings
- Space maintainers
- One series of bitewing X-rays per year
- Sealants age 15 and under
- One topical fluoride per year age 15 and under

Major | Type Three

- 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

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

Spirit Flex 2000

The Spirit Flex 2000 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. This Spirit plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as the providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit **ameritas.com** and select **Find a Health Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the dentists have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges*.

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

Spirit Flex 2000 | This policy pays for dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the $100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are : 100% for Preventive Services, 50% for Basic and 15% for Major. In year two, Basic services increase to 70% and 30% for Major Services. In year three, Basic Services increase to 80% and 40% for Major Services. Your benefit year maximum amount starts in year one at $1,000 and increases to $2,000 year two and thereafter.

Preventive | Type One

- Two exams per benefit year
- Two cleanings per benefit year

Basic | Type Two

- One series of bitewing X-rays per year
- One topical fluoride per year age 15 and under
- Sealants age 15 and under
- Space maintainers

Major | Type Three

- Basic fillings
- Simple extractions
- 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

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$1000	$2000	$2000
PREVENTIVE SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
	100%	100%	100%
BASIC SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
	50%	70%	80%
MAJOR SERVICE	**YEAR 1**	**YEAR 2**	**YEAR 3**
	15%	30%	40%

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

Spirit Flex Plus 2500

The Spirit Flex Plus 2500 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. This Spirit plan gives you the freedom to use any dentist. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as the providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit **ameritas.com** and select **Find a Health Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Additionally, when you visit a network dental provider your out-of-pocket costs may be lower because the dentists have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges*.

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

Spirit Flex Plus 2500 | This policy pays for dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the $100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are : 100% for Preventive Services, 50% for Basic and 20% for Major. In year two, Basic services increase to 70% and 40% for Major Services. In year three, Basic Services increase to 80% and 50% for Major Services. Your benefit year maximum amount starts in year one at $1,500 and increases to $2,500 year two and thereafter.

MAX BENEFIT	YEAR 1	YEAR 2	YEAR 3
	$1500	$2500	$2500
PREVENTIVE SERVICE	YEAR 1	YEAR 2	YEAR 3
	100%	100%	100%
BASIC SERVICE	YEAR 1	YEAR 2	YEAR 3
	50%	70%	80%
MAJOR SERVICE	YEAR 1	YEAR 2	YEAR 3
	20%	40%	50%

Preventive | Type One

- Two exams per benefit year
- Three cleanings per benefit year

Basic | Type Two

- Basic filings
- One series of bitewing X-rays per benefit year
- Sealants age 15 and under
- One topical fluoride per benefit year age 15 and under
- Space Maintainers

Major | Type Three

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

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

Rates and Area Definitions

Rates for: Alaska, Georgia, Louisiana, Missouri, Mississippi

Spirit Preventive Plus 1500	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Application	$23.29	$25.77	$28.26	$31.05	$34.16	$37.57	$41.30
Application + 1	$46.58	$51.54	$56.51	$62.10	$68.31	$75.14	$82.59
Application + Family	$74.52	$82.47	$90.42	$99.36	$109.30	$120.23	$132.15

Spirit Core 1200	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Application	$32.79	$36.29	$39.79	$43.72	$48.09	$52.90	$58.15
Application + 1	$66.98	$74.12	$81.26	$89.30	$98.23	$108.05	$118.77
Application + Family	$110.81	$122.63	$134.45	$147.75	$162.53	$178.78	$196.51

Spirit Preferred 3500	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Application	$47.15	$52.01	$56.88	$62.36	$68.45	$75.14	$82.44
Application + 1	$93.98	$103.72	$113.46	$124.41	$136.58	$149.97	$164.58
Application + Family	$149.50	$165.08	$180.66	$198.19	$217.67	$239.09	$262.46

Spirit Pinnacle 5000	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Application	$44.75	$49.53	$54.30	$59.67	$65.64	$72.20	$79.36
Application + 1	$90.90	$100.60	$110.29	$121.20	$133.32	$146.65	$161.20
Application + Family	$149.09	$165.00	$180.90	$198.79	$218.67	$240.54	$264.39

Spirit Flex 2000	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Application	$28.17	$31.17	$34.18	$37.56	$41.32	$45.45	$49.95
Application + 1	$56.34	$62.35	$68.36	$75.12	$82.63	$90.90	$99.91
Application + Family	$90.14	$99.76	$109.37	$120.19	$132.21	$145.43	$159.85

Spirit Flex Plus 2500	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6	AREA 7
Application	$39.32	$43.52	$47.71	$52.43	$57.67	$63.44	$69.73
Application + 1	$78.65	$87.03	$95.42	$104.86	$115.35	$126.88	$139.46
Application + Family	$125.84	$139.26	$152.68	$167.78	$184.56	$203.01	$223.15

Area Definitions for:

ALASKA

All Areas	7

GEORGIA

302, 310, 312	2
301, 304, 308-309, 315	3
303, 311, 316, 399	5
All Others	4

LOUSIANA

703-705, 707-708, 711	4
All Others	3

MISSOURI

638-639	2
634, 637, 653-655	3
630, 633, 640	5
651-652, 658	
641, 649	6
All Others	4

MISSISSIPPI

All	1

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 online your coverage can start as soon as the next day. 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 provider performing dental services within the scope of their 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. 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.
DETERMINING BENEFITS | The benefits payable will be determined by totaling all Covered Expenses submitted into each plan benefit type as shown in the Dental Summary. This amount is reduced by the Deductible, if any. The result is then multiplied by the appropriate Coinsurance Percentage(s). Benefits are subject to the Maximum, procedural and/or plan limitations.
UTILIZATION REVIEW | We have established utilization review standards to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients and characteristics of the local delivery system.

This program was developed in conjunction with actively practicing and licensed providers, is based on sound clinical principles and processes and is reviewed at least annually to ensure that criteria are applied consistently. Our program also has been developed for consistency with the standards as established by the American Dental Association ("ADA") published in their Current Dental Terminology @American Dental Association, and will be updated as these standards are updated by the ADA.

Any decisions to deny or partially deny a benefit for a covered service based on dental necessity shall be made by a peer clinical reviewer. Since November 1, 2008, Ameritas has maintained full accreditation under URAC's Health Utilization Management Accreditation Program.

***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.**

Limitations & Exclusions

Dental

Covered expenses will not include and benefits will not be payable for expenses incurred:

- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- to replace any crowns, inlays, onlays, veneers, complete or partial dentures within five years of the date of the last placement of these items. But if a replacement is required because of an accidental bodily injury sustained while the insured person is covered under this contract, it will be a covered expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed partial denture must include the replacement of the extracted tooth or teeth.
- for any procedure begun before the insured person was covered under the policy.
- for any procedure begun after the insured person's insurance under the policy terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the insured's insurance under the policy terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion; or
  - splint or replace tooth structure lost as a result of abrasion or attrition.
- for any procedure which is not shown on the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures in the policy.)
- for orthodontic treatment under the following provisions:
  - for treatment begun on or after the insured's 19th birthday;
  - for treatment begun before the insured became covered under this section;
- for which the insured person is entitled to benefits under any workmen's 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 any employment for wage or profit (except in CA & KY).
- for charges for which the insured person is not liable or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- if two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the covered expense will be equal to the charge for the least expensive procedure.

Orthodontia

Covered Expenses will not include and no benefits will be payable for expenses incurred:

- for a Program begun on or after the Insured's 19th birthday.
- for a Program which uses a material other than metal brackets for treatment. The benefit will be considered as though metal brackets were applied.
- for a Program begun before the Insured became covered under this section,
- in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
- for a Program more than once in a lifetime.
- if the Insured's insurance under this section terminates.
- for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for 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 any employment for wage or profit.
- for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
- for services not required for necessary care and treatment or not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- to fix or repair broken or damaged orthodontic appliances.
- to replace lost, missing or stolen orthodontic appliances.
- for expenses incurred as a result of the Insured not being compliant with the Treatment Program.
- for services to alter vertical dimension and/or restore or maintain the occlusion due to, but not limited to the following: equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

Hearing

Covered Expenses will not include and no benefits will be payable for expenses incurred:

- examinations performed before the Insured was covered under this section.
- any examination performed after the Insured's coverage under this section ceases.
- any hearing examination required by an employer as a condition of employment, including but not limited to, any mandatory worksite programs designed to satisfy OSHA hearing conservation programs.
- medical or surgical treatment of any part of the ear, including but not limited to, cochlear implants, or tubes in the ears.
- 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 hearing loss caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit, including an occupational hearing loss.
- charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
- any procedure not shown in the Schedule of Hearing Care Services.
- any treatment which is for cosmetic purposes.
- assistive hearing devices not listed in the Schedule of Hearing Care Services, such as phone amplification, cellular phone amplifier, hearing aid dehumidifier, loop system, etc.
- charges for services not provided by a licensed provider, such as an audiologist, hearing aid specialist, otolaryngologist (ENT) or otologist (ear doctor), within the scope of that license.
- services which are not related to a conductive or sensorineural hearing loss, such as any nonorganic hearing loss or occupational hearing loss.
- charges for a hearing screening performed as a part of or in the course of any non-hearing routine examination.
- because of war or any act of war, declared or not.

***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.**

Optional Vision Coverage

EyeMed Vision Rider

Spirit's optional vision plan utilizes the EyeMed Vision Care network. EyeMed is a leading vision benefits company, offering the following features: savings on eye care and eyewear, quality standards for care and materials and access to thousands of providers nationwide including independent providers and major retail chains.

EYE EXAMINATIONS

Annual eye exams do more than check vision. Exams can detect a variety of conditions, including diabetes, high blood pressure and glaucoma. Early detection and treatment can minimize the effect of these conditions on long-term health. Spirit Vision Insurance covers annual eye exams for maximum health benefits.

USING THE PLAN

- To search for a provider, go to eyemed.com and select the Access Network, or call (866) 289-0614.
- Present your ID card which includes your member ID number.
- The provider will do the rest! There are no claim or authorization forms necessary for in-network benefits.
- For the most accurate information, remember your Plan Number: **V00830**

Monthly Premium	
Application	$7.00
Application + 1	$14.00
Application + Family	$20.00

This EyeMed vision plan is not available in AK, KS, ID, MD, MA, MT, NM, NY, OH, PA, RI, TX or WA. Please visit spiritdental.com to see the vision plan available in your state.

In-Network Benefits

Eye Examinations
$10 deductible (once every 12 months)
Eye examinations include dilation as determined by the doctor.

Exam Options
Contact lens wearers will pay up to $55 for standard contact lens exam, including fit and follow-up, or receive 10% off retail price for premium contact lens exam, fit and follow-up.

Eyeglass Lenses
$20 deductible (once every 24 months)
Plan covers standard plastic single vision, bifocal or trifocal lenses of any size or power. Lens options are available at additional cost.

Frames
$0 deductible (once every 24 months)
Plan covers a $130 retail allowance that can be applied toward the purchase of any frame available at the provider location. The member will also receive a 20% discount off the balance if selecting a frame that costs more than $130.

Contact Lenses (instead of lenses and frame)
$20 deductible (once every 24 months)
Plan covers a $130 retail allowance that can be applied toward the purchase of conventional or disposable contact lenses.
If the member chooses conventional contact lenses with a retail price over $130, member will receive 15% off the balance. Medically necessary contact lenses are paid in full after the deductible.

Additional Discounts
Spirit Vision members will also receive unlimited additional discounts on purchases made at participating provider

- 40% off additional complete pairs of eyeglasses
- 15% off additional purchases of conventional contact lenses
- 20% off non-covered items like cleaning cloths or nonprescription sunglasses

Out-of-Network Benefits

Members receive the richest benefits when using a participating EyeMed provider. However, the plan includes an out-of-network benefit for services and materials obtained through non-network providers.

Reimbursement Levels
- Eye Examination - Up to $25 Frames - Up to $40
- Single Vision Lenses - Up to $20 Bifocal Lenses - Up to $30
- Trifocal Lenses - Up to $40 Contact Lenses - Up to $60

Using Out-of-Network Benefits
Members must file claims for out-of-network benefits. Members can obtain an out-of-network claim form from EyeMed's Web site, eyemed.com, or by calling 866-289-0614.

Members will pay for all services and materials in full, then submit the completed claim form with receipts for reimbursement.

Limitations and Exclusions

This plan has the following limitations:

- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- This plan does not cover Medically Necessary Contact Lenses more than once in any 24-month period. The treating provider determines if an Insures meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses.
  - For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
  - Patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best standard spectacle lens correction.
  - Anisometropia od 3D or more.
  - High Ametropia exceeding -10D or +10D in meridian powers.
- This plan does not cover Orthoptics or vision training and any associated testing.
- This plan does not cover Plane Lenses.
- This plan does not cover non-prescribed Lenses or sunglasses.
- This plan does not cover two pairs of glasses in lieu of Bifocals.
- This plan does not cover replacement of Lenses and Frames that are list of broken outside of the normal coverage intervals.
- This plan does not cover medical or surgical treatment of the eyes or supporting structures.
- This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.
- This plan does not cover any procedure not listed on the Schedule of Eye Care Services.

Based on applicable laws, reduced costs may vary by doctor location.

Optional Vision Coverage

EyeMed Vision Rider

GLASSES.COM AND CONTACTSDIRECT.COM

Members can use glasses.com and contactsdirect.com as an in-network option to purchase frames and contacts.

FOR GLASSES

- Simply send a picture of the prescription. Lenses are available for most prescriptions, including progressives and multifocals.
- Orders are fulfilled and shipped free the following day.
- Once received if you need an adjustment visit any LensCrafters.

FOR CONTACTS

- Select your lenses from a wide selection of top selling brands.
- Contacts will ship as soon as the prescription is verified – most that same day – and for free.

OTHER EYEMED VISION DISCOUNTS

Coatings and lens treatments can be added for the costs below:

Lens Options	
Polycarbonate lenses	$40.00
Scratch-Resistant	$15.00
coating Solid or	$15.00
gradient tint Ultraviolet	$15.00
coating	$45.00
Anti-reflective coating	
Standard Progressive	
Add on bifocal	$65.00
Lens options not listed	20% off retail price

Based on applicable laws, reduced costs may vary by doctor location.

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 866-289-0614 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.
| Visit **ameritas.com** and select **Find a Health Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

What can you tell me about Ameritas, the insurance company underwriting this plan?
| Ameritas Life Insurance Corp. offers a wide range of insurance and financial products and services to individuals, families and businesses. Ameritas has been offering dental insurance since 1959 and vision insurance since 1984. Claims service associates have earned BenchmarkPortal's Center of Excellence award since 2006.

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 20,000 agents who provide coverage to over 150,000 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

DirectBenefits AN ALERA GROUP COMPANY

Plan Distributed by Direct Benefits
7900 International Drive, Suite 1040
Bloomington, MN 55425
info@directbenefits.com | 800.620.5010
www.directbenefits.com/agents

Ameritas

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