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 #: 1-877-667-6127
Effective Date: Beginning on or after 03/01/2024
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 1-877-667-6127.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

PART II: DEDUCTIBLES

Deductible	**All Providers**
Dental	$100 combined per benefit period per individual, 3 members per family.

The dental deductible applies to all dental services.
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	$2,500 - limited to $1250 for Major services
Lifetime or Annual Maximum for Orthodontia	Not Covered

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 or services 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**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions, for a full listing refer to the 700 Table of Dental Procedures in your Policy.**
Oral Exam	Preventive & Diagnostic	Year 1: 20%, Year 2: 10%, Year 3: 0%	Year 1: 50%, Year 2: 40%, Year 3: 30%	2 of any of these procedures per benefit period.
Bitewing X-ray	Basic	Year 1: 50%, Year 2: 40%, Year 3: 20%	Year 1: 70%, Year 2: 60%, Year 3: 50%	1 of any of these procedures per benefit period.
Cleaning	Preventive & Diagnostic	Year 1: 20%, Year 2: 10%, Year 3: 0%	Year 1: 50%, Year 2: 40%, Year 3: 30%	3 of any of these procedures per benefit period.
Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions, for a full listing refer to the 700 Table of Dental Procedures in your Policy.**
Filling	Basic	Year 1: 50%, Year 2: 40%, Year 3: 20%	Year 1: 70%, Year 2: 60%, Year 3: 50%	1 of any of these procedures per 2 years.

Extraction, Erupted Tooth or Exposed Root	Major	Year 1: 80%, Year 2: 70%, Year 3: 50%	Year 1: 90%, Year 2: 80%, Year 3: 70%	
Root Canal	Major	Year 1: 80%, Year 2: 70%, Year 3: 50%	Year 1: 90%, Year 2: 80%, Year 3: 70%	Benefits are considered on permanent teeth only.
Scaling and Root Planing	Major	Year 1: 80%, Year 2: 70%, Year 3: 50%	Year 1: 90%, Year 2: 80%, Year 3: 70%	Each quadrant is limited to 1 of each of these procedures per 2 years.
Ceramic Crown	Major	Year 1: 80%, Year 2: 70%, Year 3: 50%	Year 1: 90%, Year 2: 80%, Year 3: 70%	Replacement is limited to 1 of any of these procedures per 5 years.
Removable Partial Denture	Major	Year 1: 80%, Year 2: 70%, Year 3: 50%	Year 1: 90%, Year 2: 80%, Year 3: 70%	Replacement is limited to 1 of any of these procedures per 5 years.
Extraction, Erupted Tooth with Bone Removal	Major	Year 1: 80%, Year 2: 70%, Year 3: 50%	Year 1: 90%, Year 2: 80%, Year 3: 70%	
Orthodontia	Orthodontia	Not Covered	Not Covered	

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 product to other dental products 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: $100.00 Out-of-network: $100.00	Deductible	In-network: $100.00 Out-of-network: $100.00	Deductible	In-network: $100.00 Out-of-network: $100.00
Annual Maximum (Plan Will Pay)	In-network: $2,500 - limited to $1250 for Major services Out-of-network: $2,500 - limited to $1250 for Major services	Annual Maximum (Plan Will Pay)	In-network: $2,500 - limited to $1250 for Major services Out-of-network: $2,500 - limited to $1250 for Major services	Annual Maximum (Plan Will Pay)	In-network: $2,500 - limited to $1250 for Major services Out-of-network: $2,500 - limited to $1250 for Major services

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: Year 1: 20%, Year 2: 10%, Year 3: 0% Out-of-network: Year 1: 50%, Year 2: 40%, Year 3: 30%	Patient Cost (copayment or coinsurance)	In-network: Year 1: 50%, Year 2: 40%, Year 3: 20% Out-of-network: Year 1: 70%, Year 2: 60%, Year 3: 50%	Patient Cost (copayment or coinsurance)	In-network: Year 1: 80%, Year 2: 70%, Year 3: 50% Out-of-network: Year 1: 90%, Year 2: 80%, Year 3: 70%
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	**In-network:** $160.00 **Out-of-network:** $325.00	**In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $125.00 **Out-of-network:** $170.00	**In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $1,060.00 **Out-of-network:** $1,585.00

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 5 years. Cleanings: 3 of any of these procedures per benefit period.	Summary of what is not covered or subject to a limitation:	1 of any of these procedures per 2 years.	Summary of what is not covered or subject to a limitation:	Replacement is limited to 1 of any of these procedures per 5 years.