

## Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

### Part I: GENERAL INFORMATION

<b>Insurer Name:</b> Ameritas Life Insurance Corp.	<b>Plan Name:</b> Traditional
<b>Policy Type:</b> PPO	<b>Insurer Phone #:</b> 1-800-487-5553
<b>Effective Date:</b> Beginning on or after 01/01/2025	<b>Insurer Website:</b> ameritas.com

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**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 1-800-487-5553.**

**THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.**

### PART II: DEDUCTIBLES

<b>Deductible</b>	<b>All Providers</b>
Dental	\$25 combined once per lifetime per individual
Orthodontia	None

**The \$25 lifetime combined deductible applies to all dental services, except Preventive & Diagnostic procedures.**

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

<b>Maximums</b>	<b>All Providers</b>
Annual Maximum	\$2,000
Lifetime or Annual Maximum for Orthodontia	\$2,000 Lifetime Max

**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.

<b>Common Dental Procedures</b>	<b>Category</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>Benefit Limitations and Exclusions, for a full listing refer to the 9232 Table of Dental Procedures in your Certificate of Insurance.</b>
<i>Oral Exam</i>	Preventive & Diagnostic	0%, deductible does not apply.	0%, deductible does not apply.	2 of any of these procedures per benefit period.
<i>Bitewing X-ray</i>	Preventive & Diagnostic	0%, deductible does not apply.	0%, deductible does not apply.	2 of any of these procedures per benefit period.
<i>Cleaning</i>	Preventive & Diagnostic	0%, deductible does not apply.	0%, deductible does not apply.	4 of any of these procedures per benefit period.
<b>Common Dental Procedures</b>	<b>Category</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>Benefit Limitations and Exclusions, for a full listing refer to the 9232 Table of Dental Procedures in your Certificate of Insurance.</b>
<i>Filling</i>	Basic	7%	20%	
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	7%	20%	
<i>Root Canal</i>	Basic	7%	20%	

<i>Scaling and Root Planing</i>	Basic	7%	20%	1 of any of these procedures per 60 months.
<i>Ceramic Crown</i>	Major	40%	50%	
<i>Removable Partial Denture</i>	Major	40%	50%	1 of any of these procedures per 60 months.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	7%	20%	
<i>Orthodontia</i>	Orthodontia	50%	50%	

### **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**

New patient exam, x-rays (FMX) and cleaning

#### **Sam Needs a Tooth Filled**

Resin-based composite - one surface, posterior

#### **Maria Needs a Crown**

Crown - porcelain/ceramic substrate

<b>Dana's Visit</b>	<b>Dana's Cost</b>	<b>Sam's Visit</b>	<b>Sam's Cost</b>	<b>Maria's Visit</b>	<b>Maria's Cost</b>
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: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: \$25.00 Out-of-network: \$25.00	Deductible	In-network: \$25.00 Out-of-network: \$25.00
Annual Maximum (Plan Will Pay)	In-network: \$2,000 Out-of-network: \$2,000	Annual Maximum (Plan Will Pay)	In-network: \$2,000 Out-of-network: \$2,000	Annual Maximum (Plan Will Pay)	In-network: \$2,000 Out-of-network: \$2,000

<b>Dana's Visit</b>	<b>Dana's Cost</b>	<b>Sam's Visit</b>	<b>Sam's Cost</b>	<b>Maria's Visit</b>	<b>Maria's Cost</b>
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 0%	Patient Cost (copayment or coinsurance)	In-network: 7% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 40% Out-of-network: 50%
<b>In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):</b>	<b>In-network:</b> \$0.00 <b>Out-of-network:</b> \$0.00	<b>In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):</b>	<b>In-network:</b> \$10.50 <b>Out-of-network:</b> \$40.00	<b>In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):</b>	<b>In-network:</b> \$535.00 <b>Out-of-network:</b> \$887.50
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 36 months. Cleanings: 4 of any of these procedures per benefit period.	Summary of what is not covered or subject to a limitation:		Summary of what is not covered or subject to a limitation:	1 of any of these procedures per 60 months.