Ameritas BrightOne Plans are available only to members of the Plan Services Association.

WHAT KINDS OF SERVICES ARE COVERED?

1] **TYPE 1 CARE**
- *Oral Exams*
- *Prophylaxis (cleanings)*
- *Fluoride treatments (for children under 19)*

2] **TYPE 2 CARE**
- *X-rays: full-mouth series, bitewings, occlusal, panoramic*
- *Amalgams (fillings), space maintainers*
- *Simple extractions*

3] **TYPE 3 CARE**
- *Endodontics (root canals)*
- *Periodontics (gum disease)*
- *Crowns, bridges, onlays, pontics, general anesthesia (if medically necessary)*
- *Sealants*

EYE CARE

BrightOne Access Plans provide optional access to the VSP Network to maximize cost savings. By going to a VSP member doctor, each covered person receives:

1] *One eye exam per calendar year covered in full*

2] *20% off the cost of lenses and frames when a complete pair of prescription glasses is purchased*

3] *15% discount on contact lens exam (fitting and evaluation) when purchasing contacts*

4] *No up front paperwork*

5] *Savings averaging 15% off contracted laser center's prices for laser vision correction surgery or an additional 5% off the center's promotional price.*

Insureds also have the option of choosing their own eye care provider. Benefits for service from a non-VSP provider are paid on a scheduled amount per area.

For additional information about eye care benefits, including a list of network doctors, call VSP Customer Service at ***1-800-877-7195 or visit them online at www.vsp.com.***

WHAT ALLOWANCES IMPACT MY PLAN?

WISE BUYER (Traditional Plan)
Reimbursements are based on the median dental fees charged per procedure in the specific ZIP Code area where dental services were performed.

U&C 90TH PERCENTILE (Progressive Plan and Access Plan Out-of-Network)
Usual and Customary (U&C) - Benefits for a given dental procedure are paid according to the usual and customary charge for that procedure within a particular ZIP Code area. BrightOne Plans utilize the 90th percentile of U&C, which means that 9 out of 10 dentists in a specific area charge at or below the plan allowance for a procedure.

MAC (Access Plan In-Network)
Maximum Allowable Charge (MAC) - A discounted dental procedure charge that is derived from the array of provider charges within a particular ZIP Code area. MAC fees are associated with a PPO plan and are accepted by participating providers.

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HealthPlan Services;
800-545-6441, X-6216,
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HealthPlan Services *HealthPlan Services is a leading managed health care services company, providing distribution, enrollment, billing and collection, claims administration, and risk management services for health care payors and providers. HPS customers include insurance companies, HMOs and other managed care organizations, and organizations with self-funded health care plans. Based in Tampa, Florida, the company serves over 100,000 businesses, covering over 1.6 million members in the United States.*

Insured by: AMERITAS GROUP
We're Ameritas. We're for people.®
A Division of Ameritas Life Insurance Corp.
A UNIFI Company

Ameritas Group offers the flexible, affordable dental and eye care coverage that today's employers demand. Highlights include superior customer service, choice of plan designs, dental maximum rollover, quality PPO network, accurate and fast claims-paying system, and a parent company with consistently high ratings for financial strength and stability from independent insurance industry analysts.

BRIGHT ONE® PLANS

one life dental insurance

It's smart to put your money where your mouth is.

FOR INDIVIDUALS, FAMILIES AND SOLE PROPRIETORS

COVERAGE OF TYPE 1, TYPE 2 AND TYPE 3 SERVICES

FREEDOM TO USE ANY DENTIST

CHOICE OF PLANS

EASY BILLING

ADULT AND CHILD ORTHODONTIA AVAILABLE

15471 6050 11/07 MP

A Single-Minded Focus on your HEALTH and WELL-BEING.

"According to The American Dental Hygienists' Association, every $1 spent on prevention in oral health care saves $8 to $50 on restorative and emergency procedures. That's one reason why BrightOne Plans pay 100% of the amount allowed for preventive care, and offer comprehensive benefits for you and your family, at reasonable rates. Because you can't really put a price tag on good health... and a beautiful smile."

FEATURES AND BENEFITS — THE PLANS AT A GLANCE

	TRADITIONAL PLAN	PROGRESSIVE PLAN	ACCESS PLAN *not available in all ZIP Codes*	
	This comprehensive coverage gives you the freedom to use any dentist you wish, and pays 100% of the amount allowed for Type 1 care after a short elimination period. The plan features high coinsurance levels, low deductibles and a choice of calendar year maximums.	*Visiting a dentist (PPO & non-PPO) and having a covered procedure completed each year qualifies the insured to increase their coinsurance level the next year. Insureds who do not receive a covered procedure in a calendar year revert to the lowest level. You may use the dentist of your choice, and select your calendar year maximum. Orthodontia benefits for adults and children are included after a 12-month elimination period.*	*This plan provides the opportunity to reduce your out-of-pocket costs by using an in-network provider, yet you are always free to select a dentist not associated with the Ameritas PPO. The plan also covers a yearly eye exam. Select a Vision Service Plan (VSP) participating provider for an eye exam covered at 100% and access to additional discounts. Insureds also have the option of choosing a non-VSP provider (benefits are paid on a scheduled amount per area).*	
			IN-NETWORK	**OUT-OF-NETWORK**
TYPE 1 CARE (Preventive)	**100%** 3-month elimination period	**100%** No elimination period	**100%** 3-month elimination period	**80%** 3-month elimination period
TYPE 2 CARE (Basic)	**80%** 6-month elimination period	**60% — 70% — 80%** 6-month elimination period	**80%** 6-month elimination period	**60%** 6-month elimination period
TYPE 3 CARE (Major)	**50%** 12-month elimination period	**30% — 40% — 50%** 12-month elimination period	**50%** 18-month elimination period	**40%** 18-month elimination period
CALENDAR YEAR DEDUCTIBLES per person	**$0** for Type 1 **$50** for Type 2 and Type 3	**$0** for Type 1 **$25** for Type 2 **$100** Lifetime for Type 3	**$0** for Type 1 **$5** per visit Type 2 & Type 3	**$0** for Type 1 **$50** Type 2 & Type 3
CALENDAR YEAR MAXIMUMS per person	**$750** or **$1000**	**$750** or **$1000**	**$1000** or **$1500**	**$1000** or **$1500**
ORTHODONTIA	**NOT COVERED**	**NO DEDUCTIBLE** **$600** lifetime maximum **$200** maximum per calendar year 12-month elimination period	**NOT COVERED**	**NOT COVERED**
EYE CARE EXAMS	**NOT AVAILABLE**	**NOT AVAILABLE**	**INCLUDED** 3-month elimination period	**INCLUDED** 3-month elimination period
CLAIM ALLOWANCE	**WISE BUYER** *claim allowance is based on the median dental fees charged per procedure in the specific ZIP Code area where dental services were performed.*	**USUAL AND CUSTOMARY (U&C)** - *Benefits for a given dental procedure are paid according to the usual and customary charge for that procedure within a particular ZIP Code area. This plan utilizes the 90th percentile of U&C, which means that 9 out of 10 dentists in a specific area charge at or below the plan allowance for a procedure.*	**MAXIMUM ALLOWABLE CHARGE (MAC)** - *A discounted dental procedure charge that is derived from the array of provider charges within a particular ZIP Code area. MAC fees are associated with a PPO plan and are accepted by participating providers.*	**USUAL AND CUSTOMARY (U&C)** - *Benefits for a given dental procedure are paid according to the usual and customary charge for that procedure within a particular ZIP Code area. This plan utilizes the 90th percentile of U&C, which means that 9 out of 10 dentists in a specific area charge at or below the plan allowance for a procedure.*

LIMITATIONS & EXCLUSIONS Ameritas BrightOne Plans coverage does not provide benefits:

1] *For Type 1 procedures, in the first three months that the Insured is covered under this section for Traditional and Access Plans.*
2] *For Type 2 procedures, in the first six months that the Insured is covered under this section.*
3] *For Type 3 procedures, in the first 12 months that the Insured is covered under this section for Traditional and Progressive Plans, and in the first 18 months for Access Plans.*
4] *For any treatment which is for cosmetic purposes. Facings on crowns or pontics beyond the second bicuspid are considered cosmetic.*
5] *To replace any prosthetic appliance, crown, onlay restoration, or fixed partial denture 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 section, it will be a Covered Expense.*
6] *For initial placement of any prosthetic appliance or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the Insured person is covered under this section. 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.*
7] *For any procedure begun before the Insured person was covered under this section.*
8] *For any procedure begun after the Insured's insurance under this section terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this section terminates.*
9] *To replace lost or stolen appliances.*
10] *For appliances, restorations, or procedures to:*
   a. alter vertical dimension;
   b. restore or maintain occlusion; or
   c. splint or replace tooth structure lost as a result of abrasion or attrition.
11] *For any procedure which is not shown on the Table of Dental Procedures.*
12] *For orthodontic treatment under this benefit provision.*
13] *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 any employment for wage or profit.*
14] *For charges for which the Insured person is not liable or which would not have been made had no insurance been in force.*
15] *For services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.*
16] *Because of war or any act of war, declared or not.*

ORTHODONTIA LIMITATIONS for Progressive Plan, as noted in the certificate. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1] *For a Program which was begun before the Insured became covered under this section.*
2] *Before the Insured has been insured under this section for at least 12 consecutive months.*
3] *In any quarter of a Program if the Insured was not covered under this section for the entire quarter.*
4] *After the Insured's insurance under this section terminates.*
5] *For which the Insured 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 any employment for wage or profit.*
6] *For charges which the Insured is not legally required to pay or which would not have been made had no insurance been in force.*
7] *For services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.*
8] *Because of war or any act of war, declared or not.*

ELIGIBILITY

APPLICANT *Any member of the Plan Services Association*

DEPENDENT *Any dependent who is a spouse, or an unmarried child under age 19, or under age 24 for unmarried, full-time students dependent on the applicant for support. (The limiting age for dependent children may vary by state).*

**To find provider in your area, visit http://www.ameritasgroup.com/provider*

This brochure highlights the features of our BrightOne Plans. A complete description is in the Certificate of Insurance issued to each insured member of the Plan Services Association.

All benefits are subject to provisions in group policy form 9000 issued to the Plan Services Association.