

(BRIGHT ONE[®] PLANS)

dental insurance for
individuals, families and seniors



*Smart coverage options for today's
health- and cost-conscious consumers*

NEW AND IMPROVED PLANS

DENTAL REWARDS[®] INCLUDED ON ALL PLANS

FREEDOM TO USE ANY DENTIST

EYE CARE AVAILABLE

EASY PAYMENT OPTIONS

ADULT AND CHILD ORTHODONTIA AVAILABLE
(PROGRESSIVE PLAN)

BRIGHTONE[®] PLANS

dental insurance for individuals, families and seniors

TRADITIONAL PLAN

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. Insureds have the option of adding a yearly eye exam covered at 100% if a VSP[®] Vision Care member doctor is selected.*

TYPE 1 CARE (Preventive)	100% 3-month elimination period
TYPE 2 CARE (Basic)	80% 6-month elimination period
TYPE 3 CARE (Major)	50% 12-month elimination period
CALENDAR YEAR DEDUCTIBLES <small>per person</small>	\$0 for Type 1 \$50 for Type 2 and Type 3
CALENDAR YEAR MAXIMUMS <small>per person</small>	\$1000 or \$1500
ORTHODONTIA (adult and child)	NOT COVERED
EYE CARE EXAMS	OPTIONAL (on \$1000 calendar year maximum only)
DENTAL REWARDS[®]	INCLUDED
TAKEOVER	AVAILABLE
CLAIM ALLOWANCE (*AMOUNT ALLOWED)	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.

PROGRESSIVE PLAN

Visiting a dentist and having a covered procedure completed each year qualifies insureds 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.

TYPE 1 CARE (Preventive)	100% No elimination period
TYPE 2 CARE (Basic)	60% — 70% — 80% 6-month elimination period
TYPE 3 CARE (Major)	30% — 40% — 50% 12-month elimination period
CALENDAR YEAR DEDUCTIBLES <small>per person</small>	\$0 for Type 1 \$25 for Type 2 \$100 Lifetime for Type 3
CALENDAR YEAR MAXIMUMS <small>per person</small>	\$1000
ORTHODONTIA (adult and child)	NO DEDUCTIBLE \$600 lifetime maximum \$200 maximum per calendar year 12-month elimination period
EYE CARE EXAMS	NOT AVAILABLE
DENTAL REWARDS[®]	INCLUDED
TAKEOVER	AVAILABLE
CLAIM ALLOWANCE	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.

SAVER PLAN

This plan features no elimination period for Type 1 (Preventive) care. Plus, the plan has the shortest elimination periods for Type 2 (Basic) care and Type 3 (Major) care when compared to our other plans. Insureds qualify to increase their coinsurance level annually simply by visiting the dentist of their choice each year and undergoing a covered procedure. Insureds who do not receive a covered procedure in a calendar year revert to the lowest coinsurance level.

TYPE 1 CARE (Preventive)	100% No elimination period
TYPE 2 CARE (Basic)	35% — 50% — 65% 3-month elimination period
TYPE 3 CARE (Major)	10% — 25% — 50% 6-month elimination period
CALENDAR YEAR DEDUCTIBLES <small>per person</small>	\$0 for Type 1 \$50 for Type 2 and Type 3
CALENDAR YEAR MAXIMUMS <small>per person</small>	\$1000 or \$1500
ORTHODONTIA (adult and child)	NOT AVAILABLE
EYE CARE EXAMS	NOT AVAILABLE
DENTAL REWARDS®	INCLUDED
TAKEOVER	AVAILABLE
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.

ADVANTAGE II PLAN

This plan offers 100% of the amount allowed for preventive care coverage with no elimination period, and includes Dental Rewards®. Insureds have the option of adding a yearly eye exam covered at 100% if a VSP® Vision Care member doctor is selected.*

TYPE 1 CARE (Preventive)	100% No elimination period
TYPE 2 CARE (Basic)	50% 3-month elimination period
TYPE 3 CARE (Major)	25% 6-month elimination period
CALENDAR YEAR DEDUCTIBLES <small>per person</small>	\$0 for Type 1 \$50 for Type 2 and Type 3
CALENDAR YEAR MAXIMUMS <small>per person</small>	\$1000
ORTHODONTIA (adult and child)	NOT AVAILABLE
EYE CARE EXAMS	OPTIONAL
DENTAL REWARDS®	INCLUDED
TAKEOVER	AVAILABLE
CLAIM ALLOWANCE (*AMOUNT ALLOWED)	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.

SMART I PLAN

The Smart I plan is the most affordable of our BrightOne plan designs. It includes no elimination period for Type 1 care, and Dental Rewards is automatically included. This plan doesn't offer coverage for Type 3 care. However, it does cover Endodontics (root canals) and Periodontics (gum disease) under Type 2 care.

TYPE 1 CARE (Preventive)	50% No elimination period
TYPE 2 CARE (Basic)	50% 6-month elimination period
TYPE 3 CARE (Major)	0%
CALENDAR YEAR DEDUCTIBLES <small>per person</small>	\$50 for Type 1 and Type 2
CALENDAR YEAR MAXIMUMS <small>per person</small>	\$1000
ORTHODONTIA (adult and child)	NOT AVAILABLE
EYE CARE EXAMS	NOT AVAILABLE
DENTAL REWARDS®	INCLUDED
TAKEOVER	AVAILABLE
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.

Enjoy the **BENEFITS**
of **BUILT-IN**
EYE CARE
coverage.



Available on the Traditional and Advantage II plans.

COVERED SERVICES

1] TYPE 1 CARE (Preventive)

- Oral exams
- Prophylaxis (cleanings)
- Fluoride treatments (for children under 14)
- X-rays: full-mouth series, bitewings, panoramic

2] TYPE 2 CARE (Basic)

- Amalgams (fillings)
- Simple extractions
- Endodontics (root canals) - Smart I plan only
- Periodontics (gum disease) - Smart I plan only
- Sealants (for children under 14)

3] TYPE 3 CARE (Major) - Not covered on Smart I plan

- Endodontics (root canals)
- Periodontics (gum disease)
- Crowns, bridges, onlays, pontics, general anesthesia (if medically necessary)
- Space maintainers

EYE CARE

BrightOne Traditional and Advantage II plans provide optional access to the VSP® Vision Care doctor 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.

DENTAL REWARDS®

Automatically included on all plans, this feature rewards qualifying insureds who care for their teeth by rolling over a portion of their unused annual maximum. "Earn" a bonus to add to next year's maximum by making your annual visit to one of Ameritas' Participating Provider Organization (PPO) dentists, who offer a discount on services provided.

PLAN OPTIONS

ANNUAL MAXIMUM	ANNUAL BENEFIT THRESHOLD	ANNUAL DENTAL REWARD	ANNUAL PPO BONUS	MAXIMUM REWARD ACCUMULATION
\$1000	\$250	\$125	\$50	\$500
\$1500	\$500	\$250	\$50	\$1000

TAKEOVER

Takeover is included for qualifying insureds only. This benefit waives your waiting periods if you have had dental insurance within the past 30 days prior to your policy effective date. Proof of prior coverage is required and will be reviewed by Ameritas prior to acceptance.

LIMITATIONS & EXCLUSIONS

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 plan.
- 2] For Type 2 procedures, in the first six months that the Insured is covered under this section for Traditional, Progressive and Smart I plans and in the first three months on the Saver and Advantage II plans.
- 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 six months on the Saver and Advantage II plans. Not applicable to Smart I plan.
- 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 eight 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. Not applicable to Smart I plan.
- 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. Not applicable to Smart I plan.
- 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.

ALTERNATIVE PROCEDURES. 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. This provision is NOT intended to dictate a course of treatment. Instead, 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. Accordingly, the plan member may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

ORTHODONTIA LIMITATIONS for Progressive Plan, as noted in the policy.

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 individual age 18 or older.

DEPENDENT Any dependent who is a spouse, or an unmarried child under age 19, or to age 25 for unmarried, full-time students dependent on the applicant for support. (The limiting age for dependent children may vary by state).

ZIP CODE & AREA CHART

ALASKA

995-999 AREA B

DELAWARE

199 AREA 4

197 AREA 7

198 AREA 8

DISTRICT OF COLUMBIA

200, 202-205 AREA 5

GEORGIA

304, 307, 310, 315-317 AREA 1

305-306, 312, 318-319 AREA 2

308-309, 313-314 AREA 3

301-302 AREA 4

300, 303, 311 AREA 5

LOUISIANA

703-706, 710, 712-714 AREA 1

700, 707 AREA 2

701, 708 AREA 3

711 AREA 4

MISSISSIPPI

386-389, 393-397 AREA 2

390-391 AREA 3

392 AREA 4

MONTANA

590, 592-597, 599 AREA 3

591, 598 AREA 5

NORTH DAKOTA

580, 582-588 AREA 2

581 AREA 4

SOUTH CAROLINA

293, 295-299 AREA 1

290-292 AREA 2

294 AREA 4

SOUTH DAKOTA

570-576 AREA 2

577 AREA 3

TEXAS

768-769, 780-781, 783, 785,

788, 792-793, 795, 798-799 AREA 1

754-759, 762-767, 776-779,

782, 784, 786, 789-790,

794, 796-797 AREA 2

791 AREA 3

761, 773, 775 AREA 4

751-753, 760, 770-772, 774 AREA 5

750, 787 AREA 6

VERMONT

050-059 AREA 4

WEST VIRGINIA

247-268 AREA 1

WYOMING

820-831 AREA 2

MONTHLY PREMIUM CHART

TRADITIONAL PLAN

\$1000 ANNUAL MAXIMUM

AREA	APPLICANT	APPLICANT + SPOUSE	APPLICANT + CHILD(REN)	APPLICANT + SPOUSE & CHILD(REN)
1	34.71	69.42	75.91	110.62
2	37.35	74.70	81.92	119.27
3	40.25	80.50	89.02	129.27
4	43.09	86.19	95.55	138.65
5	46.47	92.95	103.85	150.33
6	49.85	99.69	111.48	161.33
7	53.84	107.67	120.77	174.60
8	57.84	115.69	129.35	187.20
9	61.34	122.69	138.29	199.63
A	64.83	129.65	145.73	210.55
B	68.68	137.36	155.70	224.37
C	77.05	154.09	174.35	251.40

\$1500 ANNUAL MAXIMUM

AREA	APPLICANT	APPLICANT + SPOUSE	APPLICANT + CHILD(REN)	APPLICANT + SPOUSE & CHILD(REN)
1	39.22	78.44	85.78	125.00
2	42.21	84.41	92.57	134.78
3	45.48	90.96	100.59	146.07
4	48.70	97.39	107.97	156.67
5	52.52	105.03	117.35	169.87
6	56.33	112.65	125.97	182.30
7	60.83	121.67	136.47	197.30
8	65.36	130.73	146.17	211.53
9	69.32	138.64	156.27	225.59
A	73.25	146.51	164.67	237.93
B	77.61	155.21	175.94	253.54
C	87.06	174.12	197.02	284.08

PROGRESSIVE PLAN

\$1000 ANNUAL MAXIMUM

AREA	APPLICANT	APPLICANT + SPOUSE	APPLICANT + CHILD(REN)	APPLICANT + SPOUSE & CHILD(REN)
1	34.65	69.29	82.63	117.28
2	37.21	74.42	88.58	125.79
3	40.02	80.04	95.62	135.64
4	42.78	85.55	102.09	144.87
5	46.05	92.11	110.32	156.38
6	49.32	98.64	117.88	167.20
7	53.19	106.38	127.08	180.27
8	57.08	114.15	135.57	192.65
9	60.47	120.94	144.44	204.91
A	63.85	127.69	151.80	215.64
B	67.58	135.16	161.69	229.27
C	75.69	151.38	180.16	255.85

SAVER PLAN

\$1000 ANNUAL MAXIMUM

AREA	APPLICANT	APPLICANT + SPOUSE	APPLICANT + CHILD(REN)	APPLICANT + SPOUSE & CHILD(REN)
1	27.32	54.63	62.41	89.73
2	29.39	58.79	67.36	96.75
3	31.68	63.35	73.22	104.89
4	33.92	67.83	78.60	112.51
5	36.58	73.15	85.45	122.02
6	39.23	78.46	91.73	130.95
7	42.37	84.74	99.38	141.75
8	45.52	91.05	106.43	151.95
9	48.28	96.56	113.82	162.10
A	51.02	102.04	119.93	170.94
B	54.05	108.10	128.17	182.22
C	60.64	121.27	143.52	204.15

\$1500 ANNUAL MAXIMUM

AREA	APPLICANT	APPLICANT + SPOUSE	APPLICANT + CHILD(REN)	APPLICANT + SPOUSE & CHILD(REN)
1	30.87	61.73	70.52	101.39
2	33.22	66.43	76.12	109.33
3	35.79	71.59	82.73	118.53
4	38.32	76.65	88.81	127.14
5	41.33	82.66	96.56	137.89
6	44.33	88.66	103.65	147.98
7	47.88	95.75	112.30	160.18
8	51.44	102.88	120.27	171.71
9	54.55	109.11	128.61	183.17
A	57.65	115.30	135.52	193.17
B	61.08	122.15	144.83	205.91
C	68.52	137.04	162.17	230.69

QUARTERLY TREND FACTOR

For all states EXCEPT FL, PA, and WA

EFFECTIVE DATE	TREND FACTOR
10/1/10 – 12/31/10	1.060
1/1/11 – 3/31/11	1.080
4/1/11 – 6/30/11	1.100

For FL only

EFFECTIVE DATE	TREND FACTOR
10/1/10 – 12/31/10	1.045
1/1/11 – 3/31/11	1.060
4/1/11 – 6/30/11	1.075

For PA only

EFFECTIVE DATE	TREND FACTOR
10/1/10 – 6/30/11	1.040

For WA only

EFFECTIVE DATE	TREND FACTOR
10/1/10 – 12/31/10	1.010
1/1/11 – 3/31/11	1.029
4/1/11 – 6/30/11	1.048

ADVANTAGE II PLAN

\$1000 ANNUAL MAXIMUM

AREA	APPLICANT	APPLICANT + SPOUSE	APPLICANT + CHILD(REN)	APPLICANT + SPOUSE & CHILD(REN)
1	27.32	54.63	62.41	89.73
2	29.39	58.79	67.36	96.75
3	31.68	63.35	73.22	104.89
4	33.92	67.83	78.60	112.51
5	36.58	73.15	85.45	122.02
6	39.23	78.46	91.73	130.95
7	42.37	84.74	99.38	141.75
8	45.52	91.05	106.43	151.95
9	48.28	96.56	113.82	162.10
A	51.02	102.04	119.93	170.94
B	54.05	108.10	128.17	182.22
C	60.64	121.27	143.52	204.15

SMART I PLAN

\$1000 ANNUAL MAXIMUM

AREA	APPLICANT	APPLICANT + SPOUSE	APPLICANT + CHILD(REN)	APPLICANT + SPOUSE & CHILD(REN)
1	10.94	21.88	25.58	36.52
2	11.82	23.65	27.80	39.63
3	12.79	25.58	30.39	43.18
4	13.68	27.36	32.62	46.31
5	14.84	29.67	35.76	50.60
6	15.94	31.88	38.52	54.46
7	17.33	34.65	42.18	59.50
8	18.63	37.25	45.28	63.90
9	19.85	39.69	48.80	68.65
A	20.90	41.79	51.16	72.05
B	22.21	44.42	55.08	77.29
C	24.93	49.85	61.71	86.64

EYE CARE MONTHLY PREMIUM

APPLICANT	\$1.25
APPLICANT + SPOUSE	\$2.50
APPLICANT + CHILD(REN)	\$2.25
APPLICANT + SPOUSE & CHILD(REN)	\$3.50

PREMIUM PAYMENT METHOD

PAYMENT METHOD	ADMINISTRATION FEE
EZ PAY (EFT)	NONE
DIRECT BILL	\$8.00 PER BILL

HOW TO CALCULATE YOUR BRIGHTONE PLAN PREMIUM

1] Determine which plan* design you would like to apply for.

- Traditional \$1000 Annual Maximum
- Traditional \$1000 Annual Maximum + Eye Care
- Traditional \$1500 Annual Maximum
- Progressive \$1000 Annual Maximum
- Saver \$1000 Annual Maximum
- Saver \$1500 Annual Maximum
- Advantage II \$1000 Annual Maximum
- Advantage II \$1000 Annual Maximum + Eye Care
- Smart I \$1000 Annual Maximum

2] Determine whom you want to insure under the plan.

- Applicant Only
- Applicant + Spouse
- Applicant + Child(ren)
- Applicant + Spouse & Child(ren)

3] Locate your residence address ZIP Code on the ZIP Code & Area Chart to determine your Area.

4] Match your area number/letter listed in the ZIP Code & Area Charts, to the same area number/letter listed on the Monthly Premium Chart for the plan you have chosen. This is your Monthly Base Premium. Enter it on the Premium Calculation Worksheet.

5] Choose a desired effective date and corresponding trend factor number. Enter this number on the Premium Calculation Worksheet and multiply the monthly premium by this number to obtain your monthly payment.

6] If requesting eye care, (Traditional \$1000 Annual Maximum and Advantage II \$1000 Annual Maximum only) determine your eye care monthly premium from the Eye Care Monthly Premium Chart. Enter it on the Premium Calculation Worksheet.

7] Select a premium payment method and add the monthly, quarterly, semi-annual or annual administration fee on the Premium Calculation Worksheet to obtain your total payment.

EZ Pay (EFT) = No Charge

Direct Bill** = \$8.00 per bill

To apply online go to www.healthplan.com.

*All plans are not available in every state. Ask about our group dental for groups of three or more.

PREMIUM CALCULATION WORKSHEET

PREMIUM PAYMENT FREQUENCY: MONTHLY QUARTERLY SEMI-ANNUAL ANNUAL

PREMIUM PAYMENT METHOD: EZ PAY (EFT) DIRECT BILL** (CHECK)

IF DIRECT BILL, AN \$8 BILLING FEE PER PAYMENT FREQUENCY APPLIES.

MONTHLY BASE PREMIUM \$ _____

TREND FACTOR x _____

MONTHLY PAYMENT OPTION

MONTHLY PAYMENT = \$ _____

EYE CARE (IF APPLICABLE) + \$ _____

MONTHLY ADMIN. FEE + \$ 8.00

TOTAL PAYMENT WITH APPLICATION = \$ _____

QUARTERLY PAYMENT OPTION

QUARTERLY PAYMENT = \$ _____

(MONTHLY x 3)
EYE CARE (IF APPLICABLE) + \$ _____

(MONTHLY x 3)
QUARTERLY ADMIN. FEE + \$ 8.00

TOTAL PAYMENT WITH APPLICATION = \$ _____

SEMI-ANNUAL PAYMENT OPTION

SEMI-ANNUAL PAYMENT = \$ _____

(MONTHLY x 6)
EYE CARE (IF APPLICABLE) + \$ _____

(MONTHLY x 6)
SEMI-ANNUAL ADMIN. FEE + \$ 8.00

TOTAL PAYMENT WITH APPLICATION = \$ _____

ANNUAL PAYMENT OPTION

ANNUAL PAYMENT = \$ _____

(MONTHLY x 12)
EYE CARE (IF APPLICABLE) + \$ _____

(MONTHLY x 12)
ANNUAL ADMIN. FEE + \$ 8.00

TOTAL PAYMENT WITH APPLICATION = \$ _____

Make Checks Payable to "HealthPlan Services"

Mail completed, signed application with payment to: Ameritas Application Processing, 5965 Sandy Ridge, Elkridge, MD 21075
Applications without full payment and voided check (or \$8 fee for direct bill) will not be processed. Call 1-877-634-1256 with questions.

DID YOU KNOW:

People with dental insurance are 2.5 times more likely to visit a dentist than those without insurance?*

TRANSLATION:

People without the protection of dental coverage are more likely to suffer through a painful oral problem than to get the corrective care they need.

APPLY TODAY:

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

All benefits are subject to provisions in the policy.

To find a provider in your area, visit www.ameritasgroup.com.

*2007 NADP Consumer Survey

HealthPlan Services
Gain the advantage.



We're Ameritas. We're for people.
A Division of Ameritas Life Insurance Corp.
A UNIFI Company

HealthPlan Services Plans are marketed and administered by HealthPlan Services, *Gain the advantage.* 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.



Plans are insured by Ameritas Life Insurance Corp. Ameritas Group, a division of Ameritas Life, has served customers since the mid-1970s and today provides dental, eye care and hearing care products and services for more than 65,000 employer groups, insuring or administering benefits for more than 4.8 million people nationwide. Ameritas has one of the largest dental PPO networks in the country. Its customer service claims contact center earned BenchmarkPortal's prestigious Center of Excellence certification for 2009, the third year in a row.

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INDIVIDUAL DENTAL Applicant Preparation Sheet

HealthPlan Services
Gain the advantage.



* Applicant: Please fill out starred information on this page. Section 1 & 2 for office use only.

Dear Valued Agent:

In order to help ensure the application process goes smoothly, we strongly encourage you to provide the following information with the insurance application.

1. _____
Name of Writing Agent (if applicable) Agent's Business Telephone Number

2. _____
Name of General Agent (GA) (if applicable) GA's Business Telephone Number

* 3. _____
Requested Plan Name Requested Annual Maximum

* Eye Care Yes No Requested Effective Date _____

* 4. Requested Premium Payment Frequency Monthly Quarterly Semi-Annual Annual
Requested Premium Payment Method EZ Pay (EFT) Direct Bill/Check (not available in Kentucky, Michigan and Tennessee)
If direct bill, an \$8 billing fee per payment frequency applies.

* 5. If requesting EZ Pay, complete the EZ Pay Agreement.

PAYOR NAME OR DEPOSITOR IF DIFFERENT RELATIONSHIP TO APPLICANT **X** PRIMARY PAYOR SIGNATURE DATE

NAME OF FINANCIAL INSTITUTION CHECKING / SAVINGS ACCOUNT NUMBER

FINANCIAL INSTITUTION ADDRESS CITY STATE ZIP

SPECIFY TYPE OF ACCOUNT CHECKING SAVINGS ABA 9 DIGIT ROUTING NUMBER (SEE BELOW OR PLEASE CALL YOUR FINANCIAL INSTITUTION FOR ASSISTANCE)

Ameritas and/or HealthPlan Services, acting as Plan Administrator on behalf of Ameritas, is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued. I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by HealthPlan Services, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Ameritas and/or HealthPlan Services in writing.

Joe Smith 123 Main Street Anytown, IL 12345	ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT
Pay to the order of HEALTHPLAN SERVICES	Date _____ \$ _____ Dollars
For _____	ROUTING NUMBER ⑆23456789 ⑆234567891011 1117



6. Mail completed insurance application, applicant preparation sheet and first month's premium to:

Ameritas Application Processing
5965 Sandy Ridge
Elkridge, MD 21075

application

individual insurance form



5900 O Street / P.O. Box 81889
Lincoln, NE 68501-1889

Dental Dental with Eye Care Policy

Plan selected _____

policyholder information Marital Status Single Married Domestic Partner (if applicable)

Social Security number _____ Affiliation, if applicable _____

Policyholder's last name, first name, MI _____

Date of birth _____ Male Female Phone number _____

Street address _____ Apt. # _____ City _____ State _____ ZIP _____

Billing address, if different from above _____ Apt. # _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

Have you been covered under another dental policy within the last 30 days? Yes No

- If yes:** 1. Please provide an Evidence of Coverage letter, with dates of coverage, from your prior carrier if you are eligible for takeover benefits.
2. Please complete the attached Replacement form.

Applicants and Dependents cannot have the same type of coverage under another Ameritas plan (i.e. no two Ameritas dental plans, no two Ameritas eye care plans).

dependent coverage information

 List all eligible dependents to be covered. (Policyholder must be enrolled to cover dependents.)

print full legal name (last, first, MI)	relationship	sex	date of birth	social security number
1 _____				
2 _____				
3 _____				
4 _____				
5 _____				

Premium payment frequency: Monthly Quarterly Semi-annual Annual

Premium method: EFT Check

agreements by Ameritas

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information.

Any policy including riders and rate notifications issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., insurance under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

agreements by policyholder

I hereby apply for insurance, for which I am eligible. I agree to be responsible for my premiums and those of my enrolled dependents. I acknowledge receipt of the outline of coverage. I understand coverage is NOT in force until the Company issues a Policy showing a Policy Effective Date.

- I consent to receiving my Policy, Explanation of Benefits, and other plan information electronically and I will electronically affirm my consent to do so. I understand I need Internet access and that I can withdraw my consent at any time per the notification instructions below. I understand I can receive any of the documents in paper form if I choose.

I have read the statements and answers to the above questions and they are complete and true to the best of my knowledge and belief. All statements are deemed to be representations and not warranties. I understand that it is my responsibility to give notice to Ameritas of changes in my e-mail address or any information above, as well as my status and my family's status that affect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice electronically through e-mail or in writing to Ameritas or its designee:

I understand the policy I am applying for provides dental or dental and eye care benefits only and is not a Medicare supplement.

X _____
Policyholder Signature Date

X _____
Insurance Producer Name and/or Number (if applicable) Date

regulatory notes

Review your policy carefully

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements below.)

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico and Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.



NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Ameritas Life Insurance Corp. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

c. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Failure to complete this accurately may provide a basis for the company to deny any future claims and to refund your premium as stated in the coverage of your Policy. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date) (Applicant's Signature)