

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 14)

2] TYPE 2 CARE

- X-rays: full-mouth series, bitewings, panoramic
- Amalgams (fillings)
- Simple extractions

3] TYPE 3 CARE

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

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, Saver, Advantage I and Advantage II Plans)

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.



dental insurance for association members



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

For more information visit us at www.healthplan.com

PLAN Services
HealthPlan Services Plans are marketed and administered by HealthPlan Services, 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.



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 Rewards maximum rollover, quality PPO network, accurate and fast claims payment, and a parent company with consistently high ratings for financial strength and stability from independent insurance industry analysts.

© 2008 HealthPlan Services. Ameritas, the bison symbol, BrightOne, and We're Ameritas. We're for people. are registered service marks of Ameritas Life Insurance Corp. All are used with permission. Ameritas Group, a division of Ameritas Life Insurance Corp. (AmeritasLife), a UNIFI Company, offers group dental and eye care products nationwide. In New York, insurance products are offered through First Ameritas Life Insurance Corp. of New York (First Ameritas). Certain plan designs may not be available in all areas. In Arizona, exclusions and limitations must accompany plan highlights. Some states require that brokers/producers be appointed with Ameritas Group before soliciting its products. To become appointed with Ameritas Group call 1-800-793-5851. Ameritas Group's dental and eye care tailored products (Form 9000 Ed. 01-05) and trust products (Form 9000-Trust Ed. 01-05) are issued and underwritten by Ameritas Life. The master group insurance policy providing coverage is governed by the laws of Missouri.

FOR INDIVIDUALS, FAMILIES AND SOLE PROPRIETORS
WHO ARE MEMBERS OF THE PLAN SERVICES ASSOCIATION

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

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.



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.

PROGRESSIVE PLAN

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.

FEATURES AND BENEFITS — THE PLANS AT A GLANCE

TYPE 1 CARE (Preventive)	100% 3-month elimination period	100% No elimination period
TYPE 2 CARE (Basic)	80% 6-month elimination period	60% — 70% — 80% 6-month elimination period
TYPE 3 CARE (Major)	50% 12-month elimination period	30% — 40% — 50% 12-month elimination period
CALENDAR YEAR DEDUCTIBLES <small>per person</small>	\$0 for Type 1 \$50 for Type 2 and Type 3	\$0 for Type 1 \$25 for Type 2 \$100 Lifetime for Type 3
CALENDAR YEAR MAXIMUMS <small>per person</small>	\$750 or \$1000	\$750 or \$1000
ORTHODONTIA	NOT COVERED	NO DEDUCTIBLE \$600 lifetime maximum \$200 maximum per calendar year 12-month elimination period
EYE CARE EXAMS	NOT AVAILABLE	NOT AVAILABLE
DENTAL REWARDS®	NOT AVAILABLE	NOT 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.	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.

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.

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 for Traditional, Progressive and Access Plans and in the first three months on the Saver Plan.
- 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 Plan, 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 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.

- 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.

continued on next page

SAVER PLAN

This plan features no waiting period for Type 1 (Preventive) care. Plus, the plan has the shortest waiting 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. This plan also includes Dental Rewards®, which reward qualifying insureds who care for their teeth by rolling over a portion of their unused annual maximum.

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>	\$750 or \$1000
ORTHODONTIA	NOT AVAILABLE
EYE CARE EXAMS	NOT AVAILABLE
DENTAL REWARDS®	INCLUDED
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.

ACCESS PLAN *not available in all ZIP Codes*

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	80% 3-month elimination period
TYPE 2 CARE (Basic)	80% 6-month elimination period	60% 6-month elimination period
TYPE 3 CARE (Major)	50% 18-month elimination period	40% 18-month elimination period
CALENDAR YEAR DEDUCTIBLES <small>per person</small>	\$0 for Type 1 \$5 per visit Type 2 & Type 3	\$0 for Type 1 \$50 Type 2 & Type 3
CALENDAR YEAR MAXIMUMS <small>per person</small>	\$1000 or \$1500	\$1000 or \$1500
ORTHODONTIA	NOT COVERED	NOT COVERED
EYE CARE EXAMS	INCLUDED 3-month elimination period	INCLUDED 3-month elimination period
DENTAL REWARDS®	NOT AVAILABLE	NOT AVAILABLE
CLAIM ALLOWANCE	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.

- 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.

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.

BRIGHTONE[®] PLANS

dental insurance for association members

ADVANTAGE PLANS

The Advantage I and Advantage II plans are the newest and most affordable of our BrightOne plan designs. Created for today's health- and cost-conscious consumers, they offer 100% preventive care coverage with no elimination period, and include Dental Rewards[®]. The Advantage I plan is ideal for individuals desiring only one exam and cleaning a year, while the Advantage II covers two annual exams and cleanings. The calendar year maximum also differs between the two plans.

	ADVANTAGE I	ADVANTAGE II
TYPE 1 CARE (Preventive)	100% No elimination period	100% No elimination period
TYPE 2 CARE (Basic)	50% 3-month elimination period	50% 3-month elimination period
TYPE 3 CARE (Major)	25% 6-month elimination period	25% 6-month elimination period
CALENDAR YEAR DEDUCTIBLES per person	\$0 for Type 1 \$50 for Type 2 & Type 3	\$0 for Type 1 \$50 for Type 2 & Type 3
CALENDAR YEAR MAXIMUMS per person	\$750	\$1000
ORTHODONTIA	NOT AVAILABLE	NOT AVAILABLE
EYE CARE EXAMS	NOT AVAILABLE	NOT AVAILABLE
DENTAL REWARDS[®]	INCLUDED	INCLUDED
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.	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.

LIMITATIONS & EXCLUSIONS

Ameritas BrightOne Plans coverage does not provide benefits:

- 1] For Type 2 procedures, in the first three months on the Advantage I and Advantage II plans.
- 2] For Type 3 procedures, in the first 6 months that the Insured is covered under this section for Advantage I and Advantage II Plans.
- 3] For any treatment which is for cosmetic purposes. Facings on crowns or pontics beyond the second bicuspid are considered cosmetic.
- 4] 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.
- 5] 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.
- 6] For any procedure begun before the Insured person was covered under this section.
- 7] 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.
- 8] To replace lost or stolen appliances.
- 9] 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.
- 10] For any procedure which is not shown on the Table of Dental Procedures.
- 11] For orthodontic treatment under this benefit provision.
- 12] 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.
- 13] For charges for which the Insured person is not liable or which would not have been made had no insurance been in force.
- 14] For services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- 15] 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.

MONTHLY PREMIUM CHART

ADVANTAGE I PLAN

\$750 ANNUAL MAXIMUM

AREA	SINGLE	SINGLE +1	FAMILY
1	15.70	30.10	44.60
2	17.20	33.10	49.40
3	19.00	36.70	55.20
4	20.40	39.50	59.50
5	22.50	43.70	66.20
6	24.70	48.10	73.20
7	27.20	53.10	81.30
8	29.40	57.30	87.60
9	31.70	62.00	95.50
A	33.10	64.70	99.40
B	36.30	71.60	111.20
C	40.60	79.80	123.60

ADVANTAGE II PLAN

\$1000 ANNUAL MAXIMUM

AREA	SINGLE	SINGLE +1	FAMILY
1	20.50	40.10	61.70
2	22.50	44.10	68.10
3	24.70	48.70	75.60
4	26.60	52.50	81.80
5	29.20	57.80	90.50
6	32.10	63.60	99.80
7	35.30	70.20	110.40
8	38.20	75.90	119.30
9	41.20	82.00	129.60
A	43.20	85.90	135.50
B	47.50	95.10	151.30
C	53.10	106.00	168.40

HOW TO CALCULATE YOUR BRIGHTONE® PLANS PREMIUM

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

- ☐ Advantage I \$750 Annual Maximum
- ☐ Advantage II \$1000 Annual Maximum

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

- ☐ Applicant Only
- ☐ Applicant + 1 Dependent
- ☐ Applicant + 2 or More Dependents

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

- ☐ Area 1 ☐ Area 4 ☐ Area 7 ☐ Area A
- ☐ Area 2 ☐ Area 5 ☐ Area 8 ☐ Area B
- ☐ Area 3 ☐ Area 6 ☐ Area 9 ☐ Area C

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:

- ☐ 1/1/09 = 1.000 ☐ 5/1/09 = 1.028 ☐ 9/1/09 = 1.057
- ☐ 2/1/09 = 1.007 ☐ 6/1/09 = 1.035 ☐ 10/1/09 = 1.065
- ☐ 3/1/09 = 1.014 ☐ 7/1/09 = 1.043 ☐ 11/1/09 = 1.072
- ☐ 4/1/09 = 1.021 ☐ 8/1/09 = 1.050 ☐ 12/1/09 = 1.080

6] Add the PSA Monthly Association dues of \$2.00.

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

EZ Pay = No Charge
 Monthly Direct Bill = \$8.00
 Quarterly Direct Bill = \$8.00

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

PREMIUM CALCULATION WORKSHEET

- ☐ **MONTHLY EZ PAY** One month premium required (no charge)
- ☐ **MONTHLY DIRECT BILLING OPTION** One month premium required (\$8 monthly administration fee)
- ☐ **QUARTERLY DIRECT BILLING OPTION** Three months premium required (\$8 quarterly administration fee)

MONTHLY BASE PREMIUM \$ _____

TREND FACTOR x _____

MONTHLY PAYMENT = \$ _____

MONTHLY ADMIN. FEE + \$ _____

PSA MONTHLY DUES + \$ **2.00**

PAYMENT WITH APPLICATION = \$ _____

OR QUARTERLY PAYMENT (MONTHLY x 3) = \$ _____

QUARTERLY ADMIN. FEE + \$ _____

PSA QUARTERLY DUES + \$ **6.00**

PAYMENT WITH APPLICATION = \$ _____

MAKE CHECK
 PAYABLE TO: PSA

