

DENTAL INSURANCE
Outline of Coverage

THIS POLICY PROVIDES DENTAL AND HEARING CARE BENEFITS
THIS IS NOT A MEDICARE SUPPLEMENT POLICY

1. READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance policy and only the actual policy provisions will control benefit administration. The policy sets forth the definitions of the capitalized terms referred to below.

The policy itself sets forth in detail the rights and obligations of both you and Ameritas Life Insurance Corp. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. DENTAL AND HEARING CARE COVERAGE. This policy is designed to provide coverage for certain dental and hearing care services. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

3. BENEFITS. We will review benefits subject to the limitations and exclusions described here and more specifically in the policy. When you visit a Contracting Provider, a discounted fee is charged for covered services. This is intended to reduce your out-of-pocket costs. The Provider may bill you the difference between the plan payment and the discounted fee amount. If you visit a non-Contracting Provider, the Provider may bill you the difference between the plan payment and the dentist's actual charge. Plan payment may be based on usual and customary charges or a set scheduled allowance as described in your policy.

DENTAL

Deductible Amount

Type 1 Procedures	\$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	\$50

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage

Type 1 Procedures	100%
Type 2 Procedures:	
Step 1	80%
Step 2	90%
Type 3 Procedures:	
Step 1	20%
Step 2	50%

Step 1 applies during the first Benefit Period the person becomes insured.

Step 2 will apply during the second Benefit Period and each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Step 2 as if he or she were newly insured.

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

Maximum Amount -	1st Benefit Period	\$2,500
	2nd+ Benefit Period	\$3,000

In no event will expenses incurred for Type 1 Procedures count toward the Maximum Benefit.

HEARING CARE

Deductible Amount	\$0
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Coinsurance Percentage	
Exams	100%
Hearing Aids	50%
Hearing Aid Maintenance	100%

Hearing Aid Maximum Amount (per ear):	
1st 12 month Period	\$200
2nd 12 month Period	\$300
3rd 12 month Period or thereafter	\$400

4. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE POLICY:

YOUR POLICY CONTAINS A COMPLETE LISTING OF PROCEDURES COVERED AND ANY FREQUENCY OR OTHER LIMITATIONS ON SPECIFIC PROCEDURES.

Certain Covered Expenses may be subject to a Waiting Period (an Elimination Period). Please refer to your policy for details.

Alternate Benefit Provision – At times, two or more procedures are considered adequate and appropriate treatment. In this case, the benefit paid will be based on the charge for the least expensive procedure.

Certain expenses are not covered. For instance, procedures begun prior to your Effective Date are not covered. This policy does not provide benefits for lost or stolen appliances or cosmetic procedures. It also does not cover hospitalization or prescription drugs. This is not a complete list of exclusions. A full list is in your policy.

5. RENEWABILITY. The policy is renewable by payment of the premium in effect at the beginning of each renewal period. Policy termination is governed by the termination provisions in the policy.

Dental and Hearing Care Insurance	\$49.56 per Policyholder.
	\$98.81 Policyholder plus One Dependent Only.
	\$157.23 Policyholder plus Two or More Dependents.

ADJUSTMENTS IN PREMIUM RATES:

We will not change the initial premium shown on the cover of this policy in the middle of Your policy year, unless any of the following are met.

- Family members are added or deleted.
- Coverage is increased or decreased.
- You move to a different zip code, county or state.
- Premium payment method is changed.
- Any other terms and conditions of this policy change.

The premium change will be effective on the first of the month following the date of such change.

At policy renewal, Your premiums may change for any of the reasons stated above or as a result of any of the following.

- A new rate table applies.
- Any covered person's age classification increases.

We will provide written notice at least 60 days prior to the effective date of any renewal premium change.

RETAIN FOR YOUR RECORDS.

**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING
CONTRACTUAL PROVISIONS.**