

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.

For more information visit us at www.healthplan.com

PLANS Services Association
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.

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dental insurance for association members



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

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 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
CALENDAR YEAR MAXIMUMS per person	\$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.

FEATURES AND BENEFITS — THE PLANS AT A GLANCE

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).

FEATURES AND BENEFITS — THE PLANS AT A GLANCE

	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.

AMERITAS BRIGHTONE® PLANS ENROLLMENT FORM

Insured by Ameritas Life Insurance Corp.

HEALTHPLAN SERVICES PSA MEMBERSHIP ENROLLMENT FORM (IF NOT ALREADY A MEMBER).

I hereby apply for full associate membership in the Plan Services Association (PSA). Upon completion of this enrollment form and payment of initial dues (\$2 monthly), I understand that: (a) I will be entitled to PSA's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this Enrollment Form is dated and signed; (d) I am eligible to apply for Association Group dental insurance; and (e) I authorize the release of my name and address listed on this application to PSA.

X

REQUIRED MEMBER'S SIGNATURE TITLE DATE

If you wish to apply for association group dental insurance, please complete the enrollment form below.

SECTION ONE — APPLICANT INFORMATION

Name of Primary Applicant (Last, First, MI)		<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED	SOCIAL SECURITY NUMBER	DOB	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PRIMARY APPLICANTS ADDRESS (P.O. BOXES ARE NOT ACCEPTED)		CITY	STATE	ZIP	
PHONE NUMBERS	HOME	WORK	E-MAIL ADDRESS		
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)		CITY	STATE	ZIP	
DEPENDENT COVERAGE: (check one) <input type="checkbox"/> APPLICANT ONLY <input type="checkbox"/> APPLICANT PLUS ONE DEPENDENT <input type="checkbox"/> SPOUSE OR <input type="checkbox"/> CHILD <input type="checkbox"/> APPLICANT PLUS TWO OR MORE DEPENDENTS <input type="checkbox"/> SPOUSE AND/OR <input type="checkbox"/> CHILDREN HOW MANY _____					

SECTION TWO — COVERAGE INFORMATION

REQUESTED EFFECTIVE DATE: MONTH _____ YEAR _____ (NOTE: PLAN EFFECTIVE DATE IS ALWAYS FIRST OF THE MONTH AND SUBJECT TO WRITTEN APPROVAL). (PLAN NOT AVAILABLE IN ALL ZIP CODES)

SELECT PLAN DESIGN (CHOOSE ONE OF THE SIX PLANS):

<input type="checkbox"/> TRADITIONAL	<input type="checkbox"/> \$750 ANNUAL MAXIMUM	<input type="checkbox"/> PROGRESSIVE	<input type="checkbox"/> \$750 ANNUAL MAXIMUM	<input type="checkbox"/> SAVER	<input type="checkbox"/> \$750 ANNUAL MAXIMUM	<input type="checkbox"/> ACCESS	<input type="checkbox"/> \$1000 ANNUAL MAXIMUM
<input type="checkbox"/> ADVANTAGE I	<input type="checkbox"/> \$1000 ANNUAL MAXIMUM	<input type="checkbox"/> ADVANTAGE II	<input type="checkbox"/> \$1000 ANNUAL MAXIMUM	<input type="checkbox"/>	<input type="checkbox"/> \$1000 ANNUAL MAXIMUM	<input type="checkbox"/>	<input type="checkbox"/> \$1500 ANNUAL MAXIMUM

SECTION THREE — BILLING INFORMATION

PAYMENT METHOD (PRODUCER PAYMENTS ARE NOT ACCEPTED)

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	\$ _____	OR	QUARTERLY PAYMENT (MONTHLY X 3)	= \$ _____
TREND FACTOR	x _____		QUARTERLY ADMIN. FEE	+ \$ _____
MONTHLY PAYMENT	= \$ _____		PSA QUARTERLY DUES	+ \$ 6.00
MONTHLY ADMIN. FEE	+ \$ _____		PAYMENT WITH APPLICATION	= \$ _____
PSA MONTHLY DUES	+ \$ 2.00			

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 Date
Pay to the order of	PLAN SERVICES ASSOCIATION \$ _____ Dollars
For	ROUTING NUMBER 123456789 1234567891011 1117



