



Spirit
DENTAL & VISION
Kansas | Texas

Individual & Family Dental Insurance

(S12040 rev. 4.2020)

No Waiting Periods
Choose Your Own Dentist
Three Cleanings Per Benefit Year
Lifetime Deductible
Up to \$5,000 Maximum Benefit
Implant Coverage
Optional Vision Coverage

Ameritas 
fulfilling life













Plan Underwritten by:
Ameritas Life Insurance Corp.
5900 O Street, Lincoln NE 68510

The Spirit Network 3500 plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures. Spirit Dental allows you to select your own Ameritas Dental Network provider and a plan that best fits the needs for you and your family. The Ameritas Dental Network is one of the nation's largest. You save when you use a network provider as these providers have contracted fees (MAC/maximum allowable charge) through their network agreement with Ameritas. When you use a network provider, discounted fees can generally be 25-50% below the average for your area. Visit ameritas.com and select **Find a Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Network 3500

This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 65% for Basic, 10% for Major and 10% for Ortho Services in year one. In year two, Basic Services increase to 80%, 50% for Major and 25% for Ortho Services. In Year three, Basic Services increase to 90%, Major Services increase to 65% and Ortho Services increase to 50%. Your benefit year maximum amount is \$3,500 each year.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	 100%	 65%	 10%	 10%	\$3,500
Year 2	 100%	 80%	 50%	 25%	\$3,500
Year 3	 100%	 90%	 65%	 50%	\$3,500

Preventive (Type 1)	Basic (Type 2)	Major (Type 3)	Orthodontia
<ul style="list-style-type: none"> - Two exams per benefit year - Three cleanings per benefit year 	<ul style="list-style-type: none"> - Space maintainers - One series of bitewing x-rays per benefit year - Sealants under age 16 - One topical fluoride per benefit year under age 16 	<ul style="list-style-type: none"> - Simple extractions - Implants - One diagnostic x-ray, full or panoramic in any 3 year period - Oral surgery - Endodontic treatment - Periodontic services - Restoration services; inlays, onlays and crowns - Prosthetic services; bridges and dentures - Basic fillings 	<ul style="list-style-type: none"> - Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received - Coverage is 10% in benefit year one, 25% in benefit year two and 50% in benefit year three with a \$1,200 lifetime maximum per child

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Spirit Network 1200/2500/5000

This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 50% for Basic, 20% for Major and 10% for Ortho Services in year one. In year two, Basic Services increase to 60%, 30% for Major and 25% for Ortho Services. In year three, Basic Services increase to 80%, 50% for Major and Ortho Services increase to 50%. Additionally, your benefit year maximum amount will automatically increase in your second and third years of coverage. Your maximum benefit amount starts in year one at \$1,200, increases to \$2,500 in year two and in year three and subsequent years remains at \$5,000.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	50%	20%	10%	\$1,200
Year 2	100%	60%	30%	25%	\$2,500
Year 3	100%	80%	50%	50%	\$5,000

Preventive (Type 1)

- Two exams per benefit year
- Three cleanings per benefit year

Basic (Type 2)

- Basic fillings
- Space maintainers
- One series of bitewing x-rays per benefit year
- Sealants under age 16
- One topical fluoride per benefit year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% in benefit year one, 25% in benefit year two and 50% in benefit year three with a \$1,200 lifetime maximum per child

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Spirit Network 1200

This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 50% for Basic, 25% for Major and 10% for Ortho Services in year one. In year two, Basic Services increase to 65%, 50% for Major and 25% for Ortho Services. In year three, Basic Services increase to 80% and Ortho Services increase to 50%. Your benefit year maximum amount is \$1,200 each year.

	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	50%	25%	10%	\$1,200
Year 2	100%	65%	50%	25%	\$1,200
Year 3	100%	80%	50%	50%	\$1,200

Preventive (Type 1)

- Two exams per benefit year
- Three cleanings per benefit year

Basic (Type 2)

- Space maintainers
- One series of bitewing x-rays per benefit year
- Sealants under age 16
- One topical fluoride per benefit year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Basic fillings

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
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Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Network 750/1000/1250

This policy pays for covered dental expenses for in-network providers at the contracted fees (MAC) after the \$100 deductible has been satisfied on Preventive, Basic and Major Services. If you use an out-of-network dentist, you pay the difference between what the plan pays (MAB/maximum allowable benefit) and the dentist's actual charge. These percentages are: 100% for Preventive Services, 50% for Basic, and 25% for Major Services in year one. In year two, Basic Services increase to 60% and 30% for Major Services. In year three, Basic Services increase to 80% and 50% for Major Services. Your benefit year maximum amount starts in year one at \$750, increases to \$1,000 in year two and in year three and subsequent years remains at \$1,250.

	Preventive	Basic	Major	Max Benefit
Year 1	 100%	 50%	 25%	\$750
Year 2	 100%	 60%	 30%	\$1,000
Year 3	 100%	 80%	 50%	\$1,250

Preventive (Type 1)

- Two exams per benefit year
- Three cleanings per benefit year

Basic (Type 2)

- Basic fillings
- Space maintainers
- One series of bitewing x-rays per benefit year
- Sealants under age 16
- One topical fluoride per benefit year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures

Spirit Network - Rates & Area Definitions

Kansas & Texas

Spirit Network 3500			
	AREA 1	AREA 2	AREA 3
Applicant	\$38.30	\$42.39	\$46.47
Applicant + 1	\$78.05	\$86.37	\$94.69
Applicant + Family	\$128.65	\$142.37	\$156.09
Spirit Network 1200/2500/5000			
	AREA 1	AREA 2	AREA 3
Applicant	\$33.27	\$36.82	\$40.37
Applicant + 1	\$67.98	\$75.23	\$82.48
Applicant + Family	\$112.55	\$124.55	\$136.55
Spirit Network 1200			
	AREA 1	AREA 2	AREA 3
Applicant	\$26.88	\$29.75	\$32.61
Applicant + 1	\$55.20	\$61.09	\$66.98
Applicant + Family	\$92.10	\$101.92	\$111.75
Spirit Network 750/1000/1250			
	AREA 1	AREA 2	AREA 3
Applicant	\$24.94	\$27.60	\$30.26
Applicant + 1	\$49.88	\$55.20	\$60.52
Applicant + Family	\$79.80	\$88.31	\$96.82

Area (State) Definitions			
Kansas		Texas	
660-662, 666	2	750-754, 762, 770	3
670-672	2	773-775, 786-787	3
All Others	1	All Others	2

12 MONTH RATE GUARANTEE - Rates illustrated are guaranteed for initial 12 months and may change annually thereafter.

Why should you choose the Spirit Network Plan?

In addition to paying lower monthly premiums, the Spirit Network plan can help reduce your out-of-pocket costs. Network providers have contracted fees (MAC/maximum allowable charge) for each service rendered as the basis for payment under the Spirit Dental Plan. This amount is typically significantly less than the amount which could be charged by an out-of-network dentist. These network providers are prohibited (by contract with the network) from charging you the difference between their typical fee and the amount contracted with the network.

Dentists not participating in the network are not subject to the contracted amounts and are permitted to charge any fee for services they provide. This may lead to greater out-of-pocket costs for you and your family members. The sample comparison chart below will give you an idea of how you can save money by selecting one of Spirit Dental's network plans and visiting an in-network provider for services. It compares the charges between visiting in-network and out-of-network dentists.

Network Savings Example

Your Dentist says you need a Crown, which is a Major Service...

- Network Fee:	\$685.00
- Dentist's Usual Fee:	\$985.00

When you receive care from a participating network dentist

Dentist's Usual Fee:	\$985.00
Network Fee:	\$685.00
Your Plan Pays:	
50% x \$685 Network Fee:	- \$342.50
Your Out-of-Pocket Cost:	\$342.50

When you receive care from an out-of-network dentist.

Dentist's Usual Fee:	\$985.00
Network Fee:	\$685.00
Your Plan Pays:	
50% x \$685 Network Fee:	- \$342.50
Your Out-of-Pocket Cost:	\$642.50

In this example, you save \$300.00 (\$642.50 minus \$342.50) by using a participating network provider.

Savings from enrolling in the Spirit Network plan depend on various factors, including how often participants visit the dentist and the cost for services rendered.

***Please note:** These examples assume that your deductible has been met.

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Additionally, when you utilize a network dental provider your out-of-pocket costs may be lower because the providers have agreed to a contracted fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-network dentist your out-of-pocket charges will be based on Usual and Customary charges*.

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Spirit Choice 3500

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	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	65%	10%	10%	\$3,500
Year 2	100%	80%	50%	25%	\$3,500
Year 3	100%	90%	65%	50%	\$3,500

Preventive (Type 1)

- Two exams per benefit year
- Three cleanings per benefit year

Basic (Type 2)

- Space maintainers
- One series of bitewing x-rays per benefit year
- Sealants under age 16
- One topical fluoride per benefit year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Basic fillings

Orthodontia

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% in benefit year one, 25% in benefit year two and 50% in benefit year three with a \$1,200 lifetime maximum per child

*Usual and Customary - means the usual and customary charges for the area where such expenses are incurred.

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Spirit Choice 1200/2500/5000

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	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	100%	50%	20%	10%	\$1,200
Year 2	100%	60%	30%	25%	\$2,500
Year 3	100%	80%	50%	50%	\$5,000

Preventive (Type 1)	Basic (Type 2)	Major (Type 3)	Orthodontia
<ul style="list-style-type: none"> Two exams per benefit year Three cleanings per benefit year 	<ul style="list-style-type: none"> Basic fillings Space maintainers One series of bitewing x-rays per benefit year Sealants under age 16 One topical fluoride per benefit year under age 16 	<ul style="list-style-type: none"> Simple extractions Implants One diagnostic x-ray, full or panoramic in any 3 year period Oral surgery Endodontic treatment Periodontic services Restoration services; inlays, onlays and crowns Prosthetic services; bridges and dentures 	<ul style="list-style-type: none"> Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received Coverage is 10% in benefit year one, 25% in benefit year two and 50% in benefit year three with a \$1,200 lifetime maximum per child

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	Preventive	Basic	Major	Ortho	Max Benefit
Year 1	 100%	 50%	 25%	 10%	\$1,200
Year 2	 100%	 65%	 50%	 25%	\$1,200
Year 3	 100%	 80%	 50%	 50%	\$1,200

Preventive (Type 1)

- Two exams per benefit year
- Three cleanings per benefit year

Basic (Type 2)

- Space maintainers
- One series of bitewing x-rays per benefit year
- Sealants under age 16
- One topical fluoride per benefit year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Basic fillings

Orthodontia

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Plan includes a \$100 lifetime deductible combined for Preventive, Basic and Major Services. Lifetime deductible is per person covered by the plan.

Spirit Choice 750/1000/1250

This policy pays for covered dental expenses for network providers based on the contracted fee (MAC) agreement with Ameritas. Non-network dentists covered dental expenses will be based on Usual and Customary charges after the \$100 deductible (combined for Preventive, Basic and Major Services) has been satisfied. These percentages are: 100% for Preventive Services, 50% for Basic, and 25% for Major in year one. In year two, Basic Services increase to 60%, 30% for Major Services. In year three, Basic Services increase to 80% and 50% for Major Services. Your benefit year maximum amount starts in year one at \$750, increases to \$1,000 in year two and in year three and subsequent years remains at \$1,250.

	Preventive	Basic	Major	Max Benefit
Year 1	 100%	 50%	 25%	\$750
Year 2	 100%	 60%	 30%	\$1,000
Year 3	 100%	 80%	 50%	\$1,250

Preventive (Type 1)

- Two exams per benefit year
- Three cleanings per benefit year

Basic (Type 2)

- Basic fillings
- Space maintainers
- One series of bitewing x-rays per benefit year
- Sealants under age 16
- One topical fluoride per benefit year under age 16

Major (Type 3)

- Simple extractions
- Implants
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures

*Usual and Customary - means the usual and customary charges for the area where such expenses are incurred.

NOTICE: Underwritten by Ameritas Life Insurance Corp. | 5900 O Street Lincoln, NE 68510 This highlight is not a certificate of insurance or guarantee of coverage. Plan designs may not be available in all areas and are subject to individual state regulations. Rates are subject to change at any time. This information is provided by Ameritas Life Insurance Corp. (Ameritas Life). Individual dental, vision and hearing care products (Indiv. 9000 Rev. 02-19), and vision policy form (Indiv. 9000 Rev. 02-19 V, dates may vary by state) are issued by Ameritas Life. This piece is not for use in New Mexico. The Ameritas Dental Network is not available in MT or RI. In Texas, our dental network and plans are referred to as the Ameritas Dental Network. Some states require that producers be appointed with Ameritas Life before soliciting its products. Ameritas, the bison design, "fulfilling life" and product names designated with SM or ® are service marks or registered service marks of Ameritas Life Insurance Corp., affiliate Ameritas Holding Company or Ameritas Mutual Holding Company. All other brands are property of their respective owners. © 2020 Ameritas Mutual Holding Company.

Spirit Choice - Rates & Area Definitions

Kansas & Texas

Spirit Choice 3500			
	AREA 1	AREA 2	AREA 3
Applicant	\$61.28	\$67.81	\$74.35
Applicant + 1	\$123.99	\$137.22	\$150.44
Applicant + Family	\$202.16	\$223.73	\$245.29
Spirit Choice 1200/2500/5000			
	AREA 1	AREA 2	AREA 3
Applicant	\$53.31	\$59.00	\$64.68
Applicant + 1	\$108.06	\$119.59	\$131.11
Applicant + Family	\$176.68	\$195.52	\$214.37
Spirit Choice 1200			
	AREA 1	AREA 2	AREA 3
Applicant	\$40.72	\$45.06	\$49.40
Applicant + 1	\$82.88	\$91.72	\$100.56
Applicant + Family	\$136.38	\$150.93	\$165.47
Spirit Choice 750/1000/1250			
	AREA 1	AREA 2	AREA 3
Applicant	\$37.90	\$41.94	\$45.98
Applicant + 1	\$75.80	\$83.88	\$91.96
Applicant + Family	\$121.28	\$134.21	\$147.15

Area (State) Definitions			
Kansas		Texas	
660-662, 666	2	750-754, 762, 770	3
670-672	2	773-775, 786-787	3
All Others	1	All Others	2

12 MONTH RATE GUARANTEE - Rates illustrated are guaranteed for initial 12 months and may change annually thereafter.

General Information

ELIGIBILITY: The insurance coverage is available in states where it's approved to anyone age 18 and older who does not have coverage through another Ameritas dental plan. You can request coverage for your dependents; dependent eligibility varies based on state law.

DEDUCTIBLE AMOUNT: The deductible is shown in the coverage schedule. The deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

PREDETERMINATION OF BENEFITS: It is recommended that a treatment plan/course of treatment be submitted when the total cost of eligible expenses for any insured is expected to exceed the amount shown on the coverage schedule. This should be submitted to us before the work is started. If actual services submitted do not agree with the treatment plan, or if a treatment plan is not sent in, we will base our payment on treatment consistent with reasonable and customary charges. Predetermination of benefits is not a guarantee of what we will pay. The estimated benefit payment is based on your current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or this policy may alter final payment.

TERMINATION OF COVERAGE: Coverage terminates on the earliest of the following dates: the last day of the month in which you cease to be eligible for coverage; the last day of the month in which your dependent is no longer a dependent, as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by You or on your behalf; or the date the policy ends.

EFFECTIVE DATE: When you enroll online your coverage can start as soon as the next day. Do not cancel any other insurance or assume you are insured under this plan until you receive written confirmation. Please note your enrollment may take 4 business days to be processed and accessible through any network providers.

ELIGIBLE EXPENSES: Expenses must be incurred while the policy is in force and the person is covered by the policy. To become an eligible expense, the dental services must be performed by: a licensed provider performing dental services within the scope of their license; or a licensed dental hygienist acting under the supervision and direction of a dentist.

MISSING TOOTH: If an insured has lost one or more teeth prior to this policy effective date, we will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under this policy. We will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of this policy effective date if this policy immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits.

Dental Limitations & Exclusions

Covered expenses will not include and benefits will not be payable for expenses incurred:

- for any treatment which is for cosmetic purposes.
- to replace any crowns, inlays, onlays, veneers, complete or partial dentures 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 contract, it will be a covered expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. 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.
- for any procedure begun before the insured person was covered under the policy.
- for any procedure begun after the insured person's insurance under the policy terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the insured's insurance under the policy terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
 - » alter vertical dimension;
 - » restore or maintain occlusion; or
 - » splint or replace tooth structure lost as a result of abrasion or attrition.
- for any procedure which is not shown on the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures in the policy.)
- for orthodontic treatment under the following provisions:
 - » for treatment begun on or after the insured's 19th birthday;
 - » for treatment begun before the insured became covered under this section;
- for which the insured person is entitled to benefits under any workmen's 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 (except in CA & KY).
- for charges for which the insured person is not liable or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- 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.

**Plan includes a one-time non-refundable enrollment fee of \$25. This charge will be made at the time of purchase and may appear as a separate transaction from your dental insurance.*

Services Offered

Lifetime per person Deductible of \$50.00 on Lenses and Frames

Maximum Covered Expense

Examination \$50.00
(once every 12 months with \$10 deductible)

A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the member.

Frames (once every 24 months) \$65.00

Lenses (once every 12 months)

Single \$40.00
Bifocal \$60.00
Trifocal \$70.00
No line bifocal or progressive power
OR Lenticular \$100.00

Contact Lenses (in lieu of lenses and frames) \$100.00

Monthly Premium

Applicant Only	\$7.00
Applicant + 1	\$14.00
Applicant + Family	\$20.00



For more information, call Direct Benefits, Inc. at (800) 620-5010

LIMITATIONS & EXCLUSIONS

What is not covered?

Covered expenses will not include and no benefits will be payable for:

- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- Examinations performed or frames or lenses ordered before the Insured was covered under this section.
- Any examination performed or frames or lenses ordered after the Insured's coverage under this section ceases, subject to Extension of Benefits.
- Sub-normal vision aids; orthoptic or vision training or any associated testing.
- Non-prescription lenses.
- Replacement or repair of lost or broken lenses or frames except at normal intervals.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Medical or surgical treatment of the eyes.
- Any service or supply not shown on the Schedule of Eye Care Services.
- Coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
- Lenses and frames during the first twelve months that a person is insured under this section, when the person is a Late Entrant, as defined.

Frequently Asked Questions for Members of Spirit Dental and Vision Plans

Where can I locate my member identification (ID) number?

- The number will be located on the front of your ID card.

Who should I contact with questions?

- For dental and vision questions:
 - Contact GEM MD insurance broker 214.718.8806t .

How should a claim be submitted?

- You or your provider should submit an ADA dental claim form or an itemized billing statement which provides the following information:
 - Member's name, address and member ID number
 - Date of service
 - Current ADA procedure code(s)
 - Procedure fee(s)
 - Provider name, address and tax ID number

The claims mailing address is located on the back of your ID card.

Can I see the dentist I have now?

- Yes, you are always free to visit the dentist of your choice.
- Visit ameritas.com and select **Find a Provider** to find a provider near you. Simply enter your ZIP Code and choose the Classic (PPO) Network to start your search.

What can you tell me about Ameritas, the insurance company underwriting this plan?

- Ameritas Life Insurance Corp. and its affiliated companies have a proud and rich heritage dating back to the late 1880s. This tradition is deeply rooted in our commitment to our customers, a foundation of integrity and trust and a legacy of financial strength to deliver on our promises.

About Spirit Dental & Vision

Spirit Dental & Vision is available exclusively through Direct Benefits, Inc.

Direct Benefits, Inc. is a managing general agency that provides one-stop employee benefits brokerage to over 15,000 agents who provide coverage to over 150,000 Americans.

We're in it for the little people of America. Our mission is to provide individuals and small businesses with the same or better quality insurance products as Fortune 500 employers. By partnering with financially strong insurance carriers like Ameritas we are able to create exclusive niche products like Spirit Dental & Vision.





Contact GEM MD Insurance
Broker
spfeiffer@referenceinsurance.com

