New York specials

Dental plan choices for groups of 2–99, available in ZIP Codes 100–149

with Fusion: The Ultimate Choice®

- Low-cost **value** and **standard** plans feature benefits to help keep plan costs down and encourage preventive care.
- **Premium** plan features traditional benefits at competitive prices for many areas/industries.
- **No waiting** (elimination) periods on dental expenses, except for late entrants. Waiting periods may apply to orthodontia benefits.
- Includes our Fusion product, a $150 annual **vision benefit!** The annual maximum is combined for dental and vision, so the member decides how to spend their benefit dollars: use the entire amount for dental care, or apply up to $150 of their maximum benefit each year toward vision care, such as exams, lenses, frames or contacts.
- Members select the eye doctor of their choice, pay for all services, then submit a claim form and receipt(s) to Ameritas of New York within 90 days for reimbursement. Administration is easy, too: both dental and vision benefits have one certificate, one enrollment form, one payroll entry and one bill.

- Plans available in ZIP Codes 100–149 to groups with 2–99 eligible employees.
- All qualifying groups can offer one of the plans. Employers with 20 or more eligible employees can offer two of the plans to their eligible employees.
- Participation must be 20 percent or greater with a minimum of two employees enrolling.
- Employers choose a **$750**, **$1,000** or **$1,500** annual maximum. To make the most of the maximum, you may add our **Dental Rewards®** feature. It lets qualifying standard or premium plan members carry over part of their unused annual max for future use. If Dual Option selected, the dental annual maximums must match.
- Through our network, members can benefit from credentialed dentists who offer a discount on services. Plan members are always free to visit any dentist, in or out of the network.
- Our plans let you, your covered dependents and even your pets save on prescription medications through any Walmart or Sam's Club pharmacy across the nation. This **Rx discount**, which is not insurance, is offered at no additional cost.
- If the group has a bona fide Section 125 plan in place, the group is eligible for an annual open enrollment on the group's anniversary date.

Ameritas Life Insurance Corp. of New York

GR 6747 NY 4-15

Ameritas
fulfilling life.

The Plans	Standard	Premium	Value
Annual Deductible	• $50 per person in network • $75 per person out of network • waived for Type 1 (Preventive) procedures	• $50 per person • waived for Type 1 (Preventive) procedures	• $10 per visit – in and out of network
Plan Benefit Type 1/Type 2/Type 3	• (in) 100/80/50% • (out) 80/60/50%	• (in) 100/90/60% • (out) 100/80/50%	• 100/50/50
Benefit Maximums	• $1,000 or $1,500 calendar year maximum	• $1,000 or $1,500 calendar year maximum	• $750 calendar year maximum
Endodontic/Periodontal Placement	• Type 3 (Major) procedures	• Type 2 (Basic) procedures	• Type 3 (Major) procedures
Sealants & X-rays	• Type 2 (Basic) procedures	• Type 1 (Preventive) procedures	• Type 1 (Preventive) procedures
Frequencies	• exams/cleanings: 1 per 5 months • bitewing films: 1 set per 11 months	• full mouth X-rays: once every 5 years • crown, bridge & denture: once every 8 years	
In-Network Claim Allowance	• Maximum Allowable Charge (MAC)[1]	• Maximum Allowable Charge (MAC)[1]	• Maximum Allowable Charge (MAC)[1]
Out-of-Network Claim Allowance	• 80th percentile Usual & Customary (U&C)[2]	• 80th percentile Usual & Customary (U&C)[2]	• Maximum Allowable Benefit (MAB)[3]

Monthly Rates

Rates are valid for policy effective dates through 6/2/18 and guaranteed for 12 months. Rates are subject to underwriting approval and will be higher for groups with an average of more than three children per dependent unit (employee & children or employee, spouse & children). A $15 monthly administrative fee will apply for groups with 15 or fewer enrolled employees. The fee is waived if the group elects to pay by electronic funds transfer. Please call your sales representative for more information.

ZIP Codes 100-119	Standard		Premium		Value
	$1,000 Max	$1,500 Max	$1,000 Max	$1,500 Max	$750 Max
Employee Only	$28.70	$29.90	$43.20	$45.00	$23.80
Employee & Spouse	$58.00	$60.40	$86.80	$90.40	$48.50
Employee & Children	$67.10	$69.00	$102.60	$106.90	$54.60
Employee, Spouse & Children	$96.30	$100.40	$146.30	$152.50	$79.30
High utilization industries or for groups of less than 5 enrolled lives (see list)	1.12	1.12	1.12	1.12	1.12
Add Dental Rewards	1.02	1.02	1.02	1.02	N/A
Reduce out-of-network allowance to MAC[1]	.888	.888	.888	.888	
Increase out-of-network allowance to 90th U&C[2]	1.026	1.026	1.026	1.026	
Increase out-of-network deductible to $75	N/A		.946	.946	
Increase 100/90/60 in-network coinsurance to 100/100/60			1.022	1.022	
Move perio and endo to Type 3 (Major)			.934	.934	

ZIP Codes 120-149	Standard		Premium		Value
	$1,000 Max	$1,500 Max	$1,000 Max	$1,500 Max	$750 Max
Employee Only	$23.70	$24.70	$34.30	$36.30	$19.80
Employee & Spouse	$47.80	$49.80	$69.00	$73.00	$40.20
Employee & Children	$55.50	$57.80	$83.30	$88.20	$43.70
Employee, Spouse & Children	$79.70	$83.10	$117.80	$124.80	$64.00
High utilization industries or for groups of less than 5 enrolled lives (see list)	1.12	1.12	1.12	1.12	1.12
Add Dental Rewards	1.02	1.02	1.02	1.02	N/A
Reduce out-of-network allowance to MAC[1]	.912	.912	.912	.912	
Increase out-of-network allowance to 90th U&C[2]	1.026	1.026	1.026	1.026	
Increase out-of-network deductible to $75	N/A		.946	.946	
Increase 100/90/60 in-network coinsurance to 100/100/60			1.022	1.022	
Move perio and endo to Type 3 (Major)			.934	.934	

Optional Ortho* ($1,000 Lifetime Maximum)	Zip Codes 100-119	120-149
Employee & Children	$11.50	$10.50
Employee & Family	$11.50	$10.50

Available to groups with 5+ enrolled lives if orthodontia currently in place. The 12 month-elimination period is waived for initials only. If no prior orthodontia coverage in place a minimum of 10 or more enrolled lives are required to be eligible for orthodontia benefits. A 12-month elimination period applies to initials and new hires unless there are 25 or more child-paying units enrolled on the original effective date if the case is voluntary.

A Sample Monthly Rate Calculation*		Employee Only	Employee & Spouse	Employee & Children	Employee, Spouse & Children
Base rates		$43.20	$86.80	$102.60	$146.30
High utilization industries or for groups of less than 5 enrolled lives (see list)	X	1.000	1.000	1.000	1.000
Add Dental Rewards	X	1.02	1.02	1.02	1.02
Change out-of-network allowance to MAC[1]	X	.888	.888	.888	.888
Increase out-of-network deductible to $75	X	.946	.946	.946	.946
Increase 100/90/60 in-network coinsurance to 100/100/60	X	1.022	1.022	1.022	1.022
Move perio and endo to Type 3 (Major)	X	.934	.934	.934	.934
Total Rate	=	$35.33	$70.99	$83.92	$119.66
Plus Optional Ortho	+				
Ortho with Optional Pediatric & Better Benefit	+				
Plus Optional Pediatric Rider (see Pediatric Flier GR 6760 NY)	+				
TOTAL	=				

**Assumptions in this sample calculation:*

- group is located in ZIP Code 10301
- premium plan with $1,000 calendar year maximum
- low utilization industry and > 5 lives
- added Dental Rewards
- out-of-network claim allowance reduced to MAC[1]
- out-of-network annual deductible increased to $75 per person
- in-network coinsurance increased to 100/100/60
- perio and endo moved to Type 3 (Major)

High utilization industries or for groups of less than 5 enrolled lives requires a 12% load

3570-3579 . . . . . .Manufacturing of Computer & Office Equipment
3761-3769,3795..Manufacturing of Instruments and Related Products
3910-3919 . . . . . .Manufacturing of Jewelry
4720-4729 . . . . . .Passenger Transportation Arrangements
5600-5699 . . . . . .Apparel and Accessory Stores
5944 . . . . . .Jewelry Stores
6000-6199 . . . . . .Depository and Nondepository Institutions
6200-6299 . . . . . .Security and Commodity Brokers
6300-6399 . . . . . .Insurance Carriers
6400-6499 . . . . . .Insurance Agents, Brokers, and Service
6500-6599 . . . . . .Real Estate
6700-6799 . . . . . .Holding and Other Investment Companies
7231 . . . . . .Beauty Shops
7260-7261 . . . . . .Funeral Services and Crematories
7300 . . . . . .Interior Decorating or Design
8000-8049 . . . . . .Offices and Clinics of Physicians
8060-8099 . . . . . .Hospitals, Home Health Care
8110-8111 . . . . . .Law Firms
8200-8299 . . . . . .Schools
8600-8699 . . . . . .Membership Organizations and Associations
8710-8712 . . . . . .Architectural and Engineering Services
8721 . . . . . .Accounting, Auditing and Bookkeeping Firms
9000-9999 . . . . . .Public Administration

Low Utilization Industries
All industries not listed above.

[1] MAC (Maximum Allowable Charge): 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 network providers as the total fee. For the standard and premium plans, when MAC is selected as the out-of-network allowance, MAC fees also are used as the basis for plan payments to out-of-network providers but the insured must pay the difference up to the dentist's actual charge.
[2] U&C (Usual & Customary): Benefits for a given dental procedure are calculated according to the U&C charge for that procedure within a particular ZIP Code area. 90th percentile U&C means that 9 out of 10 dentists in a specific area charge at or below the plan allowance for a procedure. 80th percentile U&C means that 8 out of 10 dentists in a specific area charge at or below the plan allowance for a procedure.
[3] MAB (Maximum Allowable Benefit): The Maximum Allowable Benefit is derived from a blending of submitted provider charges within a ZIP Code area. These allowances are an option for policyholders who want to offer affordable yet comprehensive coverage. The MAB is reviewed and updated periodically to reflect increasing provider fees within the ZIP Code area.

Dependents

Your sales representative can show you the plan's complete definition of and requirements for dependent qualification. In general, dependent refers to a spouse or domestic partner, or dependent child under age 26.

Group Qualification

Ameritas Life Insurance Corp. of New York determines qualification of all groups. We do not accept carve-out groups. A carve-out occurs when a business indicates a portion of its full-time employees are not considered eligible. This includes groups that consist of management or white-collar employees only, in an industry where we generally see and expect a mix of blue- and white-collar employees.

Dental Benefit Exclusions

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

- for any procedure except exams, cleaning and fluoride applications for the first 12 months when an employee or dependent becomes classified as a late entrant. An employee or dependent who does not enroll within 31 days from the date the person qualifies for the insurance or who elects to become covered again after canceling a premium contribution agreement will be classified as a late entrant.
- for any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic.
- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within eight years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the person is covered, it will be a Covered Expense.
- for any procedure begun before the plan member was covered under the dental expense benefit.
- for any procedure begun after the member's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the member's insurance under the dental expense benefit terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to: alter vertical dimension; restore or maintain occlusion; splint or replace tooth structure lost because of abrasion or attrition.
- for any procedure not shown on the Table of Dental Procedures.
- for which the plan member 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.
- for charges for which the plan member is not liable or which would not have been made had no insurance been in force.
- for services that are not required for necessary care and treatment or not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- applies to non-takeover business: in the first 12 months that a plan member is covered 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 plan member is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

Orthodontic Benefit Exclusions

- for an orthodontic program which was begun on or after the member's 19th birthday, if orthodontia was elected.
- before the plan member has been covered under the orthodontic expense benefits for at least 12 consecutive months, however, this is waived for initials who were previously covered by the prior plan's dental and orthodontia plan and have at least 5 enrolled lives on the initial effective date otherwise a 12 month waiting period applies.
- in any quarter of a Program if the member was not covered under the orthodontic expense benefits for entire quarter.
- after the member's insurance under the orthodontic expense benefits terminate.

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.

Vision Benefit Exclusions

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

- Vision exams performed or frames or lenses ordered before the member was covered under the vision expense benefits.
- Subject to extension of benefits, any exam performed or frame or lens ordered after the member's coverage under the vision expense benefits ceases.
- 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 exam or corrective eye wear 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 Vision Procedures, coated lenses, oversize lenses (exceeding 71 mm), photogray lenses, polished edges, UV-400 coating and facets, and tints other than solid.

The insurance producer will receive compensation from Ameritas of New York if you purchase an Ameritas of New York policy. This compensation may vary based on a number of factors such as persistency or the volume of premium, cases or lives placed with Ameritas of New York. If you have questions about the amount or type of compensation, please contact your producer.

Premiums are calculated considering a health insurer fee required under the Affordable Care Act.

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Ameritas Life Insurance Corp. of New York

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