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

PLAN 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.

© 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.**

BRIGHT ONE® PLANS

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

1547INH 6688 12/08

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.

FEATURES AND BENEFITS — THE PLANS AT A GLANCE

	TRADITIONAL PLAN	PROGRESSIVE 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.	*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.*
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

FEATURES AND BENEFITS — THE PLANS AT A GLANCE

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 per person	**$0** for Type 1 **$50** for Type 2 and Type 3
CALENDAR YEAR MAXIMUMS per person	**$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.*

FEATURES AND BENEFITS — THE PLANS AT A GLANCE

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 per person	**$0** for Type 1 **$5** per visit Type 2 & Type 3	**$0** for Type 1 **$50** Type 2 & Type 3
CALENDAR YEAR MAXIMUMS per person	**$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

❑ MARRIED ❑ DIVORCED ❑ SINGLE ❑ WIDOWED | ❑ MALE ❑ FEMALE

Name of Primary Applicant (Last, First, MI) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DOB | GENDER

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)* ❑ APPLICANT ONLY ❑ APPLICANT PLUS ONE DEPENDENT ❑ APPLICANT PLUS TWO OR MORE DEPENDENTS ❑ 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).

❑ **TRADITIONAL** ❑ $750 ANNUAL MAXIMUM ❑ $1000 ANNUAL MAXIMUM

❑ **PROGRESSIVE** ❑ $750 ANNUAL MAXIMUM ❑ $1000 ANNUAL MAXIMUM

❑ **SAVER** ❑ $750 ANNUAL MAXIMUM ❑ $1000 ANNUAL MAXIMUM

❑ **ACCESS** ❑ $1000 ANNUAL MAXIMUM ❑ $1500 ANNUAL MAXIMUM

❑ **ADVANTAGE I**

❑ **ADVANTAGE II**

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 $______

TRENDFACTOR x ___.___

MONTHLY PAYMENT = $______ OR **QUARTERLY PAYMENT** (MONTHLY X 3) = $______

MONTHLY ADMIN. FEE + $______ | **QUARTERLY ADMIN. FEE** + $______

PSA MONTHLY DUES + $ 2.00 | **PSA QUARTERLY DUES** + $ 6.00

PAYMENT WITH APPLICATION = $______ | **PAYMENT WITH APPLICATION** = $______

EZ PAY AGREEMENT

X

PAYOR NAME OR DEPOSITOR IF DIFFERENT | RELATIONSHIP TO APPLICANT | **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

EZ PAY PLAN APPLICANTS ONLY

VOIDED CHECK

DEPOSIT SLIPS ARE NOT ACCEPTABLE

continued on next page

SECTION FOUR — CONTRACT PLEASE SIGN

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. ■ **Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.** ■ Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents. ■ Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. ■ Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. ■ Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. ■ Note for Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. ■ Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. ■ **As a member, I hereby apply for insurance. These benefits were explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate.**

The certificate provides dental and eye care benefits only. Review your certificate carefully.

X

APPLICANT'S SIGNATURE DATE

SECTION FIVE — PRODUCER INFORMATION

NAME SOCIAL SECURITY NUMBER LICENSE NUMBER

FOR GA'S USE

AGENCY NAME (IF APPLICABLE) E-MAIL ADDRESS

( ) ( ) ( )

PHONE NUMBERS HOME WORK FAX

ADDRESS CITY STATE ZIP

ARE YOU LICENSED / APPOINTED WITH AMERITAS LIFE INSURANCE CORP.? ❑ **YES** ❑ **NO** **SERVICE FEES PAYABLE TO** (CHECK ONE) ❑ **INDIVIDUAL** ❑ **FIRM** ❑ **OTHER, PLEASE SPECIFY** ____________

I understand and agree that before I present this product to any client if I'm not already appointed with Ameritas, I must apply to and be appointed with Ameritas.

PRODUCER'S SIGNATURE DATE

ZIP CODE & AREA CHART

ACCESS PLAN IS NOT AVAILABLE IN ALL ZIP CODES. PLEASE VERIFY WITH YOUR AGENT.

NEW HAMPSHIRE

030-038 .... AREA 5

MONTHLY PREMIUM CHART

TRADITIONAL PLAN

AREA	$1000 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY	$750 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY
1	30.70	61.50	92.20	28.70	57.20	85.80
2	33.10	66.00	98.90	30.70	61.50	92.20
3	35.80	71.60	107.50	33.30	66.50	99.80
4	38.40	76.90	115.10	35.70	71.30	107.10
5	41.30	82.70	123.80	38.40	76.90	115.10
6	44.70	89.20	133.70	41.50	82.80	124.30
7	48.20	96.00	144.10	44.70	89.40	134.10
8	51.80	103.40	154.90	48.20	96.00	144.10
9	54.70	109.30	164.00	50.90	101.80	152.70
A	57.90	115.50	173.40	53.80	107.50	161.30
B	61.60	123.10	184.80	57.20	114.40	171.70
C	68.90	137.60	206.40	64.00	128.00	192.00

PROGRESSIVE PLAN

AREA	$1000 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY	$750 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY
1	29.70	59.40	100.90	27.60	55.10	93.70
2	31.80	63.70	107.90	29.50	59.00	100.20
3	34.50	69.00	117.30	32.10	64.10	109.00
4	37.10	74.00	125.90	34.50	69.00	117.30
5	39.70	79.50	135.30	37.10	74.00	125.90
6	43.00	86.20	146.30	40.20	80.20	136.10
7	46.50	92.80	157.60	43.00	86.20	146.30
8	49.90	99.70	169.40	46.50	92.80	157.60
9	52.60	105.40	179.20	49.10	98.20	166.80
A	55.90	111.70	189.80	52.00	103.90	176.60
B	59.50	118.90	202.20	55.30	110.50	187.90
C	66.30	132.60	225.20	61.60	123.10	209.40

SAVER PLAN

AREA	$1000 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY	$750 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY
1	22.60	45.00	67.60	21.10	42.10	63.20
2	24.20	48.50	72.70	22.60	45.30	67.90
3	26.20	52.40	78.80	24.50	49.00	73.60
4	28.10	56.30	84.40	26.30	52.60	78.90
5	30.30	60.60	90.70	28.30	56.60	84.80
6	32.70	65.30	98.00	30.60	61.00	91.60
7	35.30	70.50	105.70	33.00	65.90	98.80
8	38.00	75.80	113.60	35.50	70.80	106.20
9	40.10	80.30	120.40	37.50	75.00	112.50
A	42.40	84.70	127.20	39.60	79.20	118.90
B	45.00	90.20	135.40	42.10	84.30	126.50
C	50.50	100.90	151.40	47.20	94.30	141.50

ACCESS PLAN (PLAN NOT AVAILABLE IN ALL ZIP CODES)

AREA	$1000 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY	$1500 ANNUAL MAXIMUM SINGLE	SINGLE +1	FAMILY
1	25.20	50.40	75.50	28.50	57.00	85.40
2	27.00	53.90	80.80	30.50	60.90	91.20
3	29.40	58.80	88.10	33.20	66.30	99.50
4	31.50	62.90	94.40	35.50	71.20	106.60
5	33.70	67.50	101.20	38.10	76.20	114.20
6	36.70	73.20	109.70	41.50	82.80	124.30
7	39.40	78.90	118.50	44.70	89.20	133.70
8	42.60	85.00	127.40	48.20	96.00	144.10
9	44.70	89.40	134.10	50.60	101.20	151.70
A	47.40	94.80	142.30	53.60	107.20	160.90
B	50.60	101.20	151.70	57.20	114.40	171.70
C	56.20	112.70	168.90	63.70	127.40	191.00

MONTHLY TREND FACTOR

EFFECTIVE DATE	TREND FACTOR	EFFECTIVE DATE	TREND FACTOR	EFFECTIVE DATE	TREND FACTOR	EFFECTIVE DATE	TREND FACTOR
1/1/09	1.000	4/1/09	1.021	7/1/09	1.043	10/1/09	1.065
2/1/09	1.007	5/1/09	1.028	8/1/09	1.050	11/1/09	1.072
3/1/09	1.014	6/1/09	1.035	9/1/09	1.057	12/1/09	1.080

PREMIUM PAYMENT METHOD

PAYMENT METHOD	ADMINISTRATION FEE
EZ PAY	NONE
MONTHLY DIRECT BILL	$8.00 PER MONTH
QUARTERLY DIRECT BILL	$8.00 PER QUARTER

HOW TO CALCULATE YOUR BRIGHTONE® PLANS PREMIUM

1] Determine which plan design you would like to apply for.
- ❑ Traditional $750 Annual Maximum
- ❑ Traditional $1000 Annual Maximum
- ❑ Progressive $750 Annual Maximum
- ❑ Progressive $1000 Annual Maximum
- ❑ Saver $750 Annual Maximum
- ❑ Saver $1000 Annual Maximum
- ❑ Access $1000 Annual Maximum
- ❑ Access $1500 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 ❑ 4/1/09 = 1.021 ❑ 7/1/09 = 1.043 ❑ 10/1/09 = 1.065
❑ 2/1/09 = 1.007 ❑ 5/1/09 = 1.028 ❑ 8/1/09 = 1.050 ❑ 11/1/09 = 1.072
❑ 3/1/09 = 1.014 ❑ 6/1/09 = 1.035 ❑ 9/1/09 = 1.057 ❑ 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	= $ ______	OR	QUARTERLY PAYMENT (MONTHLY ×3)	= $ ______
MONTHLY ADMIN. FEE	+ $ ______		QUARTERLY ADMIN. FEE	+ $ ______
PSA MONTHLY DUES	+ $ 2.00		PSA QUARTERLY DUES	+ $ 6.00
PAYMENT WITH APPLICATION	= $ ______		PAYMENT WITH APPLICATION	= $ ______

MAKE CHECK PAYABLE TO: **PSA**