DentalSelect

Group Benefits Proposal

Customized Quote For:

[redacted]

Quote Created On:	September 15, 2023
Quote Valid Through:	October 16, 2023
Effective Date:	October 01, 2023
Renewal Date:	October 01, 2024
Eligible Employees:	3
Agency:	BenefitMall - [redacted]

DentalSelect

Simple. Straightforward. Affordable.

Dental Select was founded on the belief that dental insurance should and can be simpler. Every day and with every quote we work hard to deliver the benefits you've requested at a price that is affordable.

Nationwide Network Access

Dental Select's proprietary regional and leased networks combine to create one of the largest in the nation. So no matter where our members live, work, or play, a contracted dentist is just a few moments away.

Find a provider at dentalselect.com.

Financial Strength

All insurance plans are marketed by Dental Select, an insurance agency, and underwritten by Ameritas Life Insurance Corp. Ameritas is rated A (Excellent) by AM Best. Ratings are an indication of the company's financial strength and ability to meet obligations to its insureds.Ratings is current as of February 2021 and subject to change.

Flexible Plan Designs for Groups

No cookie cutter plans here. Our contributory and voluntary plans are customizable to fit the needs of each employer.

- Coinsurance plans (MAB and U&C), Copay (UT and TX only), High Deductible plans
- Maximums up to $5000 or Unlimited
- Plans for business with as few as two employees
- Orthodontic coverage
- True annual open enrollment, no late entrant penalties
- Most groups can be set up in less than 10 days
- MaxRewards™ program

Availability may vary by state. Ask your Dental Select sales representative for details.

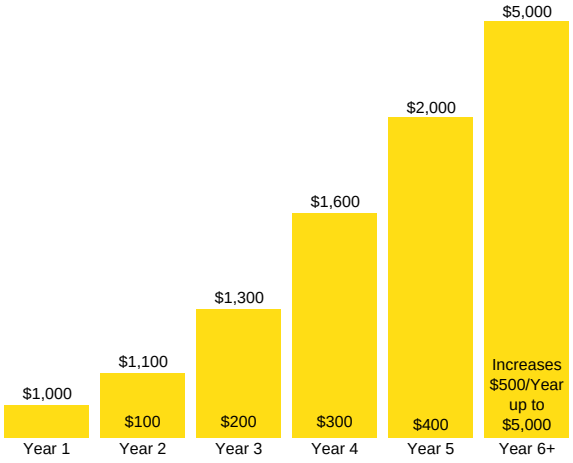
MaxRewards Program

Dental Select's MaxRewards program rewards loyal employees with a graduating annual maximum. Employers can choose a starting annual maximum, and employees will receive an increase every year until their maximum increases to $5,000. It only takes 2 employees to implement this program on any Coinsurance plan.

How it Works:

Increases are automatically applied yearly to the subscriber's annual maximum benefit. Each year, increases are based on consecutive coverage and the original maximum benefit set by the employer until the subscriber's maximum benefit reaches $5,000.*

The initial increase begins at $100, then $200, $300, $400, and finally $500 each year after until reaching $5,000



*The maximum benefit reached is subject to state law and consecutive coverage under the same employer. Please refer to your specific plan, or contact your broker or Dental Select sales representative for questions.

Double Your Vision Options

Offer employees an insured vision plan from one of the two best options available. Or, offer a plan from each and let them choose what they like best.
EyeMed and VSP both offer:

- One of the largest vision networks in the
- Wide range of providers and plans to choose from.
- Significant savings and discounts on vision services and materials.
- Savings on prescription glasses, contacts, eye exams and corrective eye surgery.

Dental Summary

DentalSelect

Customized For:
[redacted]

Effective Date: Oct 01, 2023
Renewal Date: Oct 01, 2024

Voluntary Co-Insurance MAB Classic + MaxRewards
Platinum Network

MAB
Single Option

	Contracted Dentist	Non-Contracted Dentist
Preventive Routine exams, cleanings (2 per year), topical fluoride, x-rays, space maintainers, sealants Waiting Period: None	100%	100% of Fee Schedule
Basic Composite fillings, extractions, endodontics, oral surgery Waiting Period: None	90%	90% of Fee Schedule
Major Crowns, bridges, dentures, periodontics, implant alternate Waiting Period: None	60%	60% of Fee Schedule
Orthodontics Coinsurance: Lifetime Maximum: Waiting Period:	No Benefit	
Maximum Benefit Applies to Preventive, Basic and Major Services Per Benefit Period	$1,000	
Deductible Per Member Applies to Basic and Major Services Per Lifetime	$50	$50

Includes a 12 Month Rate Guarantee

Monthly Premium	
Employee Only	$31.31
Employee + Spouse	$59.29
Employee + Child(ren)	$79.59
Family	$106.94

Dental Summary

DentalSelect

Customized For:

[redacted]

Effective Date: Oct 01, 2023
Renewal Date: Oct 01, 2024

Voluntary Co-Insurance MAB Classic + MaxRewards
Platinum Network

MAB
Single Option

	Contracted Dentist	Non-Contracted Dentist
Preventive Routine exams, cleanings (2 per year), topical fluoride, x-rays, space maintainers, sealants Waiting Period: None	100%	100% of Fee Schedule
Basic Composite fillings, extractions, endodontics, oral surgery Waiting Period: None	80%	80% of Fee Schedule
Major Crowns, bridges, dentures, periodontics, implant alternate Waiting Period: None	50%	50% of Fee Schedule
Orthodontics Coinsurance: Lifetime Maximum: Waiting Period:	No Benefit	
Maximum Benefit Applies to Preventive, Basic and Major Services Per Benefit Period	$1,000	
Deductible Per Member Applies to Basic and Major Services Per Lifetime	$50	$50

Includes a 12 Month Rate Guarantee

Monthly Premium	
Employee Only	$27.41
Employee + Spouse	$51.90
Employee + Child(ren)	$69.66
Family	$93.61

Vision Summary

DentalSelect

Customized For: [redacted]

Effective Date: Oct 01, 2023
Renewal Date: Oct 01, 2024

Voluntary Vision 12
EyeMed Select Network

Single Option

	In-Network (Member Cost)	Out-of-Network (Reimbursement)
Exams		
Exam with dilation as necessary	$10	Up to $35
Contact lens standard fit & follow-up	Up to $40	N/A
Contact lens premium fit & follow-up	10% off retail	N/A
Frames		
Any frame at provider's location	$0 copay, $100 allowance; 20% off balance over $100	Up to $50
Standard Plastic Lenses		
Single vision	$10	Up to $25
Bifocal	$10	Up to $40
Trifocal	$10	Up to $55
Standard progressive	$75	Up to $40
Premium progressive	$75 copay: $120 allowance; 20% off balance over $120	Up to $40
Lens Options		
UV coating	$15	N/A
Tint (solid & gradient)	$15	N/A
Standard scratch-resistance	$15	N/A
Standard polycarbonate	$40	N/A
Standard anti-reflective	$45	N/A
Other add-ons and services	20% discount	N/A
Contact Lenses	Declining balance allowance (may be used on multiple purchases within the same benefit period up to the maximum allowable)	
Conventional	$0 copay: $120 allowance; 15% off balance over $120	Up to $100
Disposables	$0 copay: $120 allowance; member responsible for balance over $120	Up to $100
Medically necessary	$0 copay: paid in full	Up to $200
Laser Correction (US Laser Network)		
Lasik or PRK	15% off retail price *-or-* 5% off promotional price	Not covered
Frequency		
Examination	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses and contact lenses	Once every 12 months	Once every 12 months

Members also receive a 40% discount off complete pair of prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Based on applicable laws, reduced costs may vary by doctor location.

Includes a 12 Month Rate Guarantee

Monthly Premium

Employee Only	$6.34
Employee + Spouse	$11.29
Employee + Child(ren)	$11.84
Family	$19.01

Vision Summary

DentalSelect

Customized For:

[redacted]

Effective Date: Oct 01, 2023
Renewal Date: Oct 01, 2024

Voluntary Vision 21
EyeMed Select Network

Single Option

	In-Network (Member Cost)	Out-of-Network (Reimbursement)
Exams		
Exam with dilation as necessary	$10	Up to $45
Contact lens standard fit & follow-up	Up to $40	N/A
Contact lens premium fit & follow-up	10% off retail	N/A
Frames		
Any frame at provider's location	$0 copay, $130 allowance; 20% off balance over $130	Up to $45
Standard Plastic Lenses		
Single vision	$25	Up to $40
Bifocal	$25	Up to $60
Trifocal	$25	Up to $80
Standard progressive	$25	Up to $60
Premium progressive	$25 copay: $120 allowance; 20% off balance over $120	Up to $60
Lens Options		
UV coating	$15	N/A
Tint (solid & gradient)	$15	N/A
Standard scratch-resistance	$15	N/A
Standard polycarbonate	$40	N/A
Standard anti-reflective	$45	N/A
Other add-ons and services	20% discount	N/A
Contact Lenses	Declining balance allowance (may be used on multiple purchases within the same benefit period up to the maximum allowable)	
Conventional	$0 copay: $150 allowance; 15% off balance over $150	Up to $150
Disposables	$0 copay: $150 allowance; member responsible for balance over $150	Up to $150
Medically necessary	$0 copay: paid in full	Up to $210
Laser Correction (US Laser Network)		
Lasik or PRK	15% off retail price *-or-* 5% off promotional price	Not covered
Frequency		
Examination	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months

Members also receive a 40% discount off complete pair of prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Based on applicable laws, reduced costs may vary by doctor location.

Includes a 12 Month Rate Guarantee

Monthly Premium

Employee Only	$7.73
Employee + Spouse	$13.94
Employee + Child(ren)	$14.63
Family	$23.61

Dental Limitations

DentalSelect

Plan Limitations

Limitations and Exclusions may vary by state. Refer to your Policy or contact Dental Select.

Limitations

The services covered by our co-insurance dental plans are subject to limitations and exclusions. A partial list of these limitations and exclusions is shown below. For a complete list of your plan's specific covered services, and the limitations and exclusions that apply to those services, refer to your Policy or contact Us.

(1) Routine examinations and topical fluoride (age 14 & under) – 2 per calendar year (in conjunction with all other exams).

(2) Cleanings – 2 per calendar year. An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under.

(3) Topical Fluoride - up to age 15 – 2 per calendar year.

(4) Panoramic (age 6 and older) or full mouth series x-rays (age 11 and older) – limited to one every 36 months.

(5) Bitewings x-rays – 8 total per year

(6) Occlusal x-ray – 1 every 24 months.

(7) Sealants – repair/ replacement is not covered within 36 months of application. Limited to permanent bicuspids and molars without decay or restorations for children age 15 and under.

(8) Space maintainers – to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment. Age 15 and under.

(9) Fillings – Repair or replacement is not covered within 24 months of initial placement.

(10) Full mouth debridement – limited services available on same date of service. Limited to one per lifetime.

(11) Periodontal scaling/root planing – limited to once per quadrant in any 24 month period.

(12) Periodontal maintenance – one perio maintenance (3 months after surgery then every 6 months)

(13) Stainless steel crowns – one in two years age 18 and under

(14) Occlusal guards for bruxism – one every 24 months.

(15) Crowns, bridges, inlays, onlays, dentures and gold fillings – every 60 months (age restrictions may apply; additional lab fee may be charged by provider for higher metals and porcelain that is not covered by the plan).

(16) Dentures – relining or rebasing of removable dentures – once per 12 months.

(17) General anesthesia, for the extraction of impacted teeth, based on necessity and not for anxiety management.

(18) Implants - One implant every five years..

Orthodontia Services Limitations (only included if indicated on Summary of Benefits)

No coverage or limited coverage for orthodontic treatment which began prior to the effective date of coverage.

Alternate Benefit

If a less expensive, alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition, and the alternative treatment will produce a professionally satisfactory result, then the maximum allowed will be the charge for the less expensive treatment.

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Dental Exclusions

DentalSelect

Plan Exclusions

Limitations and Exclusions may vary by state. Refer to your Policy or contact Us.

Exclusions – Coverage is not provided for expenses incurred:

(1) for services and supplies not listed in the Coverage Schedule, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.

(2) for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons, unless indicated on the Coverage Schedule, subject to the Right to Appeal provision contained in your Policy.

(3) for services related to, performed in conjunction with, or resulting from a non-covered procedure.

(4) for charges in excess of the contracted Fee-for-Service schedule or the Reasonable and Customary rate (or Usual and Customary rate), whichever applies.

(5) for any treatment program which began prior to the date the Insured is covered under the Policy. (In MD, this exclusion is subject to the pre-existing conditions limitation provision.)

(6) for crowns, inlays and onlays on teeth that can be restored by direct placement materials.

(7) for the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.

(8) for the replacement of crowns, bridges, dentures, inlays or onlays that can be restored to normal function.

(9) for any condition covered under any Worker's Compensation Act or similar law.

(10) for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.

(11) for services that are applied toward the satisfaction of a Deductible, if any.

(12) for services subject to a waiting period that were incurred during a waiting period.

(13) during any waiting period We require. When You voluntarily end Your insurance without a qualifying event and re-enroll at a later date, Your waiting period is 2 years and begins on the date Your coverage first ended.

(14) for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.

(15) for composite, resin, or white Fillings on posterior primary teeth. Benefits will be reduced to that of an Amalgam or silver filling.

(16) for hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.

(17) for drugs or the dispensing of drugs.

(18) for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).

(19) for implants, unless shown on the coverage schedule;

(20) for myofunctional therapy; athletic mouth guards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction or cleft palate (except as required by state law); or anodontia.

(21) for orthodontia, unless shown on the coverage schedule.

(22) for the replacement of retainers.

(23) to replace lost or stolen appliances.

(24) for any procedure begun after the Policy terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's coverage terminates.

(25) for payment of any claim, bill, or other demand or request for payment for dental services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

(26) 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.

(27) for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.

(28) during travel or activity outside the United States.

(29) because of war or any act of war, declared or not.

(30) for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the Insured is covered under this Policy. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

(31) (Applies to Copay Plans Only) for services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits.

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Dental Notes

DentalSelect

Customized For:

[redacted]

Quote Valid Through:	October 16, 2023	Agency:	BenefitMall - [redacted]
Rates Guaranteed Through:	September 30, 2024	Commission:	10.0%
		Effective Date:	October 01, 2023
		Eligible Employees:	3

Dental Plan Participation Requirements

Data & Acceptance

"IMPORTANT NOTICE: Acceptance of this Group Benefits Proposal "Proposal" and any subsequent offer to contract is subject to state regulatory approval, as required. In the event state regulatory approval is not obtained, this Proposal and any subsequent offer to contract will be rescinded."

This proposal is not a contract or a certificate of insurance. It contains proposed rates and benefits that are based on preliminary enrollment data. Such rates and benefits are subject to adjustment if that enrollment varies from the preliminary data or effective date.

By accepting the terms of this proposal, the final rates and benefits will be based on verification of the information provided, final enrollment, and acceptance of the Group Insurance Application.

Eligibility

This quote assumes the stated number of eligible employees. If enrollment in the plan differs by more than 10%, Dental Select reserves the right to re-quote.

Eligible employees must be considered full time and work at least 30 hours per week for a contributory plan, and 20 hours for a voluntary plan.

All employees and dependents must enroll within 30 days from the time the employee becomes eligible for their respective employer benefits program as determined by said employer.

Dependent Eligibility

Eligible dependents are covered up to age 26.

Waiting Periods & Take-Over Provision (if Applicable)

With proof of coverage and effective dates from the employer's prior dental carrier, the employee's waiting period, if any, will be reduced by the number of months the employee was covered by the prior plan. Proof of prior coverage must accompany the application in order to reduce waiting periods.

All other services and coverage relating to any other take-over provision will be based on the certificate issued under the Dental Select policy.

Contributory Coverage

PPO U&C & PPO MAB Plans

- A minimum of 2 eligible persons and 75% of all eligible must enroll.
- The employer must contribute 50% of the single premium to qualify.
- Dual option plans require a minimum of 4 total employees to enroll with a minimum of 2 employees on each plan.

Child Orthodontics

- Requires a minimum of two (2) enrolled.

Co-Pay Plans (Available in Utah & Texas only)

- A minimum of two (2) employees is required to enroll.

Voluntary Coverage

PPO U&C & PPO MAB Plans

- 2-20 eligible: 25% of eligible persons must enroll with a minimum of 2.
- 21+ eligible: Requires a minimum of 5 eligible persons to enroll.
- Dual option plans require a minimum of 4 total employees to enroll with a minimum of 2 employees on each plan.

Child Orthodontics

- Requires a minimum of two (2) enrolled.

Co-Pay Plans (Available in Utah & Texas only)

- Requires a minimum of two (2) enrolled.

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Dental Notes

DentalSelect

Customized For:

[redacted]

Quote Valid Through:	October 16, 2023	Agency:	BenefitMall - [redacted]
Rates Guaranteed Through:	September 30, 2024	Commission:	10.0%
		Effective Date:	October 01, 2023
		Eligible Employees:	3

Dental Plan Notes

U&C Plans

- Contracted: All payments made to contracted General Dentists and Specialists are based on the contracted dental fee schedule and are accepted as payment in full after the required deductible amount, as shown. Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

- Non-Contracted: Dental Select will allow up to the Reasonable & Customary (U&C) amount for dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the patient's responsibility.

MAB Plans

- Contracted: All payments made to contracted General Dentists and Specialists are based on the contracted dental fee schedule and are accepted as payment in full after the required deductible amount, as shown. Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

- Non-Contracted: Dental Select will allow up to the contracted dental fee schedule amount for dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the patient's responsibility.

MAB refers to the Maximum Allowable Benefit.

Co-Pay Plans (Available in Texas and Utah only)

- Contracted: All payments made to contracted General Dentists are based on the contracted dental fee schedule for co-pay plans. Contracted General Dentists accept a combination of fixed co-payments and insurance plan payments as payment in full. Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law*.

- Non-Contracted: All payments made to non-contracted General Dentists are based on the contracted dental fee schedule for co-pay plans. The member is responsible for paying the difference between the plan payment and the General Dentist's usual charges.

Administration Fee

Fully insured plans include a $2.00 monthly administration fee per subscriber for groups with 2-49 enrolled. The fee maximum is $20.00 per month. No monthly administration fee will be charged for groups with 50 or more enrolled.

Contracted Dentist refers to a network dentist in UT and TX.
Participating Provider refers to a network dentist in all other states.
Non-Contracted Dentist refers to a non-network dentist in UT and TX.
Non-Participating Provider refers to a non-network dentist in all other

U&C refers to or Usual & Customary amount.

- For residents of New Mexico, coverage will be administered in accordance with the minimum benefit standards required by New Mexico law. Please consult your sales representative with questions regarding these requirements.

New Group Checklist

- ☐ Group Application
- ☐ Company Check (made payable to Dental Select)
- ☐ Employee Enrollment Forms
- ☐ Census
- ☐ Waiver Enrollments
- ☐ Proof of Prior Coverage
  1. Summary of benefits from prior plan
  2. Last month's invoice from prior plan
  3. Employee's effective date on prior plan

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EyeMed Vision Exclusions

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EyeMed Plan Exclusions

Limitations and Exclusions may vary by state. Refer to your Policy or contact Dental Select.

(1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
(2) Plano lenses.
(3) Two pair of glasses, in lieu of bifocals or trifocals.
(4) Medical or surgical treatment of the eye, eyes or supporting structures.
(5) Any eye examination, or any corrective eyewear, safety eyewear required by an employer as a condition of employment, unless specifically covered under the Plan.
(6) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
(7) Sub-normal vision aids or non-prescription lenses.
(8) Services rendered or Materials purchased outside the U.S. or Canada, unless: (a) the Insured resides in the U.S. or Canada; and (b) the charges are incurred while on a business or pleasure trip.
(9) Charges in excess of the Reasonable and Customary charge for the Service or Materials.
(10) Charges incurred after: (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy.
(11) Experimental or non-conventional treatment or devices.
(12) Lost or broken Materials, except when replaced at normal intervals when Services are available.
(13) Photorefractive Keratectomy (PRK) surgery or Laser-assisted in Situ Keratomileusis (LASIK) surgery.
(14) Aniseikonic lenses.
(15) Non-prescription sunglasses. - Certain name brand Vision Materials for which the manufacturer maintains a no-discount practice.
(16) Services or Materials provided by any other group benefit providing for Vision care.
(17) Care or treatment rendered by You, Your insured Dependent, or a member of Your Immediate Family or household.

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Vision Notes

DentalSelect

Customized For:
[redacted]

		Agency:	BenefitMall - [redacted]
		Commission:	10.0%
Quote Valid Through:	October 16, 2023	Effective Date:	October 01, 2023
Rates Guaranteed Through:	September 30, 2024	Eligible Employees:	3

Vision Plan Notes

Data & Acceptance

"IMPORTANT NOTICE: Acceptance of this Group Benefits Proposal "Proposal" and any subsequent offer to contract is subject to state regulatory approval, as required. In the event state regulatory approval is not obtained, this Proposal and any subsequent offer to contract will be rescinded."

This proposal is not a contract or a certificate of insurance. It contains proposed rates and benefits that are based on preliminary enrollment data. Such rates and benefits are subject to adjustment if that enrollment varies from the preliminary data or effective date.

By accepting the terms of this proposal, the final rates and benefits will be based on verification of the information provided, final enrollment, and acceptance of the Group Insurance Application.

Lasik & PRK

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

Member Co-Pay in Utah and Texas, deductible in all other states

Discounts on products and Services are not insured benefits and not underwritten by Ameritas Life Insurance Corp.

Allowances

Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

Discounts

- Members will receive a 20% discount on items not covered by the plan when using contracted providers.
- This discount may not be combined with any other discounts or promotional offers and does not apply to EyeMed Provider's professional services or contact lenses.
- Retail prices may vary by location.
- Discounts do not apply to benefits provided by other group benefit plans.
- When enrolled on the vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at **www.eyemedvisioncare.com**. The contact lens benefit allowance is not applicable to this service.
- Based on applicable laws, reduced costs may vary by doctor location.

For residents of New Mexico, coverage will be administered in accordance with the minimum benefit standards required by New Mexico law. Please consult your sales representative with questions regarding these requirements.

Ameritas

Vision Notes

DentalSelect

Customized For:

[redacted]

		Agency:	BenefitMall - [redacted]
		Commission:	10.0%
Quote Valid Through:	October 16, 2023	Effective Date:	October 01, 2023
Rates Guaranteed Through:	September 30, 2024	Eligible Employees:	3

Vision Plan Participation Requirements

Contributory Coverage

The employer must contribute 50% of the single premium to qualify. 60% of eligible employees must enroll on the plan.

Voluntary Coverage

A minimum of 2 employees must be enrolled on the plan.

Eligibility

This quote assumes eligible employees. If enrollment on the plan differs by more than 10%, Dental Select reserves the right to re-quote. Eligible employees must be considered full time and work at least 30 hours per week for a contributory plan, and 20 hours for a voluntary plan.

All employees and dependents must enroll within 30 days from the time the employee becomes eligible for their respective employer benefits program as determined by said employer.

Dependent Eligibility

Eligible dependents are covered up to age 26.

New Group Checklist

- ☐ Group Application
- ☐ Company Check (made payable to Dental Select)
- ☐ Employee Enrollment Forms
- ☐ Census
- ☐ Waiver Enrollments
- ☐ Proof of Prior Coverage
  1. Summary of benefits from prior plan
  2. Last month's invoice from prior plan
  3. Employee's effective date on prior plan

The EyeMed Network offers access to thousands of independent vision care providers and top optical retailers nationwide, including:

EyeMed℠ INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL GLASSES.COM contactsdirect

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