DENTALSELECT.

ELIGIBILITY AND BENEFIT SUMMARY

PHONE: 800-999-9789 FAX: 888-998-8709 WWW.DENTALSELECT.COM

MEMBER ID: 000000	MEMBER NAME: JOHN DOE	DATE OF REQUEST: 01/04/2016

GENERAL INFORMATION

GROUP ID: 00000000	GROUP NAME: ABC COMPANY, INC.	
NETWORK: PLATINUM	PLAN: CO-INSURANCE	MEMBER EFFECTIVE DATE: 01/01/2016

Benefits illustrated are in summary form only and should not be construed as complete in and of themselves. They are only for comparison and in the case of a discrepancy, the plan documents apply. Patient should refer to the Plan Document or Certificate of Insurance (as applicable) for a complete description of benefits, limitations and exclusions. Benefits are subject to patient eligibility at the time services are rendered, and terms and conditions of the Policy.

ELIGIBILITY

DEDUCTIBLE		ANNUAL MAXIMUM*		ORTHODONTIC*	
INDIVIDUAL	REMAIN	MAXIMUM	REMAIN	MAXIMUM	REMAIN
$50	$50	$1,500	$1,000	$1,000	$1,000

Benefits shown are current as of 12/31/2016. To verify up to date benefits, please contact Customer Care at 800-999-9789.

* Plan will pay up to 50% of the Annual Maximum toward Major services, and up to 50% of the Orthodontic Maximum toward Orthodontic services as allowed per year.

PREVENTIVE HISTORY

PROCEDURE	ELIGIBLE
EXAM (D0120, D0140, D0150)	Y
CLEANING (D1110, D1120, D4910)	Y
FLUORIDE (D1208)	N
BITEWING X-RAY (D0270 THRU D0274)	Y
FULL MOUTH OR PANORAMIC X-RAY (D0330, D0210)	N
PA X-RAY (D0220, D0230)	Y

BENEFIT DETAIL

CODE	DESCRIPTION	BENEFIT		FREQUENCY	UP TO AGE		DEDUCTIBLE	WAITING PERIODS	
		IN	OUT		MIN	MAX		TOTAL	REMAIN
D0000	Lorem Ipsum Dolor Sit Amet	$1,000	$1,000	2x Per 1 Annual	0	99	N	12 months	1 month
D0000	Lorem Ipsum Dolor Sit Amet	80%	80%	2x Per 1 Annual	0	99	Y	18 months	7 months
D0000**	Lorem Ipsum Dolor Sit Amet								
D0000	Lorem Ipsum Dolor Sit Amet								
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Benefits shown are current as of 12/31/2016. To verify up to date benefits, please contact Customer Care at 800-999-9789. Deductible and Annual Maximums are based on either a calendar year [or] contract plan year.

* Plan will pay up to 50% of the Annual Maximum toward Major services, and up to 50% of the Orthodontic Maximum toward Orthodontic services as allowed per year.

PREVENTIVE HISTORY

PROCEDURE	ELIGIBLE
EXAM (D0120, D0140, D0150)	Y
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BENEFIT DETAIL (CONT'D.)

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** Plan allows for an alternative benefit for this procedure code.

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PLAN NOTES:

Pre-Determination of Benefits

Dental Select recommends a Pre-Determination of Benefits be submitted if the course of treatment is expected to exceed $300.

Co-Insurance Plans

CONTRACTED: Payments made to contracted General Dentists and Specialists are based on the contracted dental fee schedule, and are accepted as payment in full. Patients receive a 20% discount on orthodontic services from contracted orthodontists.

NON-CONTRACTED: Payments made to non-contracted General Dentists and Specialists are based on the dental fee schedule or usual and customary. Charges above the plan payment are the patient's responsibility.

Co-Pay Plans

CONTRACTED: Payments made to contracted General Dentists are based on the contracted co-pay dental fee schedule, and are a combination of the patient's co-pay and plan payment. Contracted General Dentists accept the contracted dental fee schedule as payment in full. Payments made to contracted Specialists are discounted 20% from the provider's usual fee. There is no plan payment for services performed by contracted Specialists, and all charges are the patient's responsibility.

NON-CONTRACTED: Payments made to non-contracted General Dentists are based on the co-pay dental fee schedule, and all charges above the plan payment are the patient's responsibility. There is no plan payment for services performed by non-contracted Specialists, and all charges are the patient's responsibility.

Missing Tooth Clause

Missing tooth clause may apply.