

When does coverage begin?

Your coverage begins on the first day of the month following the date we receive your application, enrollment fee and initial premium. The initial coverage period is for 12 months. We guarantee not to change your premiums during those 12 months, and you agree to pay premiums on time for those 12 months. Only dental treatments begun and completed while coverage is in force are eligible for benefits.

Complete details in Dental Benefit Plan Summary

This brochure is intended to provide a convenient overview of coverage, and is not intended to be a complete description. Only those services and supplies specifically listed in the Dental Benefit Plan Summary are covered under the plan, regardless of dental necessity. Please note that treatment for a missing tooth is not immediately covered under this plan.

The Dental Benefit Plan Summary is your source for complete information, including the specific dental treatments that are covered, the frequency with which those treatments are covered, benefit amounts, limitations, exclusions, and conditions under which coverage may remain in force. Exclusions and limitations are also available on our Web site, www.deltadentalmn.org.

You will receive the Dental Benefit Plan Summary with your welcome package. If you decide this coverage is not for you, simply let us know in writing within 10 days of receiving the Summary. We will then promptly refund your paid premium and enrollment fee. Any claims incurred will not be paid, and you will not be eligible to re-enroll.

Find out if your dentist is part of our network

Call **651-406-5995**, toll-free **888-223-2954** or visit www.deltadentalmn.org and click on *Dentist Search*.

3560 Delta Dental Drive
Eagan, MN 55122
Phone: 651.406.5995
Toll-free: 888.223.2954

www.deltadentalmn.org

DDMN.066.06

Freedom. Protection. Savings.

Our dental plans for individuals deliver equilaterally impressive benefits



Individual Dental

DELTA DENTAL OF MINNESOTA

With Individual Dental you'll benefit from:

Freedom

- See any dentist you like, with the greatest savings at a network dentist.
- Enjoy access to the largest dental network in the state and the nation – Delta Dental Premier® – as well as the Delta Dental PPOSM network for the greatest opportunity to save. Finding a network dentist is easy – visit www.deltadentalmn.org and click “Dentist Search” to locate one near you, or call us toll-free at 1-888-223-2954.

Protection

- Coverage for a broad spectrum of dental care (*see chart for details*).
- No waiting periods for routine exams, fillings and some more involved procedures.
- Peace of mind knowing you're backed by the hometown dental experts – in fact, we retain 98% of our customers year after year.

Savings

- Choose between two great plans – one for greater coverage and one for lower premiums.
- Coverage for emergency dental procedures whether you're traveling across the country or even internationally.

Enroll today

When you're thinking about what kind of shape your oral health is in, think “triangle” – Delta Dental of Minnesota. Everything you need to enroll is included in this brochure.

What kind of shape is your oral health in?

Whether you're self-employed, working part-time without benefits, retired, or no longer covered through a parent's plan, having an individual dental plan can pay big dividends for oral health while making a lot of sense financially.

And with a growing body of evidence now indicating a link between oral and overall health, taking care of your mouth and teeth are even more important.

Through **Individual Dental** from Delta Dental of Minnesota, the state's leading dental benefits provider for 40 years, you can take advantage of a great plan designed to protect your smile – and also protect your wallet from costly procedures or unplanned emergencies that can really put a dent in your budget.

Any Minnesotan age 18 and over can purchase this plan directly from Delta Dental of Minnesota. Add your spouse and eligible dependents, too.

Call **651-406-5995**,
toll-free **1-888-223-2954**
or enroll online at
www.deltadentalmn.org.

Your Coverage*

	Plan A \$50 annual deductible with \$1,200 annual coverage maximum	Plan B \$100 annual deductible with \$1,000 annual coverage maximum
Services covered immediately		
Diagnostic/Preventive Routine exams and cleanings, including periodontal cleaning	100% No deductible for routine check-ups with a network dentist.	80%
Prosthetic (Denture) Repairs and Adjustments	80%	50%
Basic Restorative Fillings and sealants	50%	50%
Oral Surgery Including extractions	50%	50%
Endodontics Root canals	50%	50%
Services covered after a 12-month period		
Periodontal Care Treatment of gum disease	50%	50%
Crown and Cast Restorations	50%	50%
Prosthetics Dentures, partial dentures, and bridges	50%	50%

Solid coverage at any dentist. Greatest savings at network dentists.

You're free to see any dentist, but you'll receive the greatest savings with a network dentist. You'll have access to the state's and nation's largest dental network—Delta Dental Premier®—as well as the Delta Dental PPOSM network.

Advantages of seeing a network dentist include no paperwork and lower out-of-pocket costs. That's because our network dentists agree not to charge more than Delta Dental's Maximum Amount Payable (MAP). The MAP is the maximum amount Delta Dental will pay for a given procedure. *If you receive care from a non-network dentist who charges more than the MAP, you'll be responsible for the additional amount.

Example of network vs. non-network coverage:

Plan A in-network routine check-up: We pay 100%. You pay nothing.

Plan A out-of-network routine check-up: We pay 100% of the Maximum Amount Payable. You pay anything in excess of that amount.

Premiums

Subscriber age 18 - 49			
Plan A	Monthly	Quarterly	Annual
Subscriber	\$47.17	\$141.51	\$566.04
Subscriber +1	\$91.97	\$275.91	\$1,103.64
Family	\$169.68	\$509.04	\$2,036.16

Plan B			
Subscriber	\$36.05	\$108.15	\$432.60
Subscriber +1	\$70.30	\$210.90	\$843.60
Family	\$129.70	\$389.10	\$1,556.40

Subscriber age 50 +			
Plan A	Monthly	Quarterly	Annual
Subscriber	\$42.12	\$126.36	\$505.44
Subscriber +1	\$82.14	\$246.42	\$985.68
Family	\$151.55	\$454.65	\$1,818.60

Plan B			
Subscriber	\$32.20	\$96.60	\$386.40
Subscriber +1	\$62.79	\$188.37	\$753.48
Family	\$115.84	\$347.52	\$1,390.08



PART A – SUBSCRIBER INFORMATION

Subscriber's Name:		Last	First	Middle Initial	Social Security Number / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Day Phone Number	Evening Phone Number	Email Address		Date of Birth / /
Subscriber's Address:	Address				
	City	State	Zip Code		

PART B – ENROLLMENT OPTIONS

Select One Plan Option: **Plan A** (\$50 Deductible/\$1200 Plan Maximum) **Plan B** (\$100 Deductible/\$1000 Plan Maximum)

Select Who Is To Be Enrolled: Subscriber Only Subscriber + One Dependent Family (Three or More)

Complete this section if you have selected the enrollment option of Subscriber + One Dependent or Family. If more than three family members are being enrolled, attach a list of additional dependent information in the below format. Dependent unmarried children through age 24 are eligible to enroll.

Relationship to Subscriber	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Subscriber's)	Gender	Date of Birth Month/Day/Year	Dependent Unmarried?
Spouse		M F	/ /	
Dependent Child		M F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART C – PAYMENT OPTION INFORMATION – Select payment option and billing frequency. Note: A \$25 one-time enrollment applies unless you choose the annual payment option.

Select One Payment Option and Billing Frequency

A. Direct Withdrawal from Checking Account: Monthly Quarterly Annual

Name on Checking Account: _____ Bank Name: _____

Routing Number: _____ Checking Account Number: _____

If applicable, the enrollment fee will be charged with your first premium. The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.

B. Credit Card: Quarterly Annual American Express Discover MasterCard Visa®

Credit Card Number _____ Exp. Date ____/____

Name As It Appears On Credit Card _____

If applicable, the enrollment fee will be charged with your first premium. The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.

Note: When paying by credit card, there is no monthly payment option. If you wish to pay monthly, select the Direct Withdrawal.

C. Check: Quarterly Annual Send this form and a check payable to Delta Dental of Minnesota. Please include the enrollment fee if selecting quarterly billing. Future premiums will be billed prior to the start of each coverage period.

Note: When paying by check, there is no monthly payment option. If you wish to pay monthly, select the Direct Withdrawal.

PART D – AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I have read the information contained in the application and choose to enroll. I understand the benefits and restrictions of this plan as stated in the material provided with the application. I certify the information contained in this application is true and complete. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages. I understand my enrollment is subject to receipt of payment and verification of funds. The start and cancellation dates of my insurance coverage will be determined by Delta Dental of Minnesota. The start date is generally the first day of the month following receipt of the enrollment application. If I have selected Payment Option A or B, I authorize Delta Dental to withdraw funds from my checking account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made timely I will no longer be eligible for coverage. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand that I must enroll for one full year and if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of two years.

Subscriber Signature:

Date:

Mail your application to:
Delta Dental of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis, MN 55440-0330