

Additional Details

The plan is available to employees of MSBA members in firms with four or fewer employees inclusive of the MSBA member. Firms with five or more members are eligible to purchase Delta Dental's group products.

Coverage begins following premium payment

Your coverage begins on the first day of the month following the date you completed application and initial premium are received. The initial coverage period is for 12 months, after which time continued enrollment for another 12 months is automatic unless canceled in writing by you. Delta Dental guarantees not to change your premiums during the initial 12 months, and you agree to pay premiums on time. 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 the Delta Dental 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 Delta Dental know in writing within 10 days of receiving the Summary. You will promptly be refunded your paid premium minus any paid claims. You will not be eligible to re-enroll.

Individual Dental Plans Endorsed by the Minnesota State Bar Association



Individual Dental* for Minnesota State Bar Association Members

	Plan A	Plan B
Service	Coinsurance	
<i>-Diagnostic/Preventive</i> Routine exams, X-rays and cleanings, fluoride treatments	100% No waiting period	100% No waiting period
<i>-Basic</i> Fillings and sealants, extractions, non-surgical periodontal care	50% 6-month waiting period	80% No waiting period
<i>-Major</i> Crowns, bridges, dentures, root canals	50% 12-month waiting period	50% 3-month waiting period
Annual Deductible Diagnostic and preventive services are not subject to the deductible	\$75 per person	\$50 per person
Annual Maximum	\$750 per person	\$1500 per person
Optional – Orthodontics (Available for covered dependent children only, age 8-18)	50% to lifetime max. of \$1,000 12-month waiting period	50% to lifetime max. of \$1,000 12-month waiting period

*Coverage at non-network dentists is subject to our Maximum Amount Payable, which is the maximum amount Delta Dental will pay for a given procedure.

Premiums	Plan A			Plan B		
	Monthly	Quarterly	Annual	Monthly	Quarterly	Annual
Without orthodontia						
MSBA member	\$30.17	\$90.51	\$362.04	\$39.14	\$117.42	\$469.68
MSBA member + spouse	\$61.57	\$184.71	\$738.84	\$80.42	\$241.26	\$965.04
MSBA member + children	\$57.51	\$172.53	\$690.12	\$73.14	\$219.42	\$877.68
Family	\$87.40	\$262.20	\$1048.80	\$111.17	\$333.51	\$1334.04
With orthodontia						
MSBA member + children	\$66.26	\$198.78	\$795.12	\$81.89	\$245.67	\$982.68
Family	\$96.15	\$288.45	\$1153.80	\$119.92	\$359.76	\$1439.04

Dental plans are one of the most frequently requested and commonly used group benefits. Attorneys in private practice or in small firms without group benefits know how challenging it can be to find individual dental coverage at a competitive price.

The Minnesota State Bar Association (MSBA) has you covered. Take advantage of solid, affordable dental plans endorsed by the MSBA and designed exclusively for members like you. The plans are underwritten and administered by Minnesota's leading dental benefits provider for 40 years – Delta Dental of Minnesota.

Making dental coverage a priority for you and your family is a smart move, especially as researchers come closer to understanding the impact that oral health has on general health. These plans include coverage for preventive, basic and major services to help safeguard your oral health – and overall well-being.

Features of the plans include:

- **A choice of two plan options**
 - Both provide 100% coverage for preventive care with no waiting periods (exams, cleanings and fluoride treatments)
- **Solid coverage for basic and major services** such as fillings, sealants, crowns, extractions, dentures, etc.
- **Freedom to see any dentist**, with the greatest savings from network dentists
- **An orthodontics program** available as an option for covered dependent children (age 8-18)
- **International emergency treatment** automatically included

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 Delta Dental PPOSM network and the Delta Dental Premier[®] network – the state's largest.

With more than 80% of Minnesota dentists in our network, it's very likely you're already seeing a participating provider. Find out by calling **651-406-5995** or toll-free **1-888-223-2954**, or visit **www.msbaensure.com** and click "Dentist Search."

Advantages of seeing a network dentist include no paperwork and lower out-of-pocket costs. That's because our network dentists agree to accept our Maximum Amount Payable* (MAP) as payment in full. The example below illustrates how this works.



Example: network vs. non-network coverage on Plan B

In-network filling and sealant

We pay 80%. You pay 20% of the MAP. Any covered charge over our MAP is waived by the dentist for the Delta Dental member.

Out-of-network filling and sealant

We pay 80% of our MAP. You pay 20% of our MAP, plus any amount the dentist charges in excess of our MAP.

*The Maximum Amount Payable is the maximum amount Delta Dental will pay for a given procedure.

Enroll today

Enrolling is fast and simple. In fact, everything you need to sign up is included in this brochure.

**For more information call
toll-free 1-800-501-5776.**



Minnesota State Bar Association

MINNESOTA STATE BAR ASSOCIATION DENTAL ENROLLMENT APPLICATION

Internal Use Only: Marsh Verification Date: _____

PART A – SUBSCRIBER INFORMATION - MSBA Member or Employee

Marsh Representative Signature: _____

Subscriber 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 Address:	Address	City	State	Zip Code

PART B – ENROLLMENT OPTIONS – Select one plan option and one orthodontic option.

- Plan A** (\$75 Deductible/\$750 Plan Maximum) **Plan B** (\$50 Deductible/\$1500 Plan Maximum)
 Yes, I Elect Orthodontic Coverage **No**, I Do Not Elect Orthodontic Coverage

- Select Who Is To Be Enrolled:** Subscriber Only Subscriber + Spouse/Partner
 Subscriber + Children Subscriber + Family

Complete this section if you selected an enrollment option other than Subscriber Only. If enrolling more than four family members, 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)	Gender	Date of Birth Month/Day/Year	Dependent Unmarried?
Spouse/Domestic Partner		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
Dependent Child		M F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART C – PAYMENT OPTION INFORMATION – 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: _____
 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 _____
 The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.

C. Check: **Quarterly** **Annual** Send a check with this form payable to Delta Dental of Minnesota.
 Future premiums will be billed prior to the start of each coverage period.

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. I understand my enrollment is subject to receipt of payment and verification of funds. 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. 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 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:** _____