

MEDICA.



MEDICA DIRECT DENTALSM

 **DELTA DENTAL[®]**

DELTA DENTAL OF MINNESOTA

Good dental health is part of overall health and well-being.

That's why we are pleased to offer coverage through a partnership between Medica and Delta Dental of Minnesota — the state's largest dental benefits administrator. If you pay for your own insurance, or the insurance for a spouse or dependent(s), Medica Direct Dental offers affordable, comprehensive coverage that protects you and your family.

Medica Direct Dental benefits include:

- Coverage for individuals and families
- The choice of three dental plans and coverage levels with a range of premium options
- Freedom to see any dentist and cost savings with network dentists
- Premium rates that are guaranteed for the initial 12 months
- No waiting periods for many services, including routine care, fillings, sealants, oral surgery and root canal therapy

It's easy to enroll

Simply complete our online application at www.medica.com. Or complete the application form included in this brochure and mail it to the address listed on the form.

For more information, contact your local Medica broker or call Medica directly:

952-992-2080 or 1-800-670-5935

8 a.m. – 5 p.m. Monday – Thursday;

9 a.m. – 5 p.m. Friday.



Eligibility and Enrollment – It's easy to qualify!

- You can enroll if you are a current member of a Medica individual plan – Medica SoloSM, Medica EncoreSM, Medica Direct HSASM or Medica Symphony.[®]
- You can enroll within 60 days of applying for individual medical coverage from Medica (not available for Medica PreludeSM members). If Medica cannot offer you medical coverage, you may still keep your dental policy.
- You must be a Minnesota resident age 18 through 64 to enroll as the policyholder. Dependent coverage is available, including dependent children through age 25.
- Applicants currently enrolled in a Medica dental plan or a Delta Dental of Minnesota group or individual plan are not eligible for coverage.

Once your coverage is issued, there are a few more things to know.

- Coverage begins on the first day of the month that follows the date we receive your application for coverage and premium payment. Your dental effective date might not match the effective date of your medical coverage.
- Medical coverage and dental coverage are billed separately.
- Your dental coverage period is for 12 months from the date your coverage begins. You may not cancel your policy for the first 12 months (except during the first 10 days).
- Your premium will be the same for these 12 months.
- After your first year of coverage, you are automatically re-enrolled for the following year. You may cancel your dental plan with a 30-day written notice to Medica.
- After your initial 12 months of enrollment, if you decide to cancel your coverage, you may not re-enroll in Medica Direct Dental for 24 months.

Medica Direct Dental

For policyholders ages 18 through 64 and eligible dependents

COINSURANCE*			
	Plan 1	Plan 2	Plan 3
Diagnostic/Preventive (No waiting period)			
Routine exams	100%	100%	100%
X-rays and cleanings	100%	100%	100%
Fluoride treatments	100%	100%	100%
Basic (No waiting period except where noted)			
Fillings and sealants	80%	50%	–
Oral Surgery	50%	50%	–
Endodontics – root-canal therapy	50%	50%	–
Periodontics – treatment of gum disease (12-month waiting period)	50%	50%	–
Major (12-month waiting period)			
Crowns	50%	50%	–
Dentures and bridges	50%	50%	–
Denture/bridge repairs	50%	50%	–
Annual Deductible <i>Does not apply to diagnostic and preventive services</i>	\$50 per person	\$50 per person	None
Annual Maximum	\$1,200 per person	\$1,000 per person	\$500 per person

* 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. If you choose to see a dentist who is not in Medica's dental network of providers, you are responsible for all charges that exceed the plan payment for the services you receive.

This plan only covers those dental treatments or procedures that begin after coverage is issued. Medica cannot cover treatments or procedures begun before you enroll in this dental plan, regardless of necessity.

To find a dentist in Medica's dental network, please call: 651-406-5914 or 1-800-981-8125.

You may also visit www.medica.com. Click "Find Physicians and Facilities" at the top of the page and select the "Individual and Family" option. Then click the "Dentist" option.

PLAN 1 PREMIUMS

	Monthly	Quarterly	Annually
Individual	\$50.30	\$150.90	\$603.60
Individual + 1	\$93.05	\$279.15	\$1,116.60
Family	\$172.60	\$517.80	\$2,071.20

PLAN 2 PREMIUMS

	Monthly	Quarterly	Annually
Individual	\$45.35	\$136.05	\$544.20
Individual + 1	\$83.90	\$251.70	\$1,006.80
Family	\$155.55	\$466.65	\$1,866.60

PLAN 3 PREMIUMS

	Monthly	Quarterly	Annually
Individual	\$20.40	\$61.20	\$244.80
Individual + 1	\$37.65	\$112.95	\$451.80
Family	\$69.90	\$209.70	\$838.80



This brochure is an overview of the dental coverage options available on this plan. It is not intended as a complete description. A more detailed Summary of Exclusions and Limitations can be found at www.medica.com.

The Dental Benefit Plan Summary is your source for complete descriptions and benefit reviews, limitations, exclusions, and other important information. Members receive a copy of this Summary in their new member Welcome Package. If, after reviewing this material, you decide this coverage is not right for you, simply let us know in writing within 10 days of receiving the Summary. We will promptly refund your premium minus any paid claims. You are not eligible to re-enroll for 24 months.

Delta Dental is a registered mark of Delta Dental Plans Association (“DDPA”). Delta Dental of Minnesota is an independent nonprofit dental services company and is an authorized licensee of DDPA. DDPA has licensed Medica to use the Delta Dental service marks in connection with Medica branded dental insurance services marketed and sold with Medica health insurance services. None of Medica’s health insurance products or services are sponsored, approved, recommended or endorsed by DDPA.

Medica® is a registered service mark of Medica Health Plans. “Medica” refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured, and Medica Health Management, LLC.

Medica Direct DentalSM is a service mark of Medica Health Plans.

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Medica Direct DentalSM Application Form

Underwritten and administered by Delta Dental of Minnesota

Please complete this application and mail it to: Medica Direct Dental, PO Box 330, Minneapolis, MN 55440-0330

PART A – APPLICANT 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

Medica Member Number: Refer to your Medical ID Card to obtain number.

Broker Information:	Name	Phone Number	Medica Broker BTS#
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PART B – DENTAL PLAN SELECTION AND DEPENDENT INFORMATION – Select one plan option

- Plan 1** (\$50 Deductible/\$1200 Annual Maximum Per Person) **Plan 2** (\$50 Deductible/\$1000 Annual Maximum Per Person)
 Plan 3 (No Deductible/\$500 Annual Maximum Per Person)

Select Who Is To Be Enrolled: Applicant Only Applicant + One Dependent Family (applicant plus more than one dependent)

Complete this section if you have selected the enrollment option of Applicant + One Dependent or Family. If more than four family members are being enrolled, attach a list of additional dependent information in the below format. Dependent children through age 25 are eligible to enroll.

Relationship to Applicant	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Applicant's)	Gender	Date of Birth Month/Day/Year
Spouse/Domestic Partner		M F	/ /
Dependent Child		M F	/ /
Dependent Child		M F	/ /
Dependent Child		M F	/ /

PART C – PAYMENT INFORMATION

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

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 of Minnesota 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.

Applicant's Signature:

Date: