



**BlueCross BlueShield  
of Minnesota**

An Independent Licensee of the Blue Cross and Blue Shield Association



## Additional coverage details

**Coverage begins following premium payment.** Your coverage will take effect on the first day of the month following the date Delta Dental of Minnesota receives your application and initial premium. The initial coverage period is for 12 months, regardless of the terms, conditions and coverage period of your medical plan. Delta Dental guarantees not to change your premiums during those 12 months, and you agree to pay premiums on time for those 12 months. Your effective dental coverage date may or may not coincide with your medical coverage date. Only dental treatments begun and completed while coverage is in force are eligible for benefits.

**Cancellation.** You may only purchase the dental plan within 60 days of purchasing or renewing the Aware Care or Personal Blue medical plan. You may cancel the Delta Dental plan at its renewal date without cancelling the medical plan; however, once dental coverage is cancelled, you cannot re-enroll for two years.

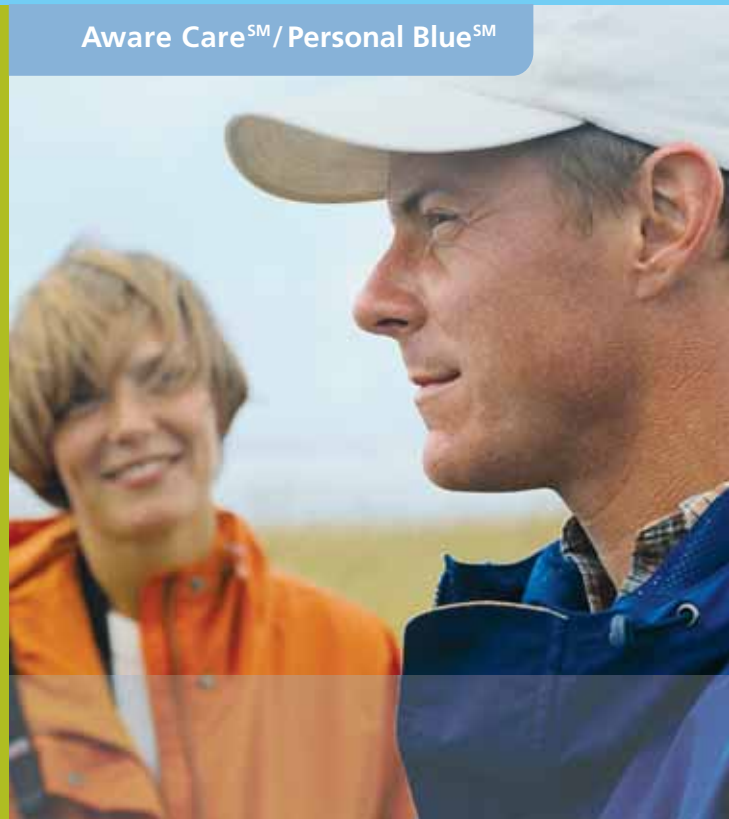
**You'll find complete details in the Delta Dental Benefit Plan Summary.** This brochure is intended to provide a convenient overview of coverage and is not intended to be a complete description. Only those services and supplies specifically listed in the Delta Dental Benefit Plan Summary are covered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

The Delta 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 at [www.deltadentalmn.org](http://www.deltadentalmn.org).

You will receive the Delta 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, minus any paid claims. You will not be eligible to re-enroll for two years.

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Aware Care<sup>SM</sup> / Personal Blue<sup>SM</sup>



# Dental coverage

*An individual dental plan for Aware Care  
and Personal Blue members*

2010

## A dental plan for your way of life

You're on your own. You're in charge. And getting health care coverage to protect you was priority one. That's why you chose Aware Care or Personal Blue.

Now, you can take charge of your oral health by purchasing a dental plan designed to complement your Aware Care or Personal Blue plan. It's a smart move, especially as a growing body of evidence links oral health to overall health. Plus, you have a choice of coverage options and prices to fit your needs and budget.

These plans are available for Aware Care or Personal Blue members through an arrangement with Delta Dental of Minnesota — the state's largest dental benefits administrator.

## Get coverage you can count on

When you choose this dental plan, you can be sure that you'll get the kind of coverage you expect, including:

- Coverage for a broad spectrum of dental care
- Optional orthodontic coverage for children
- No waiting periods for routine exams, fillings and some more involved procedures
- Freedom to see any dentist
- More savings if you use a dentist within the Delta Dental Premier® network
- Access to the Delta Dental Premier network, the largest dental network in the state and nation. It's likely you're already seeing a participating provider. To find out, call **(651) 406-5995** or toll free at **1-888-223-2954**, or visit [www.deltadentalmn.org](http://www.deltadentalmn.org) and click "Dentist Search."
- Service you can trust

## It's easy to get started

Enrolling in this dental plan is fast and simple. Enroll online at [www.deltadentalmn.org](http://www.deltadentalmn.org). Or, use the application form included in this brochure. Just follow the instructions for filling it out. Then detach the completed application, place it in the postage-paid envelope and drop it in the mail to:

**Individual Dental  
Delta Dental of Minnesota  
Attn.: Enrollment Department  
P.O. Box 330  
Minneapolis, MN 55440-0330**

If you have questions or need help completing the application, call customer service at **(651) 406-5995** or toll free at **1-888-223-2954**.



DELTA DENTAL OF MINNESOTA

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Delta Dental of Minnesota does not provide Blue Cross products or services and is solely responsible for this dental product.

# Individual dental plan benefits and rates for Aware Care and Personal Blue members

Your coverage*	Plan A \$50 annual deductible with \$1,250 annual coverage maximum	Plan B \$100 annual deductible with \$1,000 annual coverage maximum
<b>Services covered immediately</b>		
Diagnostic/ preventive – routine exams and cleanings, including periodontal cleaning	100% No deductible for routine checkups	80%
Prosthodontic – (denture) repairs and adjustments	80%	50%
Basic restorative – fillings and sealants	80%	50%
Oral surgery – including extractions	50%	50%
Endodontics – root canals	50%	50%
<b>Services covered after a 12-month period</b>		
Periodontal care – Treatment of gum disease	50%	50%
Crown and cast restorations	50%	50%
Prosthodontics – dentures, partial dentures and bridges	50%	50%
Orthodontics (optional) – Available for dependent children only, ages 8 – 18	50% <b>\$1,000 lifetime maximum</b>	50% <b>\$1,000 lifetime maximum</b>

\*Coverage at non-network dentists is subject to the **maximum amount payable (MAP)**, which 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. Delta Dental network dentists agree not to charge more than the MAP.

## Premiums

Effective April 1, 2009

<b>Subscriber age 18 – 49</b>			
Plan A	Monthly	Quarterly	Annual
Subscriber	\$50.34	\$151.02	\$604.08
Subscriber + 1	\$98.16	\$294.48	\$1,177.92
Family	\$178.31	\$534.93	\$2,139.72
<b>with orthodontia</b>			
Subscriber + 1	\$104.29	\$312.87	\$1,251.48
Family	\$188.78	\$566.34	\$2,265.36
<b>Plan B</b>			
Subscriber	\$36.35	\$109.05	\$436.20
Subscriber + 1	\$70.87	\$212.61	\$850.44
Family	\$128.75	\$386.25	\$1,545.00
<b>with orthodontia</b>			
Subscriber + 1	\$77.00	\$231.00	\$924.00
Family	\$139.22	\$417.66	\$1,670.64
<b>Subscriber age 50+</b>			
Plan A	Monthly	Quarterly	Annual
Subscriber	\$45.79	\$137.37	\$549.48
Subscriber + 1	\$89.28	\$267.84	\$1,071.36
Family	\$162.17	\$486.51	\$1,946.04
<b>with orthodontia</b>			
Subscriber + 1	\$95.41	\$286.23	\$1,144.92
Family	\$172.65	\$517.95	\$2,071.80
<b>Plan B</b>			
Subscriber	\$33.04	\$99.12	\$396.48
Subscriber + 1	\$64.43	\$193.29	\$773.16
Family	\$117.04	\$351.12	\$1,404.48
<b>with orthodontia</b>			
Subscriber + 1	\$70.56	\$211.68	\$846.72
Family	\$127.51	\$382.53	\$1,530.12

Delta Dental plan coverage for Aware Care and Personal Blue members

**Enrollment application**

**PART A – SUBSCRIBER INFORMATION**

<b>Subscriber's Name:</b>	Last	First	Middle Initial	<b>Social Security Number</b> / /
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	Day Phone Number ( )	Evening Phone Number ( )	e-mail Address	<b>Date of Birth</b> / /
<b>Subscriber's Address:</b>	Address		City	State ZIP Code
<b>Aware Care or Personal Blue Member's XZ Number:</b> Refer to your Medical ID Card to obtain number.				
<b>Aware Care or Personal Blue Agent Information:</b>	Agent Name		Agent Phone Number	Agency Code/Number

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

**Dental:**  **Plan A** (\$50 Deductible/\$1250 Plan Maximum)  **Plan B** (\$100 Deductible/\$1000 Plan Maximum)  
 **Yes, I Elect Orthodontic Coverage**  **No, I Do Not Elect Orthodontic Coverage**

**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 four 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/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:** \_\_\_\_\_

Send completed application to:

Individual Dental  
 Delta Dental of Minnesota  
 Attn.: Enrollment Department  
 P.O. Box 330  
 Minneapolis, MN 55440-0330