

Discover
the Dental Insurance Plan that
helps you reach *new*
heights.



one life plan

Dual Choice



Higher Level Dental Care
www.denalidental.com

For Individuals, Families and Seniors

The Denali Dental group dental insurance plans are underwritten by Madison National Life Insurance Company (form # MNL ADEN-POL 0905), except in NH and NY, where they are underwritten by Standard Security Life Insurance Company of New York (form # SSL ADEN-POL 0905). Denali Dental is marketed by Direct Benefits, Inc.

DB IN WP 0210

A Dental Insurance Plan for You and Your Family

Covered Services

Good oral health is important. That's why there's Denali Dental. Don't have employer dental coverage? No problem. Denali Dental allows you to select your own dentist, and is affordable for you and your family. Choose the PPO plan and save on out-of-pocket costs when visiting an in-network Dentemax provider.

To keep your premiums low, Denali Dental applies the following waiting periods:

- Type 1: Immediate coverage
- Type 2: 3 months
- Type 3: 12 months
- Type 4: 24 months

BENEFITS

Plan A and Plan B*

Calendar Year Maximum	\$1,500 per insured
Lifetime Deductible	\$100 per person
Office Visit Copay	\$10.00

Coverage Percentage	100%	Type 1
	80%	Type 2
	50%	Type 3
	50%	Type 4

Type 1

- Two exams per year
- Two cleanings per calendar year

Type 2

- One series of bitewing x-rays per year
- Basic fillings

Type 3

- Simple extractions
- One diagnostic x-ray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Veneers
- Endosteal Implants

Type 4

Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received. After a 24-month waiting period, orthodontia has an annual maximum of \$350 and a lifetime maximum of \$1,000.

REASONABLE AND CUSTOMARY

Dental expenses are paid based on a percentage of Reasonable and Customary (R&C) fees. This means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred. The most common charge means the lesser of:

- the actual amount charged by the provider;
- the negotiated rate;
- the usual charge which would have been made by a provider (Dentist, Hospital, etc) for the same or a comparable professional services, drugs, procedures, devices, supplies or treatment within the same Geographic Area, as determined by Us.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

APPLYING

Send all original forms to:

Direct Benefits, Inc.
325 Cedar Street Suite 800,
St. Paul MN 55101
651-649-3503 / 800-620-5010
651-649-3502 fax

Information must be postmarked by the 25th of the month to be effective by the first of the following month.



* Plan B PPO in- and out-of-network subject to Dentemax schedule. For Dentemax PPO providers please visit www.dentemax.com

MONTHLY PREMIUMS

Indemnity - PLAN A

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Single	\$24.42	\$27.44	\$30.15	\$32.87	\$35.88	\$38.60	\$42.21	\$48.24
Single +1	\$45.92	\$51.59	\$56.69	\$61.79	\$67.46	\$72.56	\$79.36	\$90.70
Single +2	\$60.57	\$68.05	\$74.78	\$81.51	\$88.99	\$95.72	\$104.69	\$119.65
Single +3	\$75.22	\$84.51	\$92.87	\$101.23	\$110.52	\$118.87	\$130.02	\$148.59
Single +4	\$89.88	\$100.97	\$110.96	\$120.95	\$132.04	\$142.03	\$155.35	\$177.54
Single +5	\$104.53	\$117.44	\$129.05	\$140.67	\$153.57	\$165.19	\$180.67	\$206.48
Single +6 or more	\$133.84	\$150.36	\$165.24	\$180.11	\$196.63	\$211.50	\$231.33	\$264.38

Dentemax PPO - PLAN B

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Single	\$21.98	\$24.69	\$27.14	\$29.58	\$32.29	\$34.74	\$37.99	\$43.42
Single +1	\$41.32	\$46.43	\$51.02	\$55.61	\$60.71	\$65.30	\$71.43	\$81.63
Single +2	\$54.51	\$61.24	\$67.30	\$73.36	\$80.09	\$86.14	\$94.22	\$107.68
Single +3	\$67.70	\$76.06	\$83.58	\$91.11	\$99.46	\$106.99	\$117.02	\$133.73
Single +4	\$80.89	\$90.88	\$99.87	\$108.85	\$118.84	\$127.83	\$139.81	\$159.78
Single +5	\$94.08	\$105.69	\$116.15	\$126.60	\$138.22	\$148.67	\$162.61	\$185.84
Single +6 or more	\$120.46	\$135.33	\$148.71	\$162.10	\$176.97	\$190.35	\$208.20	\$237.94

Monthly rates do not include the \$1 monthly, \$3 quarterly, or \$12 annually association fee.
Choose from a \$5 monthly, a \$7.50 quarterly, or a \$10.00 annual billing fee.

Rates are guaranteed for 12 months from effective date.
Rates are effective through January 31, 2011.

INDEMNITY AND PPO AREA FACTORS

Alabama	1	Hawaii	4	Michigan	2	North Carolina	2	Texas	1
Alaska	8	Idaho	1	480-485	3	275 -277	3	762-764,768-769	2
Arizona	2	837	3	Minnesota	2	282	4	788,790-799	2
850-853	3	Illinois	1	554	4	North Dakota	1	750,751,760	3
Arkansas	1	600,600-608	4	550-553,555	3	Ohio	1	761,770	3
California	4	610-619	2	Mississippi	1	430-432,434-436	2	772-777,786	3
900-904	6	Indiana	1	Missouri	1	439-445,450-452	2	787,789	3
905-916	5	460-466,469,473	2	630-634	2	456	2	752-753	3
926-931	5	Iowa	2	640-641	2	Oklahoma	1	Utah	3
940-944	6	Kansas	1	Montana	2	730-731,740-741	2	Vermont	3
945-951	5	660-661,664-666	2	Nebraska	1	Oregon	3	Virginia	2
Colorado	3	672	2	Nevada	4	970-975	4	201	5
800-804	4	Kentucky	1	893-898	5	Pennsylvania	2	220-223	4
808-809	4	Louisiana	1	New Hampshire	4	190-191	4	233-237	3
Connecticut	5	700-701	2	New Jersey	4	189,192-194	4	Washington	4
68-69	6	707-712	2	070,074-076	5	Rhode Island	3	980-981	6
Delaware	5	Maine	3	078,079	5	South Carolina	2	982-986	5
Dist of Columbia	5	Maryland	2	088-089	5	South Dakota	1	West Virginia	1
Florida	3	206-209	4	New Mexico	2	Tennessee	1	Wisconsin	2
330,332-334,340	4	210-214	3	New York	2	370-372,380-384	2	532-534,537	3
331	5	Massachusetts	4	100 - 102	8			Wyoming	1
Georgia	2	017 - 019	5	103-114	5				
301-302	3	020 - 022	6	115-119	4				
300,303,311	4			120 - 129	3				

PLAN INFORMATION

The following provides a brief overview of Denali Dental plan guidelines, definitions, limitations and exclusions. This brochure is not the insurance group policy or certificate. Please refer to the Certificate of Insurance under group policy form MNL ADEN-POL 0905, issued to Communicating for America, Inc., for detailed definitions along with a full explanation of plan guidelines, benefits, exclusions and limitations.

GROUP ASSOCIATION

Denali Dental is a group association dental plan available to individuals and families. Membership enrollment in Communicating for America, Inc. (CA) is effective upon receipt of association dues, which are added to the plan premium. Communicating for America is a nonprofit association headquartered in Fergus Falls, Minn., providing members valued benefits and savings since 1972.

ELIGIBILITY

Individuals, their spouse and dependent children are eligible for coverage. In order to be considered an eligible dependent child, he/she must be unmarried and under age 19, or 25 if a full-time student. The primary insured must be a member of CA and all family members must be residents of the United States in order to be covered.

COVERED CHARGES

Covered charges must be incurred while the policy is in force and the person is covered by the policy. To become a covered charge, the dental services must be performed by: a licensed dentist performing dental services within the scope of his license; or a licensed dental hygienist acting under the supervision and direction of a dentist. A covered charge is considered incurred on the following dates: for full and partial dentures—on the date the final impression is taken; for fixed bridges, crowns, inlays and onlays—on the date the teeth are first prepared; for root canal therapy—on the date the pulp chamber is opened; for periodontal surgery—on the date surgery is performed; for all other services—on the date the service is performed.

ALTERNATE BENEFIT

If we determine that a less expensive alternate procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition and the alternative treatment will produce a professionally satisfactory result, then the maximum we will allow will be the charge for the less expensive treatment.

PREDETERMINATION OF BENEFITS

Except in an emergency, before you begin treatment that will cost more than the predetermination amount shown on the Certificate's schedule of benefits page, your dentist must submit a claim to us describing the treatment necessary and its cost. This estimate is not a guarantee of payment. We will still consider a claim for which you have not obtained prior approval. However, the claims will be subject to reduced benefits based on our determination of reasonable and customary charges, and medically necessary treatment.

COORDINATION OF BENEFITS

This plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits.

DENTAL EXPENSES NOT COVERED/LIMITATIONS

Benefits will not be paid for dental expenses arising from or in connection with:

1. Treatment, services or supplies which:
 - A. Are not Medically Necessary;
 - B. Are not prescribed by a Dentist;
 - C. Are determined to be Experimental/ Investigational in nature by Us;
 - D. Are received without charge or legal obligation to pay;
 - E. Would not routinely be paid in the absence of insurance;
 - F. Are received from any Family Member;
 - G. Are not Covered Procedures.
2. Selfinflicted injuries.
3. War or an act of war, whether or not declared.
4. A Covered Person's commission of a felony or an assault on another person.
5. Riot, nuclear accident, or a major disaster.
6. Employment; whether caused by, related to, or as a condition of employment, including self employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges.
7. Treatment which began, before the Covered Person's Effective Date of coverage or after the Covered Person's termination of coverage.
8. Congenital or development malformations existing on the Covered Person's effective date as shown on the Schedule of Benefits.
9. Cosmetic procedures, unless the coverage is elected by the Insured Person and the required premium is paid.
10. Periodontal splinting.
11. Porcelain on crowns, or pontics posterior to the 2nd bicuspid.
12. Replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any [5 year period].
13. Relining of dentures more often than once in any [2 year period].
14. Lost, stolen, or missing dentures or bridges or for duplicates.
15. Fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective Date of coverage as shown on the Schedule of Benefits. Benefits may be payable for bridgework required for loss of teeth while covered under the Policy, if such bridgework is not an abutment for noncovered bridgework.
16. Prescription Drugs and analgesia premedication.
17. Telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending Dentist statements, and any other services or supplies which are not part of the direct treatment of the Covered Person.
18. Dental education or training programs including oral hygiene or plaque control programs.
19. Counseling on diet and nutrition.
20. Military service, including service in a military reserve unit.
21. Prosthodontics, unless this coverage is elected by the Insured Person and the required premium is paid.
22. Charges payable under any medical insurance.
23. Charges made by any government entity unless the Covered Person is required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made.
24. Use of materials, other than fluorides or sealants, to prevent tooth decay.
25. Bite registrations.
26. Bacteriologic cultures in connection with a covered dental service.
27. Therapeutic injections administered by a Dentist.
28. Cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling).
29. Replacement of 3rd molars.
30. Composites on teeth posterior to the 2nd bicuspid.
31. Crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.
32. Temporomandibular joint syndrome.

NOTICE: This brochure provides a very brief description of some important features of your Plan. It is not the Insurance Contract, nor does it represent the Insurance Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Policy Forms MNL ADEN-POL 0905 and SSL ADEN-POL 0905 issued to Communicating for America.



"Your Source for Dental, Disability, Life and Vision Benefits"

325 Cedar Street, Suite 800 Saint Paul, MN 55101 • ph 651.649.3503 800.620.5010 fax 651.649.3502 • www.directbenefits.com



Payment Information

If you are not completely satisfied with this coverage, and you have not filed a claim, you may return the Policy/ Certificate of Insurance within 10 days and receive a premium refund (minus administration fees and dues).

Please choose your payment method below and complete the payment and signature forms to complete your online application.

Credit Card Number: _____ **Expiration:** _____

We accept Visa, Master Card and Discover.

*Credit card payments can only be made for annual premium.

or

Automatic Bank Withdraw

By selecting Automatic Bank Withdrawal, Madison National Life Insurance Company of America's or Standard Security Life Insurance Company of New York's monthly premium will automatically be withdrawn from your checking account at the following bank.

Name on Checking Account: _____

Checking Account Number: _____

Bank (Institution) Name: _____

Bank Routing Number: _____

I request that you pay and charge my account debits from my account by IHC Health Solutions to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advanced written notice to me. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

- Automatic withdrawals to occur on the first of the month.
- The payment option you chose will continue through the duration of your coverage. If you want to change your payment option please contact IHC Health Solutions at 800-228-6790.
- My insurance will not go into effect until the application is approved and the payment is received by IHC Health Solutions. If payment is not received, my application will be considered void and no coverage will be issued.

I understand that my application is subject to approval by the issuing insurance carrier and the submission and acceptance of my credit card information does not constitute approval of or issuance of my coverage.

Signature of Applicant

Date

Agent Name

Agent Signature

Date

Direct Benefits, Inc.

325 Cedar Street, Suite 800 • St. Paul, MN 55101
651-649-3503 / 800-620-5010 • Fax: 651-649-3502

Madison National Life Insurance Company, Inc. - P.O. Box 5008,
Madison, Wisconsin

- Indemnity
 Dentemax PPO



Higher Level Dental Care

PLEASE PRINT IN SPACE PROVIDED

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER ()	BIRTH DATE / /	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED

COVERAGE - Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only)

Dental Insurance

Self SPOUSE CHILDREN REQUESTED EFFECTIVE DATE: _____

DEPENDENT INFORMATION SPOUSE NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:

REFUSAL/WAIVER - Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE DENTAL COVERAGE FOR: MYSELF MY SPOUSE MY CHILDREN

REASON FOR REFUSAL: _____

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by Denali Dental. I reserve the right to revoke or change this authorization by written notice. I declare all answers are true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE	CITY AND STATE
SIGNATURE	

MNL ADEN-MBR APP 0905

Direct Benefits, Inc.

325 Cedar Street, Suite 800 • St. Paul, MN 55101
651-649-3503 / 800-620-5010 • Fax: 651-649-3502



Higher Level Dental Care

NEW APPLICATION CHECKLIST

To expedite processing please confirm that the following is submitted.

- Completed Application
- Signed Application
- Premium Payment (Credit Card or Automatic Bank Withdrawal)
- Completed and Signed Agent Information section when applicable

Premiums are determined by area. To determine your monthly premium rate, refer to the Area Factor Chart (area factors are based on the first three digits of your home zip code).

Rate + \$ _____

Association fee + \$ _____
(\$1 monthly, \$3 quarterly or \$12 annually)

Billing fee + \$ _____
(\$5 monthly, \$7.50 quarterly or \$10 annually)

TOTAL REMITTANCE = \$ _____

Payment options include Visa/MasterCard/Discover or checking/savings account bank draft.

After all of the information listed above is completed and signed send all original forms to:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
651.649.3502 fax
Carrissa@directbenefits.com

Submission Date:

Information must be postmarked by the 25th of the month to be effective by the first of the following month.