Individual & Family Dental Insurance

Choose Any Provider
Benefit up to $4,000
Preventive Services at 100%
National Network Coverage
Graduating Basic Service Benefit
Discount Vision Included

MAGNUM

Administered by:

DENTALSELECT

Marketed by:

DIRECT BENEFITS INC.

Plans available in the following states: AL, AZ, CA, CO, DC, DE, HI, KS, KY, MN, ND, NE, NV, OK, OR, SD, TX, UT, VT, WI & WY

You No Longer Have to Search the Galaxy for Great Individual Dental Insurance

We are your shining star and will lead the way when you and your family need new or replacement coverage for dental.

The Magnum plans are marketed exclusively by Direct Benefits, providing full-service, one-stop individual and family dental benefits consulting nationwide. Administered by Dental Select and underwritten by ACE American Insurance Company A.M. Best Rated A++ (Superior)*, the Magnum individual and family plans bring you experience and strength. Together, our solid balance puts the best individual and family dental plans within your reach.

Universal Network Savings

Committed to providing superior access, the Magnum individual and family dental plans offer large, quality networks in your area. You and your family can visit any dentist you choose but the out-of-pocket savings are best when visiting an in-network provider. All network providers are contracted to accept a lower than standard fee, which results in lower claims costs and affordable premiums. To find a provider go to www.magnumdental.com.

Magnum discount vision is included with every dental plan and is supported by EyeMed Vision Care. EyeMed offers access to more than 46,000 independent practitioners and optical retail providers at more than 22,000 locations nationwide such as: LensCrafters, Pearle Vision, JCPenney, Sears Optical, Private Practitioners and Target Optical.

Simple Administration

Members can enjoy freedom from having to submit claims paperwork for in-network services. We coordinate with your provider for all network claims, so there is nothing more you need to do. Magnum individual and family plans are affordable and convenient, making it easy for you and your family to reduce your out-of-pocket costs for needed dental & vision care.

*A.M. Best rating ranges from A++ to D. This rating is an indication of a company's financial strength and ability to meet obligation to its insureds.

Out of This World Benefits

Dental

- Maximum benefits up to $4,000
- Competitively priced dental benefits
- 100% preventive care with no waiting periods*
- Graduating basic service benefit feature
- Access to nationwide dental network
- Freedom to choose any provider*
- Discount Vision included with every dental plan

Discount Vision (Included)

- Access to more than 46,000 independent practitioners and optical retail providers at more than 22,000 locations nationwide
- Many locations open 7 days/wk, including evenings

*Members who receive services from out-of-network providers may be balance billed for services amounts not reimbursed under the plan. For the best possible experience we encourage all members to verify a provider's network status prior to service being rendered.

Stellar Service

Performance is the key to both Direct Benefits' and Dental Select's commitment to serving every client. Together we shine as we guide you through each process and answer your questions with our highly trained and knowledgeable staff.

Direct Benefits will put you at ease with their focus on member communications, enrollment assistance, clarification of contract benefits and identification of participating network providers.

Dental Select's ability to effectively and efficiently administer your individual and family dental plan with simple billing, quick claims turnaround, expert call center staff and the ability to provide each client and member that small-town, personal service with big city corporate benefits offers you the ultimate administration experience.

Administered by:

DentalSelect.

Marketed by:

DIRECT BENEFITS INC.

Underwritten by:
ACE American Insurance Company

ace usa

Learn more about your Magnum individual and family dental plan
Call Direct Benefits at 651-649-3503 or 800-620-5010,
or visit **MAGNUMDENTAL.COM**.

The best individual and family dental plans are just within your reach.

Individual Dental Plans

Toll Free Phone: 800-620-5010 Fax: 651-649-3502

Sign Up Today!

Enroll Online at: www.magnumdental.com

Three Easy Ways To Enroll:

1. Enroll online* at **www.magnumdental.com** with only a $25 enrollment fee.
2. Visit **www.magnumdental.com** and print out the Enrollment Form and return to Direct Benefits with your $40 enrollment fee included.
3. Call your insurance agent.

*Call a Direct Benefits representative at 1-800-620-5010 with enrollment questions.

Dental Plan Summary of Benefits	Co-Insurance Plan
Can I go out of network?	**Yes***
When is my plan effective?	1st day of the following month from the date we receive your enrollment
Who can I include on my plan?	Spouse & any unmarried children up to age 26
What if I require specialist services? (You are not required to receive services from a specialist, most general dentists perform specialist services)	After waiting periods and deductibles are met members receive a paid benefit for covered services provided by both general and specialist providers
Type of Plan	**Insured** In-Network based on contracted fee schedule. Out-of-Network based on contracted fee schedule*
Preventive Cleanings (2 per year), exams and fluoride (14 & under)	100%
Basic Includes fillings, oral surgery and bitewing x-rays	50% - Year 1 then 80% - Year 2+
Major Includes crowns, bridges, periodontics, endodontics, dentures, implant crown only & panoramic x-rays	50%
Lifetime Preventive Deductible Per person, one-time payment. Applies to Preventive services.	$50
Deductible - Basic & Major Per calendar year. Maximum three per family. Applies to Basic & Major services	$50/$150
Maximum Benefit Applies to all services excluding orthodontics. Per person, per calendar year	$1,000 / $500 Major†
	Alternative Maximum Benefit Choices
	$2,000 / $1,000 Major† | $3,000 / $1,500 Major† | $4,000 / $2,000 Major†
	†The amount shown is the maximum amount available per year for Major Services
Waiting Periods: Basic	None
Major	12 Months
Orthodontic	18 months
Orthodontics 18 & Under	50%
Orthodontic Maximum	$500 per year $1,000 lifetime maximum

*For services rendered by out-of-network providers, the patient is responsible for the difference between the plan payment and the provider's standard fee.
No balance billing for services rendered by a contracted provider.
This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. Please refer to your certificate of coverage (AH-10335) for a complete description of the plan benefits, limitations and exclusions.

EyeMed Discount Vision included for your entire family on every dental plan.

Individual Plan Rate Sheet

Toll Free Phone: 800-620-5010 Fax: 651-649-3502

Magnum Individual and Family Plan Rates - Rates based on Standard $1,000 Maximum Benefit

For additional annual maximum options for areas 1-15, use the applicable Plan Factor in the table below to calculate your premium amount.

Rates valid through February 1, 2016

	Co-Insurance														
Monthly Rates	**Area 1**	**Area 2**	**Area 3**	**Area 4**	**Area 5**	**Area 6**	**Area 7**	**Area 8**	**Area 9**	**Area 10**	**Area 11**	**Area 12**	**Area 13**	**Area 14**	**Area 15**
Subscriber Only	$19.12	$19.70	$20.32	$20.37	$22.47	$23.43	$24.67	$25.53	$26.68	$28.91	$30.64	$31.08	$33.26	$36.00	$22.87
Subscriber + 1	$36.83	$37.95	$39.13	$39.25	$43.29	$45.13	$47.52	$49.19	$51.39	$55.68	$59.00	$59.85	$64.08	$69.34	$44.04
Family	$52.00	$53.58	$55.23	$55.41	$61.11	$63.71	$67.08	$69.43	$72.55	$78.61	$83.29	$84.49	$90.45	$97.89	$62.17

Monthly Rates Area 16

*For area 16, subscribers will add the noted premium amount for each additional dependent up to six (6). After six (6) dependents, the total premium amount will be capped.

	$1,000 Annual Maximum	$2,000 Annual Maximum	$3,000 Annual Maximum	$4,000 Annual Maximum
Subscriber Only	$16.28	$18.88	$20.19	$21.16
Additional Dependents*	$15.40 each	$17.86 each	$19.10 each	$20.02 each

Plan Factors	Rate Impact
$2,000 Annual Maximum	1.16

Plan Factors	Rate Impact
$3,000 Annual Maximum	1.24

Plan Factors	Rate Impact
$4,000 Annual Maximum	1.30

Area Factors

Alabama	359-364, 367, 368	1	Kentucky	400, 401, 407-409, 411-418, 420-427	2	South Dakota	All	15
	350, 351, 354, 355	2		403, 404, 410	3	Texas	754-759, 765, 768-769, 776-785, 788, 790-799, 885	5
	352, 356-358, 365, 366, 369	5		402, 405, 406	5		762-764, 766, 767, 773-775	6
Arizona	855, 859, 863, 864	6	Minnesota	561, 562	4		752, 753, 760, 761, 770, 772, 786-789	9
	856, 857	8		556, 557, 565-567	5		750, 751	7
	850-852, 853, 860, 865	9		558 - 560, 563, 564	6	Utah	All	16
California	922-925, 932-937, 952-955, 959-961	9		550	8	Vermont	050-053, 056-059	9
	905-921, 930, 939, 942, 956-958	10		551, 553-555	9		054	11
	900-904, 926-928, 931	11	Nebraska	683-686, 688-693	2	Wisconsin	540, 545, 546, 548	5
	940, 941, 950, 951, 943-949	12		680, 681, 684, 687	5		535, 538, 539, 541, 542, 544, 547	6
Colorado	800-804, 816	10	Nevada	889, 890, 891	9		530-532, 534, 543, 549	8
	805-807	11		893-895, 897, 898	10		537	9
	808-815	9	North Dakota	All	15	Wyoming	All	15
Delaware	All	11	Oklahoma	730, 731, 740, 741	6			
DC	200, 202-205	10		734-736, 745, 747, 749	4			
Hawaii	All	9		737-739, 743, 744, 746, 748	3			
Kansas	660-662, 664-679	3	Oregon	All	9			

Marketed by:

DIRECT BENEFITS INC.

Network Availability by State

Premier - Minnesota

Platinum - Alabama, Arizona, California, Colorado, Delaware, District of Columbia, Hawaii, Kansas, Kentucky, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Vermont, Wisconsin, Wyoming

To find a provider go to:
www.magnumdental.com

Administered by:

DENTALSELECT.

MAGNUM

Guidelines

DENTALSELECT
DIRECT BENEFITS INC.
Toll Free: 800-620-5010
Fax: 651-649-3502

DENTAL – No benefits will be paid for expenses incurred:

1. for services and supplies not listed in the Coverage Schedule, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental. (Not applicable to SD.)
2. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
3. for services related to, performed in conjunction with, or resulting from a non-covered procedure.
4. for charges in excess of the contracted Fee-for-Service schedule or the Usual and Customary rate, whichever applies.
5. for any treatment program which began prior to the date the Insured is covered under the Policy.
6. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
7. for the replacement of crowns, bridges, dentures, inlays or onlays that can be restored to normal function.
8. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
9. for any unmarried child age 26 and over unless he is dependent upon You for support and You claim as an exemption on Your federal income tax.
10. for service or supplies payable under any medical expense, auto or no-fault plan. (In KS, this exclusion is deleted and replaced with: "for service or supplies payable under any medical expense payment provision (by whatever terminology used – including such benefits mandated by law) of any automobile policy.")
11. for any condition covered under any Worker's Compensation Act or similar law. (In SD: "covered under" is replaced with "paid by." In KS, this exclusion is deleted and replaced with: "for dental services related to the Insured's job to the extent the Insured is covered or is required to be covered by the Workers' Compensation law. If the Insured enters into a settlement giving up his or her right to recover future dental benefits under a Workers' Compensation law, this Policy will not pay those dental benefits that would have been payable in the absence of that settlement.")
12. for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
13. during any waiting period We require. When You voluntarily end Your insurance without a qualifying event and re-enroll at a later date, Your waiting period is 2 years and begins on the date Your coverage first ended. (This exclusion applies to: KS, KY, NV, OR, and VT)
14. for services that are applied toward the satisfaction of a Deductible, if any.
15. for services subject to a waiting period that were incurred during the waiting period.
16. for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
17. for hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
18. for drugs or the dispensing of drugs.
19. for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
20. myofunctional therapy; athletic mouthguards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction (except as provided under the Mandated Coverage Provision in MN); cleft palate (except as provided under the Mandated Coverage Provision in MN); or anodontia.
21. for orthodontia, unless included within the Coverage Schedule.
22. for services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 24 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits. (CA, NV, TX, & WY: This exclusion does not apply if the device covers one or more natural teeth lost or extracted while covered under the Plan, or if the prosthetic device was in place when the policy became effective.)
23. for composite, resin, or white fillings on posterior teeth (unless included within the Coverage Schedule). Benefits will be reduced to that of an amalgam or silver filling.
24. for the replacement of a filling within 24 months of placement, unless for specific health reasons.
25. for the replacement of retainers.
26. for sealants not applied to permanent molar; applied at age 16 or older; applied 3 years from a previous sealant application; applied to a decayed tooth.
27. for lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays.
28. during travel or activity outside the United States. (This exclusion applies to: AL, CA, DE, DC, HI, KS, KY, NE, NV, OK, SD, TX, WY.)

Version Date: November 4, 2014
States: AL, AZ, CA, CO, DE, DC, HI, KS, KY, MN, NE, NV, ND, OK, OR, SD, TX, UT, VT, WI, WY

Guidelines

DentalSelect
DIRECT BENEFITS INC.
Toll Free: 800-620-5010
Fax: 651-649-3502

Individual Plans – Payment Rules

Your account will be drafted on or around the 16th of the month. If you enroll on the plan after the 15th of the month, two (2) month's premiums will be drafted from your account on or around the 16th of the following month to include the previous month and the current month's premiums. Thereafter, you will only be drafted for one month's premiums on or around the 16th of the month.

Waiving Waiting Periods

New Policy
Basic, Major and Orthodontic waiting periods may be waived for the number of comparable months effective (max 12 months) with the prior carrier when a letter of creditable coverage and summary of benefits for the prior carrier are received and reviewed within 30 days of enrollment.

Existing Policy
Waiting periods may be waived based on continuous coverage if a subscriber passes away and dependents move to a new policy; divorce; gain in coverage; or plan change at renewal.

Orthodontic waiting periods may be waived on a case-by-case basis.

Individual Vision Plans

Toll Free Phone: 800-620-5010 Fax: 651-649-3502

Sign Up Today!

Enroll Online at:
www.magnumdental.com

- No Maximums
- No Waiting Periods
- No Claims to Submit
- No Visit Limitations

The EyeMed Access Network offers convenient availability of quality independent providers and leading optical retailers such as:

LensCrafters, Pearle Vision, eyeMed, JCPenney jcp.com, Sears Optical, Private Practitioners, Target Optical

To locate an EyeMed Access Network provider, go to www.magnumdental.com and select the "Find a Provider" button at the top of the home page.

EyeMed Discount Vision

EyeMed Discount Vision included for your entire family on every plan

Summary of Discount Vision Benefits	
Vision Care Services	**Member Cost**
Exam with Dilation as Necessary:*	$5 off routine exam $10 off contact lens exam
Complete Pair of Glasses Purchase: frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard Plastic Lenses:	
Single Vision	$50
Bifocal	$70
Trifocal	$105
Progressive	$135
Frames:	
Any frame available at provider location	35% off retail price
Lens Options:	
UV Coating	$15
Tint (Solid & Gradient)	$15
Standard Scratch-Resistance	$15
Standard Polycarbonate	$40
Standard Anti-Reflective Coating	$45
Other Add-ons & Services	20% Discount
Contact Lens Materials: (Discount applies to materials only)	
Disposable	N/A
Conventional	15% off retail price
Laser Vision Correction:	15% off retail price -or-
Lasik or PRK	5% off promotional price
* Under contract, ACCESS Vision Providers may charge usual & customary rates for a comprehensive exam up to a contracted fee per region.	

The EyeMed Discount Vision Plan is a fee for service discount plan, it is not an insured product. This program provides discounts only from a certain network of vision providers. The member is responsible to pay for all services but will receive a discount from vision providers who are contracted on the EyeMed Network.

Marketed by: DIRECT BENEFITS INC.

Administered by: DentalSelect

Dental Plan Enrollment Form

Toll Free: 800-620-5010 **Fax:** 651-649-3502 **www.magnumdental.com**

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

Last Name	**First Name**		
Street Address			
City	**State**	**Zip Code**	
Phone Number	**Date of Birth** (MM/DD/YYYY)		
SSN	**Marital Status** ☐ Married ☐ Single	**Gender** ☐ Male ☐ Female	
Employer's Name & Phone Number			
Agent Name			
Agent Number	**Requested Effective Date** (MM/DD/YYYY)		
Where did you hear about us?			

List all dependents to be covered

Spouse Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN -** **DOB -**
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN -** **DOB -**
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN -** **DOB -**
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN -** **DOB -**
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN -** **DOB -**
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN -** **DOB -**
For additional dependents attach an additional sheet		
Covered by other DENTAL Insurance? ☐ Yes ☐ No	Name of Person Insured	
If Yes, Name of other Dental Insurance Company	Social Security Number	

Plan Type – Individual & Family Plan

Choose Your Plan Options *(Plan choices may vary per state)*

(Choose only one dental option)

Dental Co-Insurance Plan: ☐$1,000 Standard Benefit

Alternative Maximum Benefit Choices: ☐$2,000 ☐$3,000 ☐$4,000

Premiums are determined by area. To determine your monthly premium rate, refer to the Area/State chart. Calculate the base rate by the optional benefit increase factor.

Base Rate = _____

☐ Optional $2,000 benefit (base rate x .16) = _____

☐ Optional $3,000 benefit (base rate x .24) = _____

☐ Optional $4,000 benefit (base rate x .30) = _____

Monthly Total = _____

Application Fee + $40.00

Total Remittance = _____

EyeMed Discount Vision Plan included with all dental plans

Payment Options *(Choose either Checking/Savings or Credit Card Payment. All checks must be payable to Dental Select.)*

Billing Period: ☐ Monthly *(Withdrawn on the 15th or next 2 business days)* ☐ Annual *(Check or Credit Card)*

Checking or Savings *(Include a $40.00 enrollment fee with your payment / $25 if online enrollment)*

☐ Checking Account *(Include Voided Check)* ☐ Savings Account *(Include Deposit Slip)*

Financial Institution:

Routing Number:

Account Number:

Credit Card Payment *(Include your check for the $40.00 enrollment fee)*

☐ **VISA** ☐ **MASTERCARD**

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date: ☐☐/☐☐

Account Holder Name:

Account Holder Signature: Date:

I wish to enroll in the plan I have selected. I authorize and agree to account deduction of the required premium.

This authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution at least three business days before the withdrawal is made. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. Please direct billing inquiries to Dental Select, 5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123. I have read and understand the statements above pertaining to the billing option. Your cancellation will be effective the first day of the month following the month your written request is received.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Fraud Warning for Kentucky Applicants:

WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

In the event there are insufficient funds when a draft is charged to my account, I agree to pay $25 NSF Fee. The 3rd returned check in any 12 month period will result in the immediate cancellation of my policy. Dental Select reserves the right to deny me the ability to be reinstated on any personal Dental Select plan for two years.

Signature: Date:

Please fill out and return this enrollment form with your payment to:

DIRECT BENEFITS 325 Cedar Street, Suite 800, Saint Paul, MN 55101 Toll free: 800-620-5010 Fax: 651-649-3502