Delta Dental Plan Highlights at a Glance

Select the plan that best meets your and/or your family needs. You now have two (2) plans to choose from for dental coverage. The following gives you a summary description of each plan benefit; plus there is a Benefit Summary and Participating Provider Directory for each plan included in your packet

KCTCS

	DeltaPremier	***Delta Preferred Option***	
Deductible (Calendar Year)	$ 50 Individual $150 Family	$25 Individual $75 Family	
		In Network	Out-of-Network
Preventive Services	(Deductible does not Apply)		
Oral Exams	100%	100%	75%
X-Rays	100%	100%	75%
Teeth Cleaning	100%	100%	75%
Fluoride Treatments	100%	100%	75%
		In Network	Out-of-Network
Minor Services	(Subject to Deductible)	(Subject to Deductible)	
Fillings/Extractions	In and Out of Network Benefits	80%	60%
Root Canals	50%	80%	60%
Oral Surgery	50%	80%	60%
	50%		
		In Network	Out-of-Network
Major Services	(Subject to Deductible)	(Subject to Deductible)	
Crowns	In and Out of Network Benefits	50%	40%
Bridges	50%	50%	40%
Dentures	50%	50%	40%
Periodontic Services	50%		
Dependents	Dependents to age 26	Dependents to age 26	
Claim Forms	Participating Dentists will file your claims (patient does not need form)	Participating Dentists will file your claims (patient does not need form)	
Annual Maximum	$1,000	$1,000	
Waiting Period	6-month Waiting Period on Oral Surgery 12-Month Waiting Period on Major	6-month Waiting Period on Oral Surgery 12-Month Waiting Period on Major	
Pre-Existing	Missing Tooth Exclusion (Teeth missing prior to coverage)	Missing Tooth Exclusion (Teeth missing prior to coverage)	
Network	Any dentist in the Delta Premier Directory or any licensed dentist; however, if you go to a non-participating dentist (not in the directory), you may be balance billed.	Any Dentist in the Delta Preferred Option Directory, if you go to a non-participating dentist your benefits are reduced	
Monthly Rates			
Employee	$23.70	$20.76	
Employee + One	$45.50	$39.84	
Employee + Family	$75.20	$68.46	

Delta Dental of Kentucky
Delta Dental Premier
Summary of Dental Plan Benefits

Group Name: KCTCS

Group Number: M00146-1888

Benefit Year: January 1 through December 31

Covered Services –

	Plan Pays*	You Pay
Diagnostic & Preventive		
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	0%
Emergency Palliative Treatment – to temporarily relieve pain	100%	0%
Sealants – to prevent decay of permanent teeth	100%	0%
Brush Biopsy – to detect oral cancer	100%	0%
Radiographs – X-rays	100%	0%
Basic Services		
Minor Restorative Services – fillings and crown repair	50%	50%
Endodontic Services – root canals	50%	50%
Periodontic Services – to treat gum disease	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%
Major Restorative Services – crowns	50%	50%
Other Basic Services – misc. services	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%
Major Services		
Prosthodontic Services – bridges and dentures	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Fluoride treatments are payable once per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per two-year period for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- The initial installation of any prosthodontic service is not a Covered Service to replace missing teeth or teeth that were lost before coverage began.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and related services are not Covered Services.

Deductible – $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, and sealants.

Customer Service Toll-Free Number: (800) 955-2030
www.DeltaDentalKY.com

Maximum Payment – $1,000 per person total per Benefit Year on all services.

Dependent Age Limit – Dependents are covered up to age 26.

Waiting Period – There is a 12-month waiting period for certain services. Periodontic Services, Major Restorative Services, Relines and Adjustments, Fixed Prosthodontic Repair, and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months. Other Oral Surgery and Other Basic Services will not be covered until after a person is enrolled in the dental plan for 6 consecutive months.

Eligible People – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflict with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages above are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Delta Dental of Kentucky
Delta Dental PPO (Standard)
Summary of Dental Plan Benefits

Group Name: KCTCS

Group Number: M00146-2888

Benefit Year: January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	**Delta Dental Premier Dentist**	**Non-participating Dentist**
	Plan Pays	**Plan Pays***	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	75%	75%
Emergency Palliative Treatment – to temporarily relieve pain	100%	75%	75%
Sealants – to prevent decay of permanent teeth	100%	75%	75%
Brush Biopsy – to detect oral cancer	100%	75%	75%
Radiographs – X-rays	100%	75%	75%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	60%	60%
Endodontic Services – root canals	80%	60%	60%
Periodontic Services – to treat gum disease	80%	60%	60%
Oral Surgery Services – extractions and dental surgery	80%	60%	60%
Other Basic Services – misc. services	80%	60%	60%
Denture Repair – repairs to complete or partial dentures	80%	60%	60%
Major Services			
Major Restorative Services – crowns	50%	40%	40%
Fixed Prosthodontic Repair – to bridges	50%	40%	40%
Implant Repair – implant maintenance, repair, and removal	50%	40%	40%
Relines and Rebase – to dentures	50%	40%	40%
Adjustments to Dentures – adjustments to complete or partial dentures	50%	40%	40%
Prosthodontic Services – bridges and dentures	50%	40%	40%

* When services are received from a Delta Dental Premier or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule (or the Nonparticipating Dentist Fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.

- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Fluoride treatments are payable once per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per two-year period for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- The initial installation of any prosthodontic service is not a Covered Service to replace missing teeth or teeth that were lost before coverage began.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and related services are not Covered Services.

Deductible – $25 Deductible per person total per Benefit Year limited to a maximum Deductible of $75 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, and sealants.

Maximum Payment – $1,000 per person total per Benefit Year on all services.

Dependent Age Limit – Dependents are covered up to age 26.

Waiting Period – There is a 12-month waiting period for certain services. Major Restorative Services, Relines and Adjustments, Fixed Prosthodontic Repair, and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months. Other Oral Surgery and Other Basic Services will not be covered until after a person is enrolled in the dental plan for 6 consecutive months.

Eligible People – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflict with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages above are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

How to find a Delta Dental participating provider

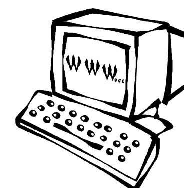
First, *determine the Delta Dental plan(s) you are looking at for your dental benefits. You can find the plan name on the benefit summary supplied by your employer or on your identification card.*

- **Delta Dental PPO** – In-network benefits are available through providers who participate in the Delta Dental PPO network. (See your benefit summary for specific coverage levels by network.)
- **Delta Dental Premier** – In-network benefits are available through providers who participate in the Delta Dental Premier network. (See your benefit summary for specific coverage levels by network.)
- **DeltaCare** – Benefits are available ***only*** through providers who participate in the DeltaCare network.
- **Delta Dental PPO Plus Premier** – In-network benefits are available through providers who participate in either the Delta Dental PPO or Delta Dental Premier networks. (See your benefit summary for specific coverage levels by network.)

Second, *choose one of the following methods to identify a participating provider who is in your plan:*

Internet

If you have access to the Internet, you may use our website (www.deltadentalky.com) and request the information by city, state, zip code, provider's name or specialty.



Mobile App

Our mobile app is available for mobile devices using iOS (Apple or Andriod). To download, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. The dentist search tool makes it easy to search for a Delta Dental Premier or Delta Dental PPO dentist in your area. DeltaCare subscribers must go to our website (www.deltadentalky.com) to find participating providers.

Fax Back

If you have access to a fax machine, you may call the Delta Dental customer assistance line at 1-800-955-2030 (select option 4) and request a directory by zip code and it will be faxed to you momentarily.

Telephone

You may call the Delta Dental customer assistance line at 1-800-955-2030 (select option 4) and request a list of providers by zip code and the system will read those selections to you.

Customer Service

You may call a Delta Dental customer service representative at the same toll free number listed above and ask if your provider is participating in the network associated with the plan that you have chosen.

Call Your Provider

You should call your provider's office and ask if he/she participates in the network associated with the plan that you have chosen.

It is important that you verify a provider's status each time you seek care as a provider contract may change. It is your responsibility to verify that the provider you use is contracted with the Delta Dental network associated with the plan that you have chosen. If you receive treatment from a non-network provider, your benefits may be paid at a lower percentage or you may be balance billed.

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DDPK PROV R. 6/14

Underwritten by Delta Dental of Kentucky

VSP® Vision Savings Pass™

VSP Vision Savings Pass is a discount vision program that offers immediate savings on eye care and eyewear. This is not an insurance plan.

See the Savings

- Access to discounts through a trusted, private-practice VSP doctor
- One rate of $50 for an eye exam[1]
- Special pricing on complete pairs of glasses and sunglasses
- 15% savings on a contact lens exam[2]
- Unlimited use on materials throughout the year
- Exclusive Member Extras, like rebates and special offers

Unlimited Annual Material Use[3]

Your VSP Vision Savings Pass can be used as often as you like throughout the year. With the best choices in eyewear, we make it easy to find the perfect frame that's right for you, your family, and your budget. Choose from great brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more.[4]

Service	Reduced prices and savings
Wellvision Exam®	• $50 with purchase of a complete pair of prescription glasses. • 20% off without purchase. • Once every calendar year.
Retinal Screening	• Guaranteed pricing with Wellvision Exam, not to exceed $39.
Lenses	With purchase of a complete pair of prescription glasses: • Single vision $40 • Lined trifocals $75 • Lined bifocals $60 • Polycarbonate for children $0
Lens Enhancements	• Average savings of 20-25% on lens enhancements such as progressive, scratch-resistant, and anti-reflective coatings.
Frames	• 25% savings when a complete pair of prescription glasses is purchased.
Sunglasses	• 20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last Wellvision Exam.
Contact Lenses	• 15% savings on contact lens exam (fitting and evaluation).
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

How to Use Your VSP Vision Savings Pass

1. Find a VSP doctor at **vsp.com** or call **800.877.7195**.
2. Save immediately on an eye exam[1] and eyewear at the time of service.
3. Take advantage of your VSP Vision Savings Pass over and over—use is unlimited on materials.[3]

SEE WHY WE'RE CONSUMERS' #1 CHOICE IN VISION CARE[5]

Contact us.
vsp.com | 800.877.7195

1. This cost is only available with the purchase of a complete pair of prescription glasses; otherwise, you'll receive 20% off an eye exam only.
2. Applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost.
3. Unlimited use is for materials only. An eye exam is limited to once a year per member.
4. Brands subject to change.
5. Blueocean Market Intelligence National Vision Plan Member Research, 2014.

THIS PLAN IS NOT INSURANCE and is not intended to replace health insurance. This plan is not a Qualified Health Plan under the Affordable Care Act. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN. There is no cost to join this discount program. The plan provides discounts at certain health care providers for services. The range of discounts will vary depending on the type of provider and service. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have agreed to provide discounts. The plan and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. This plan is not available in Washington. Void where prohibited.

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DELTA DENTAL®

(800) 955-2030

Easy Reference Card

DASI (DELTA DENTAL'S AUTOMATED SERVICE INQUIRY)

OUR DASI SYSTEM IS QUICK AND EASY TO USE

With DASI, you're able to access coverage and claims information 24 hours a day, 7 days a week.

What do you need to use DASI?

Members, clients and other non-dental office callers need to provide the subscriber's member number (usually Social Security number), relationship of the patient/member to the subscriber and the date of birth of the patient/member.

What information is available?

With DASI, you can receive the following for any Delta Dental of Arkansas, Indiana, Kentucky, Michigan, New Mexico, North Carolina, Ohio or Tennessee member:

- Eligibility
- Current effective date of coverage
- Eligibility for specific benefits (exams, cleanings, fluoride, X-rays, and occlusal guard)
- ID cards by fax or mail
- Fax copies of benefits and eligibility, explanation of benefits, and pre-treatment estimates
- Lists of participating dentists via voice, fax or mail
- Mailing address information
- Claim and pre-treatment estimate status
- Check status for paid claims
- Maximums and deductibles, including amount met to date and services that apply
- Coordination of benefits allowances

To assist you in navigating the system most efficiently, the main menu is listed here. Listening to the entire menu is not necessary. Once you become familiar with the system and know what information you want, you can speak or press the digits on your touch-tone keypad and go directly to the data.

At the greeting:

- SAY "SUBSCRIBER" or PRESS 2

DASI will then offer the following menu of choices:

- SAY "COVERAGE INFORMATION"[1] or PRESS 1 for general eligibility, availability of benefits for services with time limitations (cleanings, exams and more), FaxBack of benefits and eligibility, and maximums and deductibles.
- SAY "FIND A DENTIST" or PRESS 2 to find an in-network dentist.
- SAY "ID CARDS" or PRESS 3 to receive an ID card by fax or mail.
- SAY "SOMETHING ELSE" or PRESS 4 for additional content. Within the "something else" menu:
  - SAY "CLAIMS"[1] or PRESS 1 for claim and pre-treatment estimate status, process dates, check date, check status, and fax copy of a processed claim or pre-treatment estimate.
  - SAY "TOOLKIT SUPPORT"[1] or PRESS 2 to be transferred to a Consumer Toolkit® support representative.
  - SAY "DELTA DENTAL'S MAILING ADDRESS" or PRESS 3 to hear the mailing address for claims and inquiries.
  - SAY "REPRESENTATIVE" or PRESS 4 to speak with a customer service representative.

1 Member number and patient's date of birth required

DELTA DENTAL®

Stay informed about your dental benefits with Consumer Toolkit®

Stay current on your dental benefits with Delta Dental of Kentucky's easy-to-use Consumer Toolkit. This secure online tool is designed to give you 24/7 access to important information regarding your dental benefits, including:

- Eligibility information
- Current benefits information (such as how much of your yearly benefit has been used to date, how much is still available to use, and levels of coverage for specific dental services, etc.)
- Specific claims information, including what has been approved and when it was paid

The site also allows you to sign up for electronic delivery of Explanation of Benefits (EOB) statements, print claim forms and identification cards, and browse oral health information.

All users must first register to gain access to the Consumer Toolkit. Privacy of your online benefit information is assured through highly secure encryption technology.

Eligibility

Up-to-date benefit information

Get started today

To start taking advantage of this innovative tool, follow these simple steps:

1. Visit www.deltadentalky.com.
2. Select "Consumer Toolkit" from the drop-down Toolkit menu on the homepage.
3. Register as a new Toolkit user by clicking the "New User" button.
   - NOTE: You will need the subscriber's (the person whose name is on the benefit package) member ID. The member ID is an assigned number unique to the subscriber. In most cases, the member ID is the same as the subscriber's Social Security number.
4. Complete required fields and follow the on-screen instructions.
5. Select your own username and password to access the site.

Additional help topics can be found by selecting "Help" or clicking the ? at any time within the Toolkit. If you need further assistance, please contact our Customer Service department at (800) 955-2030.

Mobile App

Delta Dental's mobile app is available for mobile devices using iOS (Apple) or Android. To download and install the app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. The app provides the ability to search for a Delta Dental Premier® or Delta Dental PPO℠ dentist in your area (DeltaCare® members must go to our website at www.deltadentalky.com to find participating providers), check your claims and coverage information on the go, get estimated cost ranges for common dental services, and access a mobile ID card that you can show your dental office.

ENROLLMENT/STATUS CHANGE FORM

☐ **Delta Dental Premier** ☐ **Delta Dental PPO** ☐ **Delta Dental PPO Plus Premier** ☐ **DeltaCare**

Delta Dental Premier, Delta Dental PPO and Delta Dental PPO Plus Premier are offered by Delta Dental of Kentucky, Inc.

DeltaCare is offered by Dental Choice, Inc.

☐ **OPEN ENROLLMENT** ☐ **NEW ENROLLMENT** ☐ **STATUS CHANGE** ☐ **COBRA** ___________

Complete Status Change information below. *COBRA effective date.*

Social Security Number	Name – Last	First	MI	Birthdate / /
Home Address – Number and Street	City	State	Zip	Group Number
Sex (Circle one) M or F	Employer Name		Hire Date Required / /	Section Number

Check the type of contract and list all members:

☐ **Single** ☐ **Employee and Spouse** ☐ **Employee and child** ☐ **Employee and children** ☐ **Family**

MEMBERS Please list all dependents below, if applicable. If additional space is required, attach a list to this form.

Last	First	MI	Date of Birth MO	DAY	YR	Sex M	F	STATUS CHANGES ONLY (Circle one)	Does member have other dental coverage? If so, give insurance company name and telephone number, policyholder's name and identification number.
Spouse								ADD DELETE	
Dependent								ADD DELETE	
Dependent								ADD DELETE	
Dependent								ADD DELETE	
Dependent								ADD DELETE	

STATUS CHANGES ONLY (Complete all that apply. Qualifying event required.)

Indicate new contract type below and add or delete dependents in MEMBERS grid above:

☐ **Single** ☐ **Employee and Spouse** ☐ **Employee and child** ☐ **Employee and children** ☐ **Family**

Qualifying Event: ________________________ **QE Effective Date:** ____________

Terminate Subscriber's Contract as of ________________________

____

Name Change: Previous Name: ____________________ **New Name:** ____________________

Address Change: ________________________________

SHADED AREA FOR OFFICE USE ONLY

Effective Date	Process Date	Processed By

READ THE PROVISIONS ON THE BACK OF THIS ENROLLMENT FORM CAREFULLY BEFORE SIGNING.
PLEASE REVIEW YOUR ENROLLMENT FORM FOR ERRORS OR OMISSIONS.

I acknowledge I have read the provisions on the back of this enrollment form and I expressly accept such provisions as a condition of coverage. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Dental Choice (DeltaCare) or Delta Dental (Delta Dental Premier and Delta Dental PPO) in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). If accepted, this form, the member certificate, the identification card, and the group contract will constitute the contract.

Signature ________________________________ Date ________________

Please make a copy for your records and return original to your Human Resources Director.

2014-025-DD

® Registered Mark of Delta Dental Plans Association.

ENROLLMENT FORM FOR GROUP COVERAGE

In consideration of the acceptance of this enrollment form, I represent and agree for myself and my dependents that:

1. My coverage, and that of any dependents, will become effective on the date established by my dental contract (referred to as "Plan"). I agree to be bound by the provisions of the Group Contract(s) and Certificates of Coverage issued to me. Any dependents who are later added to my Plan may have different effective dates.
2. If I have selected the DeltaCare plan, offered by Dental Choice, Inc., my coverage provides for coordination of covered services through a designated Primary Care Dentist and benefits for services covered under the program will be provided only when furnished by the participating dentist. I also understand that no benefits are available under this coverage if I or any dependents fail to receive services through a Primary Care Dentist.
3. If I have selected the DeltaCare plan, I am entitled to select a new Primary Care Dentist at any time during my coverage period.

   If I have selected the Delta Dental Premier or Delta Dental PPO plan, offered by Delta Dental of Kentucky, Inc., I understand that all benefits payable under my dental contract for services rendered by any participating provider will be paid to such provider. Payment for services rendered by a non-participating provider will be sent to me.
4. My employer or group administrator is authorized to deduct my share of dental premiums from my wages for 12 months and 12 month renewal periods, and is authorized to remit a premium to the Plan and to receive all notices from the Plan relating to my coverage. I understand that enrollments are by Group Contract for consecutive 12 month period(s) and my subscription fee is subject to change on the anniversary date of the Group. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period.
5. I am responsible to notify the Plan upon any change that would make me or any dependent ineligible for coverage.
6. I will cooperate with the Plan and furnish all information requested by the Plan to enforce its right of subrogation and to coordinate benefits. Subrogation is the Plan's right to recover from a third party that may be liable to me for any injury which resulted in Dental Services paid by Plan.
7. I will reimburse the Plan for any erroneous payment and Plan may offset these amounts against future claim payments.
8. Any omitted or incorrect information or false statements made here may, at the sole option of the Plan, void or terminate my coverage or result in denial of services or benefits otherwise available hereunder for me or my dependents. I understand that if I have Delta Dental or Dental Choice coverage on an employee paid (voluntary) plan and I terminate my coverage before the end of any 12 month enrollment period while I am still eligible to participate in the Group Contract, my benefits will be voided for the entire enrollment period, and I must reimburse my Primary Care Dentist, or the Plan if the Plan has already paid the dentist, at the dentist's normal fee for service, for any services or benefits received by me or my dependents during that 12 month period. I understand and agree that no agent has the authority to waive a complete answer to any question, make a determination as to applicable underwriting requirements, make or alter any contract, or waive any of the Plan's other rights or requirements.
9. My employer, any other organization or person, any provider of dental care, any insurance company or insurance support agency, is hereby authorized to give the Plan any information about me and my listed dependents necessary for determining eligibility for insurance, benefits, risk classification, detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. This authorization includes any records or knowledge about my medical history, mental or physical condition, diagnosis, treatment or prognosis, including information relating to the use of drugs or alcohol. This information may also be given by the Plan to its legal representatives and reinsurers.
10. To the extent allowed by law, the Plan is authorized to furnish all information and copies of records requested by other insurers, dental plans or other parties for the purposes of determining eligibility for coverage or benefits, exercising the right of subrogation, utilization review or audit. I give the Plan, its legal representatives or any person or organization administering claims on its behalf, permission to release to my employer or group policyholder a summary of claims incurred by me or my eligible dependents for the purpose of verifying the claims submitted under my group health plan, utilization review, or for the purpose of conducting an audit of operations or services. If my benefits are provided under a self-funded plan, the above listed parties are authorized to release any necessary information to the self-funded plan, and I understand that all information under the Plan are the property of my employer and may be retained by my employer.
11. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). 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. If accepted, this application, the identification card and the group contract will constitute the contract.

PLEASE SIGN APPLICATION ON FRONT

Delta Dental of Kentucky, Inc.
10100 Linn Station Road
Louisville, KY 40223