dental health OPTIONS® by Health Resources, Inc.

Dental Health Options 6B Plan for KCTCS Employees

January 1, 2018 – December 31, 2018

DHO 6B for KCTCS Employees Includes:

100/50/50 Plan design

$1000 calendar year benefit per member

$1000 lifetime Orthodontic children's Benefit

(See attached Product Summary Guide with Ortho Rider)

- NO Waiting Periods
- NO Pre-Existing Conditions
- NO Deductible
- NO Balance Billing
- Backed by Kentucky's Strongest Dental Network

Monthly Rates:	2018
Employee:	$22.50
Employee + Spouse:	$59.30
Employee + Dependent(s):	$65.20
Employee + Family:	$97.50

A dental plan that encourages you to take control of your dental health!

Visit **InsuringSmiles.com** to Find a Dentist, view your benefits, view past claims history and more...

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Product Summary Guide for KCTCS

DHO 6

To find a dentist visit:
InsuringSmiles.com/FindADentist

Plan Features:
Network Option: In and Out of Network
Plan Year: January

PLAN ANNUAL MAXIMUM BENEFIT: $1,000

DENTAL SERVICES COVERED AT 100% *

PREVENTIVE SERVICES
- Routine teeth cleaning
- Fluoride applications
- Sealants (permanent molar teeth only)
- Space maintainers (not orthodontic retainers)

DIAGNOSTIC SERVICES
- Evaluations (exams)
  - Periodic, limited, comprehensive, periodontal
- Radiographs (x-rays)
  - Complete series
  - Panoramic films
  - Bitewings
  - TMJ films
- Other procedures
  - Pulp vitality tests
  - Diagnostic casts

DENTAL SERVICES COVERED AT 50% *

RESTORATIVE
- Silver fillings
  - Primary teeth
  - Permanent teeth
- White fillings
  - Anterior teeth
  - Posterior teeth
- Inlay/Onlay (metallic & porcelain)
- Crowns
  - Porcelain/ceramic
  - Full cast/¾ cast
  - Prefabricated stainless steel
  - Recementation
- Other restorative services
  - Protective restoration
  - Core buildup including pins
  - Pin retention
  - Post & core
  - Labial veneers (anterior teeth)

ENDODONTICS
- Vital pulpotomy (primary teeth only)
- Pulp therapy (primary teeth only)
- Root canal therapy
  - Anteriors
  - Premolars
  - Molars
  - Retreatment
- Apexification
- Apicoectomy
- Root amputation

PERIODONTICS
- Gingivectomy, per quadrant
- Crown lengthening
- Osseous surgery
- Soft tissue grafts
- Guided tissue regeneration
- Scaling and root planing
- Full mouth debridement
- Periodontal maintenance

PROSTHODONTICS
- Removable
  - Complete/Immediate dentures
  - Partial dentures
    - All acrylic
    - Metal framework, acrylic saddles
  - Repairs/Rebase/Reline
  - Tissue conditioning
  - Overdentures
- Fixed bridgework
  - Bridge pontics & retainers
  - Resin bonded (Maryland) bridge
  - Recementation
  - Post & core

IMPLANT SUPPORTED PROSTHETICS (RESTORATIONS)
- Removable dentures, abutment supported
- Crowns, abutment supported
  - Porcelain/ceramic/cast metal
- Fixed bridgework, abutment supported
  - Porcelain/ceramic/cast metal

ORAL SURGERY
- Extractions
  - Routine removals or exposed roots
  - Surgical removals
  - Impactions
- Natural tooth reimplantation
- Surgical exposure or unerupted tooth
- Biopsy, soft tissue
- Incision and drainage of abscess
- Frenectomy
- Excise hyperplastic tissue
- Alveoloplasty (smoothing of bone)
- Removal of benign lesions & cysts
- TMJ manipulation under anesthesia
- Sialolithotomy

ADJUNCTIVE
- Palliative emergency treatment
- Anesthesia
  - General anesthesia
  - Intravenous sedation
  - Analgesia (nitrous oxide)
- Occlusal splints for bruxism
- Athletic mouth guards
- Bleaching (anterior teeth, supervised in office)

LIFETIME ORTHODONTIC BENEFIT RIDER: $1,000

Dependent Children Only

Procedures listed herein are payable at 50% up to the lifetime maximum benefit. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

- Limited Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Treatment to Control Harmful Habits

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in the Employer group contract and your Member handbook, which are available on our website or by calling HRI at 800-727-1444.

*Applicable to covered services obtained from a network dentist. Non-participating dentists may balance bill.

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ENROLLMENT APPLICATION – SUBSCRIBER
ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES, AND PROCESS CLAIMS

Group Legal Name:	Group Number:	Site Location / Cabinet:	DHO Plan:

☐ **DENTAL ONLY ELECTION**
☐ **DENTAL & VISION ELECTION**

DATE(MM/DD/YY):
Coverage Start Date:_______________

Coverage End Date:________________

☐ **Decline**: I decline coverage for myself & dependent(s)

COVERAGE ELECTION:
- ☐ Employee Only
- ☐ Employee and Spouse/Partner
- ☐ Employee and One Dependent
- ☐ Employee and Dependents
- ☐ Employee and Family (Spouse/Partner &Dependent(s)

EVENT:
- ☐ Open Enrollment
- ☐ New Hire
- ☐ Termination
- ☐ Coverage Gained
- ☐ Coverage Lost
- ☐ Death
- ☐ Marriage
- ☐ Reduction of Hours Worked
- ☐ Divorced or Legal Separation
- ☐ Over Age Limit
- ☐ No Longer Full Time Student
- ☐ Birth / Adoption
- ☐ COBRA (if applicable)

EMPLOYEE (Subscriber) ☐ Add ☐ Term ☐ Update	Social Security Number		Employee Hire Date		
	Last Name	First Name	MI	Birth Date	
	Home Address	City		State	Zip
	Contact Phone Number	Email			

SPOUSE / PARTNER ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date		Other Dental Coverage? ☐ Yes ☐ No
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No

DEPENDENT ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date	☐ Permanent Disability ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No

DEPENDENT ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date	☐ Permanent Disability ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No

DEPENDENT ☐ Add ☐ Term ☐ Update	Social Security Number	Birth Date	☐ Permanent Disability ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No
	Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: 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.

Employee____ Date________________

Employer Benefits Administrator/Authorized Agent______________________ Date________________

Benefits Administrator signature not required if Subscriber application is submitted with Employer application or renewal.