Dear Retiree:

Thank you for considering Delta Dental of Kentucky for your dental insurance needs. You can select the Delta Dental PPO™ plan or the Delta Dental Premier® plan. You can also purchase the DeltaVision® vision plan with one of the Delta Dental plans and receive a rate discount.

The enclosed materials will help explain the benefit options and the costs.

- Delta Dental overview that provides comparison of PPO and Premier benefits
- How to choose a plan guide that will help you decide which plan is best for you
- Rate sheet that gives the monthly and annual prices of the options available
- Enrollment form
- DeltaVision plan overview
- Healthy Mouth, Healthy Body program overview for members with high-risk medical conditions
- Automatic Debit form for monthly payment
- How to find a participating provider guide

Delta Dental is a Kentucky headquartered company, and the oldest and largest dental carrier in the state. If you have questions after reviewing this information, please call 1-800-955-2030.

Sincerely,

Delta Dental of Kentucky

DELTA DENTAL®

Retiree Individual and Family Plans

Thank you for your interest in the Delta Dental Retiree Individual and Family plan options. You will feel secure to have your dental coverage with the largest, most experienced dental benefits company in Kentucky. Our knowledge and focus allow us to present an individual benefit plans that will meet your needs. We recognize the importance of good dental health, even after you retire. Learn more about our PPO™ and Premier® networks.

Which network is best for you?

Delta Dental PPO™

- Access to more than 1,400 in-network dentists in Kentucky.
- Receive higher benefits for services provided by network dentists. There is limited coverage for services provided by out-of-network dentists.
- Delta Dental PPO participating providers will not be able to balance bill for more than the allowed fee amount.
- Preventive and Diagnostic has no copayment or deductible and is paid at 100% in-network.
- All claims will be filed by the network dentist.

Delta Dental Premier®

- Access to more than 2,000 in-network dentists in Kentucky.
- You may visit *any* licensed provider.
- Out-of-pocket expenses will be lower if seeing a participating Premier dentist.
- Delta Dental Premier participating providers will not be able to balance bill for more than the allowed fee amount.
- Preventive and Diagnostic has no copayment or deductible and is paid at 100% in-network.
- All claims will be filed by the network dentist.

Delta Dental of Kentucky | ky.deltadental.com | 800-955-2030

Delta Dental of Kentucky has provided more than $20 million to Non-profits across Kentucky since 2003.

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DELTA DENTAL®

Benefit Plan Options

	Option 1		Option 2
	PPO™ Participating Dentist	Non-participating PPO™ Dentist	Premier® Participating Dentist
Preventive and Diagnostic			
Exams (initial, periodic, and emergency; limited to 2 in a benefit period)	100%	80%	100%
Bitewing x-rays (limited to 1 in a benefit period)	100%	80%	100%
Full-mouth or panoramic (limited to 1 in a 5 year period)	100%	80%	100%
Cleanings (limited to 2 in a benefit period)	100%	80%	100%
Pulp Vitality Test	100%	80%	100%
Emergency Treatment (relief of pain)	100%	80%	100%
Minor Services			
Routine Fillings	50%	40%	50%
Stainless Steel Crown	50%	40%	50%
Sedative Filling (relief of pain)	50%	40%	50%
Pin Retention	50%	40%	50%
Crown Repair	50%	40%	50%
Root Canal and Pulp Therapy (excluding final restoration)	50%	40%	50%
Periodontal Procedures	50%	40%	50%
Simple denture repairs to an existing denture or partial	50%	40%	50%
Oral Surgery	50%	40%	50%
Major Services — *12 Month Waiting Period on Major Services*			
Crowns (permanent; limited to once per tooth in 5 years)	50%	40%	50%
Recement Crown	50%	40%	50%
Crown Build-up	50%	40%	50%
Periodontal Procedures	50%	40%	50%
Dentures (complete and partial)*	50%	40%	50%
Denture repairs for adding a tooth or clasp to an existing denture or partial*	50%	40%	50%
Bridges*	50%	40%	50%

*Replacement or teeth missing prior to the effective date of this plan are not covered.

- Policy is an annual contract.
- Deductibles: $50 individual/$150 family deductible per year for Minor and Major Services. No deductible for Preventive and Diagnostic Services.
- Plan pays a maximum of $1,000 per member, per benefit year for covered services. Only services listed above will be covered.
- Dependents covered through age 19; Full-time students covered through age 25.

This is a partial list of covered services and is not a contract of insurance. Your coverage is subject to the limitations, exclusions, and other terms and conditions of the member certificate of insurance.

To enroll, please enroll online at ky.deltadental.com/KRS or complete the enrollment form and include payment in the envelope provided

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DELTA DENTAL®

Individual and Family Plan Rate Sheet

Rates for effective dates of 8-1-2021 through 7-31-2022

Monthly Premium Payment Option

	Option 1 Delta Dental PPO™	Option 1V Delta Dental PPO ™ plus DeltaVision®	Option 2 Delta Dental Premier®	Option 2V Delta Dental Premier® plus DeltaVision®
Retiree	$25.69	$31.85	$33.05	$39.21
Retiree plus One Dependent	$49.31	$61.64	$63.46	$75.79
Retiree plus Two or more Dependents	$84.79	$99.20	$109.07	$123.48

Paid on a monthly basis by credit card or bank draft

Annual Premium Payment Option

	Option 1 Delta Dental PPO™	Option 1V Delta Dental PPO ™ plus DeltaVision®	Option 2 Delta Dental Premier®	Option 2V Delta Dental Premier® plus DeltaVision®
Retiree	$308.28	$382.20	$396.60	$470.52
Retiree plus One Dependent	$591.72	$739.68	$761.52	$909.48
Retiree plus Two or more Dependents	$1,017.48	$1,190.40	$1,308.84	$1,481.76

Paid on an annual basis by credit card or bank draft

Applications received by the 20th of the month will be effective the 1st of the following month. If received after the 20th, effective date is the 1st of the second following month.

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DELTA DENTAL®

Enrollment and Renewal Form

Please select the plan in which you would like to enroll.

- ❑ Option 1 – Delta Dental PPO™ - Dental Coverage Only
- ❑ Option 1V – Delta Dental PPO™ - Dental Coverage with DeltaVision® Plan Included
- ❑ Option 2 – Delta Dental Premier® - Dental Coverage Only
- ❑ Option 2V – Delta Dental Premier® - Dental Coverage with DeltaVision® Plan Included

Please complete the information below. You must be a Kentucky resident to enroll.

Social Security Number	Name – Last First MI			Home Phone ( )	
Sex (Circle one) M or F	Date of Birth MO DAY YR	Home Address – Number and Street	City	State KY	Zip
Email Address					

Check the type of contract and list all covered dependents below, if applicable:

❑ Retiree Only ❑ Retiree Plus One Dependent ❑ Retiree Plus Two or More Dependents

COVERED DEPENDENTS List all Covered Dependents below. If additional space is required, attach a list to this form.

Last	First	MI	SSN	Date of Birth MO	DAY	YR	Sex M	F
Spouse								
Dependent								
Dependent								
Dependent								

Dependents covered through the end of the year in which they turn 25.

Please select one of the three payment methods below. Please provide all necessary information.

1. ❑ Credit Card – ❑ Annual ❑ SemiAnnual ❑ Quarterly ❑ Monthly

❑ **Visa** ❑ **MasterCard** ❑ **American Express** ❑ **Discover**

Card Number _____

Expiration Date _____

Signature _____

2. ❑ Paper Check – Annual premium only

(Please include your check with this form.)

3. ❑ Bank Draft – ❑ Annual ❑ SemiAnnual ❑ Quarterly ❑ Monthly

A) Please complete the enclosed "Did You Know?" authorization form or send a voided check with this form in order to accurately establish your new withdrawal. The draft process will originate the 1st of each month and should reach your account for processing within three working days.

B) Monthly bank drafts will remain in full force and effective until Delta Dental of Kentucky/Morgan White and your bank (depository) have received written notification from you of termination and in such time and in such manner as to afford the depository a reasonable time to act on it.

Please carefully read the Contract Provisions on the back of this form. Signature required.

Please carefully read the Contract Provisions below. Signature required.

Contract Provisions

IMPORTANT: If you do not want the contract for any reason, you may return it to us within 10 days after you receive it. Upon return, the contract will be deemed void, and any money you have paid will be refunded. This is an annual contract. If you have elected the annual payment option, you may not terminate this contract prior to the end of the term. If you have elected the monthly payment option and we do not receive your premium within 30 days of the date the premium is due, your contract will be cancelled effective the due date of your premium, whether or not a specific condition was incurred prior to the termination date. Your Covered Dependents will terminate on your termination date. Covered Services are eligible for payment only if your contract is in effect at the time such services are provided.

I acknowledge that I have read the provisions of this enrollment form and I expressly accept such provisions as a condition of coverage. I understand that my membership is for a 12-month period and on my anniversary date I can renew or cancel or change how I pay my premium. 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 Delta Dental of Kentucky, Inc. in accepting this form. 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 form, the dental contract, and the identification card will constitute the contract.

Applicant Signature_____ Date_____

You can enroll online at deltadentalky.com/KRS

by phone at 1-800-955-2030

or

Delta Dental of Kentucky, Inc.
ATTN: IPU
PO Box 242810
Louisville, KY 40224

If enrolling by mail, please make a copy for your records.

SHADED AREA FOR OFFICE USE ONLY

Effective Date	Process Date	Processed By

DELTA DENTAL®

Delta Dental of Kentucky

Healthy Mouth, Healthy Body Program

Delta Dental of Kentucky believes everyone deserves a healthy and happy Smile. The Healthy Mouth, Healthy Body program can integrate with medical carriers and review medical data to determine employees that may qualify for additional services. Communication outreach can be sent to identified members encouraging enrollment in the program.

Enhanced coverage for at-risk conditions

Congratulations! Your Delta Dental coverage has been enhanced to keep you healthy and happy. Your plan now provides enhanced coverage for enrollees with certain high-risk medical conditions. These benefits will help you better manage your oral and overall health.

Scientific research shows that oral health can have a significant impact on specific medical conditions. Delta Dental closely monitors oral health-related scientific studies and technology through our Research and Data Institute. We use this information to enhance our plan designs in ways that improve your health and save you money.

Your new coverage includes additional routine teeth cleanings (prophylaxes) or periodontal maintenance cleanings per benefit period (rather than the standard two) for people with certain health conditions.

Health conditions that qualify for up to 4 cleanings per year:

- Diabetes and Periodontal Disease
- Renal Failure/Dialysis
- Infective Endocarditis High Risk Patients
- Dementia
- Chemotherapy/Radiation
- HIV Positive Status
- Stem Cell (Bone Marrow) Transplants

Health conditions that qualify for up to 3 cleanings per year:

- Patients in Active Orthodontic Treatment
- Pregnant Women with Periodontal Disease

If you have one or more of the conditions listed above, ask your dentist and physician how you can better manage your oral health to prevent infection and improve your condition. Keep in mind, the timing of your treatment can be critically important. Your dentist and physician can help you make the best treatment decisions at the most appropriate time, based on your health and history.

Questions?

Please call Delta Dental of Kentucky's Customer Service department at (800) 955-2030, or visit our website at www.ky.deltadental.com.

Delta Dental of Kentucky | ky.deltadental.com | 800-955-2030

Delta Dental of Kentucky has provided more than $20 million to Non-profits across Kentucky since 2003.

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DELTA DENTAL®

Healthy Mouth, Healthy Body
Enrollment Form

Enrolling in the Healthy Mouth, Healthy Body program will help you manage your oral and overall health! Scientific research shows that oral health can have a significant impact on special medical conditions. Once enrolled, you will be eligible for additional cleanings* (or periodontal maintenance procedures if you have a history of periodontal surgery) — regardless of your plan's normal frequency limits.

ENROLLING IS AS EASY AS IMPROVING YOUR SMILE.

Complete the form below, including your physician's name and signature.
Mail or fax the completed form to Delta Dental of Kentucky:

Delta Dental of Kentucky
ATTN: Healthy Mouth, Healthy Body
PO Box 242810, Louisville, KY 40224-2810
Fax: 877-664-3607

You will be enrolled in Delta Dental of Kentucky's Healthy Mouth, Healthy Body program when your completed enrollment form is received by us. Questions? For more information, please call our Customer Service Department at 800.955.2030.

Enrollee name: _____

Subscriber name: _____

Subscriber ID number: _____ Group (plan) number: _____

Group name: _____

Condition (please check one):

☐ Pregnancy - Due date: _____

☐ Diabetes - Diagnosis date: _____

Pregnancy and diabetes require proof of prior periodontal (gum) disease. Please have your dentist sign and date this form along with your physician.

Dentist signature: _____ Date: _____

☐ Renal failure/dialysis - Diagnosis date: _____

☐ HIV Positive - Diagnosis date: _____

☐ Dementia - Diagnosis date: _____

☐ Stem Cell Transplant - Date: _____

☐ Chemotherapy/Radiation - Start date: _____

☐ Orthodontic Treatment - Start Date: _____

☐ Infective endocarditis - Diagnosis date: _____

Enrollee signature: _____

Physician name: _____

Physician signature: _____ Date: _____

NOTE: Your coverage is limited to up to two oral examinations per benefit period depending on your health condition. Pregnant women with periodontal disease and patients in active orthodontic treatment qualify for 3 cleanings per benefit period. The following conditions qualify for 4 cleanings per benefit period: Patients with diabetes and periodontal disease, renal failure/dialysis, infective endocarditis high risk patients, dementia, chemotherapy/radiation treatment, HIV positive and stem cell (bone marrow) transplant.

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.

Delta Dental of Kentucky | ky.deltadental.com | 800-955-2030

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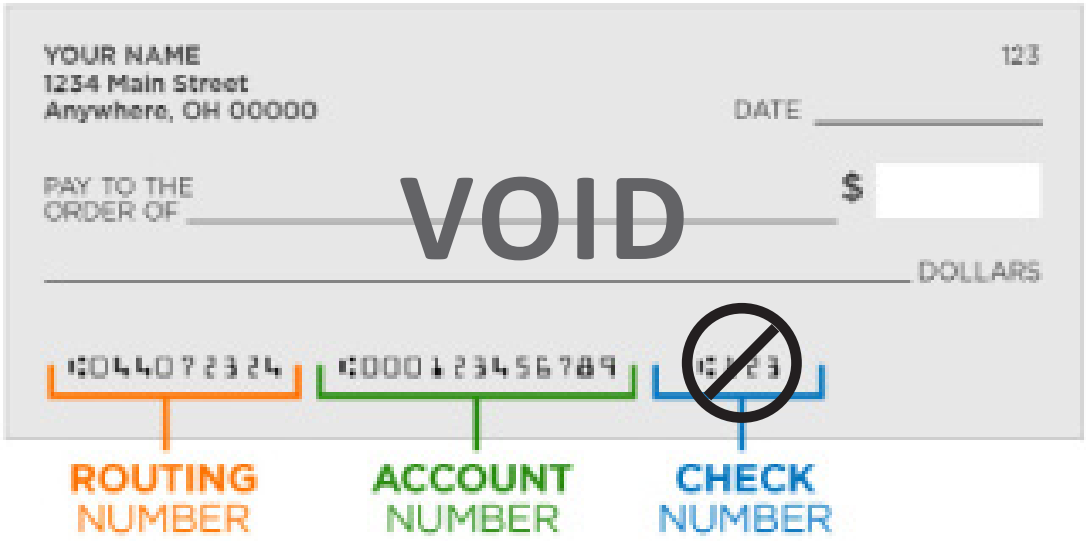
DELTA DENTAL®

DID YOU KNOW?

Delta Dental can automatically debit your monthly payment from a checking or savings account.

If you would like to be set up for the automatic debit process, please fill out the form below, attach a copy of your blank voided check and mail it with your enrollment form.



Bank Name:_____

Account Holder Name:_____

❑ Checking Account

❑ Savings Account

_____ _____

Bank Routing Number | Bank Account Number

Please do not include the check number.

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until I choose to not to renew my contract with Delta Dental or change payment methods.

Name on account (please print): _____

Account Holder Signature:_____ Date:_____

DELTA DENTAL®

Delta Dental of Kentucky
Find a Dental or Vision Provider

How to find a Delta Dental participating provider:

First, determine the Delta Dental plan(s) you are looking at for your dental benefits and then search using the methods below:

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.)

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

DeltaCare® USA – Benefits are only available through providers who participate in the DeltaCare network.

Internet
Visit ky.deltadental.com and request the information by city, state, zip code, provider's name or specialty.

Mobile App
Download the mobile app for Apple or Android. To download, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental.

Customer Service
Call Delta Dental customer service at 800-955-2030 and ask if your provider is participating in the network associated with the plan that you have chosen.

Call Your Provider
Call your provider's office and ask if he/she participates in the network associated with the plan that you have chosen.

How to find a VSP participating provider:

Search under the VSP Choice Network for any DeltaVision® plan:

Internet
Visit VSP.com and request the information by city, state, zip code, provider's name or specialty.

Mobile App
Download the mobile app for Apple or Android. To download, visit the App Store (Apple) or Google Play (Android) and search for VSP.

Customer Service
Call VSP customer service representatives at 800-877-7195 and ask if your provider is participating in the VSP Choice Network.

Call Your Provider
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.

Delta Dental of Kentucky | ky.deltadental.com | 800-955-2030

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You can enroll online at deltadentalky.com/KRS,
by phone at 1-800-955-2030
or, by mail:
Delta Dental of Kentucky, Inc.
ATTN: IPU
PO Box 242810
Louisville, KY 40224

If enrolling by mail, please make a copy for your records.

Once enrolled, you can call our Customer Service department at 800.955.2030 or visit our Consumer Toolkit at toolkitsonline.com for benefit information.

Thank you for choosing Delta Dental as your dental and vision benefits carrier!