Delta Dental of Kentucky
Individual & Family™ Dental and Vision Plan Options

Dental Plans by Delta Dental of Kentucky

Protecting your smile and keeping up with good oral health habits has a direct impact on your overall health. Delta Dental of Kentucky offers individual and family plan options designed for every stage of your smile. Invest in your smile today and let Delta Dental keep you healthy.

Plan Features

- Benefits and Annual Maximums increase after first year
- Advance to Year 2 benefits with proof of 12 previous months of dental benefits
- 100% in-network coverage for twice a year cleanings on all plans
- Whitening services with Happy & Bright plans
- Orthodontics for any age with Bright plan
- Implant coverage with Perfect, Bright & Vibrant plans
- Access to Delta Dental Mobile App with cost estimators and appointment scheduling

Networks

All plans provide access to the largest dental network in the nation. Delta Dental networks provide access to discounted fees- even after yearly annual maximums have been met.

Delta Dental PPO™ Network: 64% of Kentucky dentists participate in this network. These dentists offer the lowest fees and belong to Kentucky's largest PPO network.

Delta Dental Premier® Network: 90% of Kentucky dentists participate in this network. These dentists also offer reduced fees, just not as low as PPO fees.

DeltaVision® by Delta Dental of Kentucky

administered by VSP

Delta Dental of Kentucky can help protect your eyes along with your smile.
DeltaVision, administered by VSP, is available alone or bundled with a dental plan for individuals and families.

Plan Features

- WellVision® Exams - most comprehensive exam designed to detect eye and health conditions
- Lowest out-of-pocket costs
- Wholesale frame pricing guarantee
- 100% coverage on polycarbonate lenses for children
- Access to both Delta Dental and VSP top rated customer service

Networks

DeltaVision plans provide access to the largest national network of independent eye doctors. DeltaVision utilizes the robust VSP Choice Network.

VSP Choice: 38,000 preferred providers nationwide, 91,000 access points nationwide

Contact your agent for enrollment information.

®Registered Mark of Delta Dental Plans Association

DELTA DENTAL®

VSP® Vision Care

Delta Dental of Kentucky
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Dental Plans

Happy Smiles Delta Dental PPO™ plan

	Benefit Level Year 1	Year 2	Year 3
Diagnostic & Preventive Cleanings, Exams, X-rays, Sealants, Fluoride	100%	100%	100%
Minor Services Fillings, Extractions, Bleaching, Oral Surgery	10%	30%	50%
Annual Maximum Per covered individual	$500	$750	$1,000

Perfect Smiles Delta Dental PPO Plus Premier™ plan

	Benefit Level Year 1	Year 2	Year 3
Diagnostic & Preventive Cleanings, Exams, X-rays, Sealants, Fluoride	100%	100%	100%
Minor Services Fillings, Extractions	10%	30%	50%
Major Services Crowns, Implants, Dentures & Bridges, Oral Surgery, Endodontics, Periodontics	10%	30%	50%
Annual Maximum Per covered individual	$750	$1,000	$1,250

Dental Plans Deductible:
$50 per person per benefit year
$150 maximum per family.
Applies to all services except diagnostic and preventive benefits.

Bright Smiles Delta Dental PPO™ plan

	Benefit Level Year 1	Year 2	Year 3
Diagnostic & Preventive Cleanings, X-rays, Sealants, Fluoride	100%	100%	100%
Minor Services Fillings, Extractions	50%	80%	80%
Major Services Bleaching, Crowns, Veneers, Implants, Dentures & Bridges, Oral Surgery, Endodontics, Periodontics	25%	50%	50%
Orthodontics No Age Limit $1,000 Lifetime Maximum	n/a	50%	50%
Annual Maximum Per covered individual	$500	$1,000	$1,500

Vibrant Smiles Delta Dental PPO Plus Premier™ plan

	Benefit Level Year 1	Year 2	Year 3
Diagnostic & Preventive Cleanings, X-rays, Sealants, Fluoride	100%	100%	100%
Minor Services Fillings, Extractions	25%	50%	80%
Major Services Crowns, Implants, Dentures & Bridges, Oral Surgery, Endodontics, Periodontics	25%	40%	50%
Annual Maximum Per covered individual	$1,000	$1,750	$2,000

DeltaVision® Plan

Benefit Frequency	
Exams:	every 12 months
Lenses:	every 12 months
Frames:	every 24 months
Contacts:	every 12 months *(in lieu of glasses)*
Copayments	
Exam:	$10
Prescription Glasses:	$10
Contact Lens Exam:	up to $60
In-Network Allowances	
Retail Frame Value:	$150
Contact Lenses:	$150
Covered Lenses:	Polycarbonate for Children & Standard Progressive Lenses

Dental & Vision Plans Rates

Monthly rates effective 1/1/2020

Happy Smiles
Subscriber: $21.20
Subscriber +1: $38.49
Family: $58.41

Perfect Smiles
Subscriber: $31.32
Subscriber +1: $58.37
Family: $91.25

Bright Smiles
Subscriber: $38.81
Subscriber +1: $73.49
Family: $125.78

Vibrant Smiles
Subscriber: $39.93
Subscriber +1: $71.14
Family: $109.58

Vision Rates
Subscriber: $8.32
Subscriber +1: $16.64
Family: $26.78

Contact your agent for enrollment information.

DELTA DENTAL®

Individual and Family Plan
Dental & Vision Enrollment Form

Requested Effective Date _____

Applications received by the 25th of the month are effective the 1st of the following month.

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

❑ ***Happy Smiles*** ❑ ***Perfect Smiles*** ❑ ***Bright Smiles*** ❑ ***Vibrant Smiles***

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

❑ ***DeltaVision 150***

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

Social Security Number	Name – First	Middle	Last

Gender	Date of Birth MM DD YY	Home Address – Number and Street	City	State	Zip
M or F				KY	

Email Address	Phone Number ( )

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

❑ **Subscriber only** ❑ **Subscriber plus one** ❑ **Family**

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

First	Middle	Last	SSN (Required)	Date of Birth MM	DD	YY	Gender M	F
Spouse/Domestic Partner								
Dependent								
Dependent								
Dependent								
Dependent								

Dependents are covered through the end of the benefit period in which they turn age 26.

Have you had prior dental coverage within the last 60 days and for at least 12 months?

❑ **No** ❑ **Yes – Please provide proof of prior coverage.**

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

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

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

Card Number_____

Expiration Date _____

Signature_____

Annual credit card payments will be automatically withdrawn from your account at your renewal.

2. ❑ **Bank Draft –** ❑ **Annual** ❑ **Monthly** ❑ **Quarterly**

A) Please send a voided check with this form in order to accurately establish your new withdrawal. The draft process will originate the 18th **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 is required.

® Registered Marks Delta Dental Plans Association
Underwritten by Delta Dental of Kentucky, Inc.

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 _____

If Applicant is under the age of 18 at the time of enrollment, a parent or guardian must agree to the above conditions on behalf of Applicant and must agree to assume financial responsibility for Applicant.

Agreed_____ Date _____

Relationship to Applicant _____

Delta Dental of Kentucky reserves the right to assign effective dates.

FOR AGENT USE ONLY (IF YOU DO NOT HAVE AN AGENT REPRESENTING YOU, PLEASE LEAVE BLANK.)

Agent Name (printed)	
Agent Email	Agent Phone Number
Agent Signature	Date

SHADED AREA BELOW FOR OFFICE USE ONLY

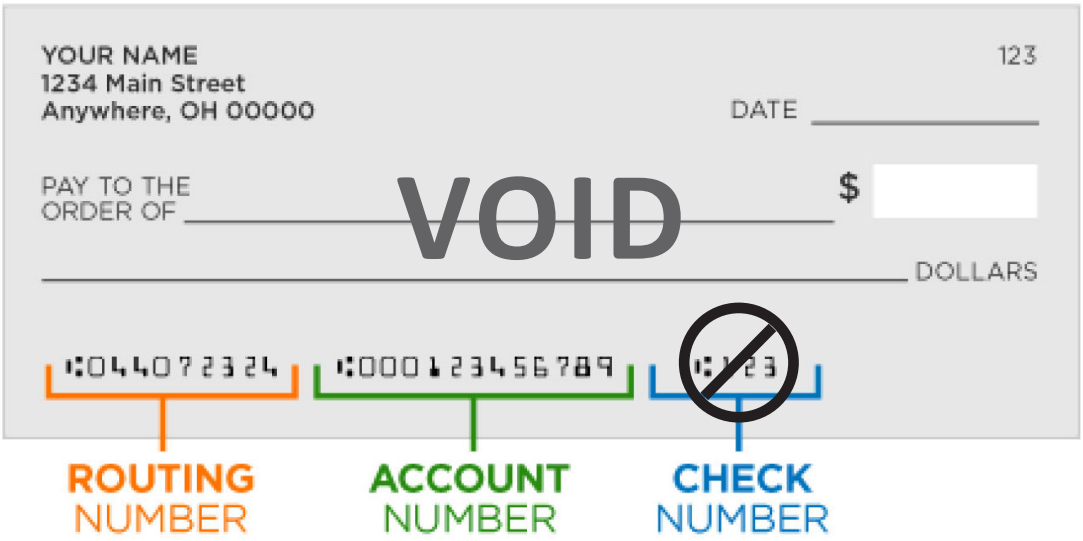
Effective Date	Process Date	Processed By

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:_____