Individual and Family™ Plans

Delta Dental of Kentucky

DELTA DENTAL®

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Individual & Family Dental and Vision Plans

Individual and Family™ 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 happy and healthy.

Delta Dental Network Features

The Delta Dental PPO™ Network
64% of Kentucky dentists participate in this network, offering the deepest discounts.

Delta Dental Premier® Network
90% of Kentucky dentists participate in this network.

Dental 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 & veneer services with Bright & Radiant plans
- Orthodontics for any age with Bright & Radiant plans
- Implant coverage with all plans

**Advance to year 2 dental benefits with proof of 12 previous months of dental benefits, with less than a 60 day lapse in coverage. Medicare or Medicaid coverage does not apply.*

DeltaVision® by Delta Dental of Kentucky

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. DeltaVision plans provide access to the largest national network of eye doctors with more than 109,000 access points nationwide.

vsp vision care

DeltaVision Plan Features

- WellVision® Exam - 100% coverage after $10 exam copay
- 100% coverage on polycarbonate lenses for children
- 100% coverage for standard progressive lenses for adults
- $150-$175 frame allowance
- In-network with Walmart/Sam's Club and Costco

Plan Choice®
Our Plans. *Your Choice.*

Enroll online 24/7

Contact a Plan Choice agent
844-593-3582 I kydelta@planchoice.com

DeltaVision® by Delta Dental of Kentucky

Administered by VSP®

vsp vision care

DELTA DENTAL®

	DeltaVision 150	DeltaVision 175
WellVision Exam®		
Exam Co-Pay	$10	$10
Exam Frequency	12 months	12 months
Prescription Glasses		
Glasses Co-Pay	$10	$10
Frame Allowance	$150	$175
Lenses Frequency	12 months	12 months
Frame Frequency	24 months	12 months
Covered Lenses	Single vision, lined bifocal and lined trifocal lenses. Polycarbonate lenses for children.	Single vision, lined bifocal and lined trifocal lenses. Polycarbonate lenses for children.
Contact Lenses *(in lieu of glasses)*		
Contact Lens Exam Co-Pay *(fitting and evaluation)*	Up to $60	Up to $60
Contacts Allowance	$150	$175
Contacts Frequency	12 months	12 months
Extra Discounts and Savings		
Featured Frames	$195 allowance on featured frame brands. Check vsp.com for current offers	
Glasses and Sunglasses	20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam	
Retinal Screening	No more than a $39 co-pay on routine retinal screening as an enhancement to WellVision Exam	
Laser Vision Correction	Average 15-20% discount	

Monthly Rates *3/1/2025 - 12/31/2025*	DeltaVision 150	DeltaVision 175
Subscriber Only	$8.97	$14.26
Subscriber + 1	$17.93	$28.51
Family	$29.24	$48.22

Delta Dental of Kentucky | deltadentalky.com | 800-955-2030

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

Rev. 10/2024

DELTA DENTAL®

Find a Delta Dental Participating Provider

Dentists who participate in Delta Dental's networks agree to charge discounted rates for their services – which saves you money. With 3 out of 4 dentists participating in the Delta Dental network, it's easy to find a qualified in-network dentist.

First, determine the Delta Dental plan(s) you are looking at for your dental benefits:

- **Delta Dental PPO™** – In-network benefits are available through providers who participate in the Delta Dental PPO network.
- **Delta Dental Premier®** – In-network benefits are available through providers who participate in the Delta Dental Premier 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.
- **DeltaCare® USA** – Benefits are only available through providers who participate in the DeltaCare network.

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

Internet
Visit deltadentalky.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.

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Delta Dental of Kentucky
Individual and Family Plans

Frequently Asked Questions

If I have current dental coverage, can I move up a benefit level?
Yes, if you or your dependents have current dental coverage that has been in force a minimum of 12 months, we will move you to year two of benefits. You will need to provide evidence of this coverage (a certificate of credible coverage from your prior carrier) to Delta Dental of Kentucky.

I have had prior dental coverage for 12 months, but my dependent has not, do we both get to move to the year two benefit level?
No, each enrollee is treated separately. So you (the subscriber) would be placed in the year two benefit level while your dependent (who did not have 12 months of prior coverage) will start with year one benefits.

Will I be able to cancel the dental plan after I have enrolled?
No, unless there is a qualifying event (proof required). These policies are 12 month contracts that will renew annually upon your benefit anniversary date. If you choose to cancel coverage upon the expiration of your policy, you must provide a written notice of termination 30 days prior to the anniversary date.

What should I expect to see on my Bank/Credit Card Statement for my premium payments?
Delta Dental of Kentucky will appear on your statement as the charge for your premiums.

When will my first payment be taken?
Your first month's premium is due at time of enrollment. Banking/Saving account – Please allow up to 3 business days. Credit/Debit Card - Will be taken immediately.

What is the deadline for enrollments?
Applications submitted by the 25th of the month can become effective on the 1st of the following month. Any applications received after the 25th can become effective on the 1st of the second month.

What are my options for selecting an Effective Date?
Plan effective dates are always the 1st of the month. Incomplete enrollment or failure to submit the required initial premium amount may cause an initial delay in issuance of insurance. We advise you not to cancel any other insurance or assume you are insured under this insurance policy until you receive your confirmation of coverage.

When will I receive my enrollment package and what will it include?
You will be emailed upon completion of enrollment and payment of applicable premiums, or a few days prior to the effective date. The ID card will be mailed and your enrollment package will be available in the Member Web Portal

What if I need to make changes to my coverage (example: add or remove a dependent/spouse)?
Call Delta Dental of Kentucky Customer Service at (800) 955-2030. This plan is a 12-month contract and you will be unable to make any changes until the next open enrollment.

Who is eligible for coverage under this plan?
Coverage is offered to all ages. The primary subscriber may also cover dependents (spouse or domestic partner and unmarried children from birth to the end of the benefit year in which they turn age 26).

Will I receive a renewal notice?
The plan will continue to automatically renew unless you send a cancellation notice. All cancellations require a 30 day notice via email to individualsales@deltadentalky.com. Renewals will be mailed 45 days prior to renewal date.

Do I need to obtain claim forms?
One of the advantages of visiting Delta Dental network dentists is that they will file all claims on your behalf. If services are provided by an out-of-network dentist, you may be required to file a claim yourself.

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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.

❑ ***Perfect Smiles*** ❑ ***Bright Smiles*** ❑ ***Vibrant Smiles*** ❑ ***Radiant Smiles***

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

❑ ***DeltaVision 150*** ❑ ***DeltaVision 175***

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	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**

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

Card Number_____

Expiration Date _____ CVV_____

Signature _____

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

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

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 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.

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

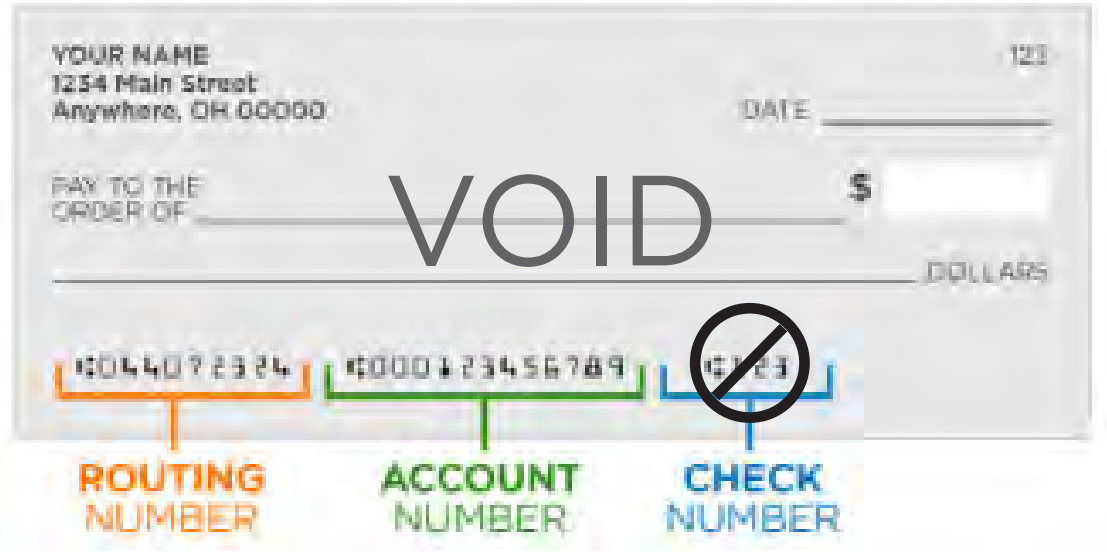
SHADED AREA BELOW FOR OFFICE USE ONLY

Effective Date	Process Date	Processed By

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:_____