

KRTA eligible for Delta Dental coverage!



The oldest and largest dental insurance carrier in Kentucky with the largest dentist networks offers you a choice of three dental programs. You have several different ways to pay the premium. We offer monthly bank draft, annual check and annual credit card payments.

| <i>Select the plan that best meets your needs...</i> | Option A Delta Dental PPO | | Option B Delta Dental PPO Plus Premier | Option C DeltaCare |
|--|--|-----|--|-------------------------------|
| <i>What each plan pays:</i> | Delta Dental PPO Network Out-of-Network (Percent of Allowable Amount) | | Dual Network Option* (Percent of Allowable Amount) | Member Copayment |
| Diagnostic & Preventive Services | | | | |
| ◆ Oral examination (limited to 2 per calendar year) | 100% | 75% | 100% | \$0 |
| ◆ Emergency Exam | 100% | 75% | 100% | \$25 |
| ◆ Palliative emergency treatment | 100% | 75% | 100% | \$35 |
| ◆ Periapical, bitewing, panoramic or complete series x-ray | 100% | 75% | 100% | \$0 |
| ◆ Topical fluoride application (up to age 19) | 100% | 75% | 100% | \$0 |
| ◆ Routine cleanings | 100% | 75% | 100% | \$0 |
| ◆ Sealants (up to age 16) | 100% | 75% | 100% | \$22 |
| ◆ Space maintainers (up to age 11) | 100% | 75% | 100% | \$115-\$220 |
| Minor Services | | | | |
| ◆ Routine fillings (including composites) | 50% | 25% | 50% | \$47-\$105 |
| ◆ Simple extractions | 50% | 25% | 50% | \$32 |
| ◆ Periodontic services | 50% | 25% | 50% | \$57-\$420 |
| Major Services | <i>There is a 12-month waiting period on Major Services.</i> | | <i>There is a 12-month waiting period on Major Services.</i> | |
| ◆ Inlays or crowns | 50% | 25% | 25% | \$203-\$400 |
| ◆ Prosthetic services (bridges, dentures and partials) | 50% | 25% | 25% | \$290-\$448 |
| ◆ Root canal therapy | 50% | 25% | 25% | \$229-\$380 |
| ◆ Oral surgery | 50% | 25% | 25% | \$50-\$195 |
| ◆ Simple denture repair | 50% | 25% | 25% | \$35-\$57 |
| ◆ Implants | 50% | 25% | 25% | Not covered. |
| Deductibles | \$50 Individual/\$150 Family | | \$50 Individual/\$150 Family | |
| Benefit Period Maximum | \$1,000 | | \$1,000 | |
| Age Limits | Dependents to age 19 Full-time Students to age 23 | | Dependents to age 19 Full-time Students to age 23 | |
| | | | Dependents to age 19 Full-time Students to age 23 | |

* This dental program allows members to utilize any licensed provider. Members who choose a Delta Dental PPO network provider have the lowest out of pocket expenses and cannot be balance billed. Members who choose a Delta Dental Premier network provider cannot be balance billed.

To receive an informational packet with more plan details, please call 1-866-480-4872 or log on to our website at www.deltadentalky.com and click on the KRTA Information link.

For effective dates of 4/1/2011 through 1/1/2012

Monthly rates - Bank Draft Option Only

| Contract Type | Option A Delta Dental PPO | Option B Delta Dental PPO Plus Premier | Option C DeltaCare |
|------------------------------------|------------------------------|---|-----------------------|
| Member Only | \$31.80 | \$33.24 | \$14.47 |
| Member Plus One Dependent | \$61.05 | \$63.83 | \$27.62 |
| Member Plus Two or More Dependents | \$104.94 | \$109.70 | \$43.64 |

Prorated annual rates based on effective date of coverage - Check, Visa, MasterCard or Money Order

Option A – Delta Dental PPO

| Effective Date of Coverage | 4/1/2011-3/31/2012 | 5/1/2011-3/31/2012 | 6/1/2011-3/31/2012 | 7/1/2011-3/31/2012 | 8/1/2011-3/31/2012 | 9/1/2011-3/31/2012 | 10/1/2011-3/31/2012 | 11/1/2011-3/31/2012 | 12/1/2011-3/31/2012 | 1/1/2012-3/31/2012 |
|------------------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|---------------------|---------------------|---------------------|--------------------|
| Member Only | \$381.60 | \$349.80 | \$318.00 | \$286.20 | \$254.40 | \$222.60 | \$190.80 | \$159.00 | \$127.20 | \$95.40 |
| Member Plus One Dependent | \$732.60 | \$671.55 | \$610.50 | \$549.45 | \$488.40 | \$427.35 | \$366.30 | \$305.25 | \$244.20 | \$183.15 |
| Member Plus Two or More Dependents | \$1,259.28 | \$1,154.34 | \$1,049.40 | \$944.46 | \$839.52 | \$734.58 | \$629.64 | \$524.70 | \$419.76 | \$314.82 |

Option B – Delta Dental PPO Plus Premier

| Effective Date of Coverage | 4/1/2011-3/31/2012 | 5/1/2011-3/31/2012 | 6/1/2011-3/31/2012 | 7/1/2011-3/31/2012 | 8/1/2011-3/31/2012 | 9/1/2011-3/31/2012 | 10/1/2011-3/31/2012 | 11/1/2011-3/31/2012 | 12/1/2011-3/31/2012 | 1/1/2012-3/31/2012 |
|------------------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|---------------------|---------------------|---------------------|--------------------|
| Member Only | \$398.88 | \$365.64 | \$332.40 | \$299.16 | \$265.92 | \$232.68 | \$199.44 | \$166.20 | \$132.96 | \$99.72 |
| Member Plus One Dependent | \$765.96 | \$702.13 | \$638.30 | \$574.47 | \$510.64 | \$446.81 | \$382.98 | \$319.15 | \$255.32 | \$191.49 |
| Member Plus Two or More Dependents | \$1,316.40 | \$1,206.70 | \$1,097.00 | \$987.30 | \$877.60 | \$767.90 | \$658.20 | \$548.50 | \$438.80 | \$329.10 |

Option C – DeltaCare

| Effective Date of Coverage | 4/1/2011-3/31/2012 | 5/1/2011-3/31/2012 | 6/1/2011-3/31/2012 | 7/1/2011-3/31/2012 | 8/1/2011-3/31/2012 | 9/1/2011-3/31/2012 | 10/1/2011-3/31/2012 | 11/1/2011-3/31/2012 | 12/1/2011-3/31/2012 | 1/1/2012-3/31/2012 |
|------------------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|---------------------|---------------------|---------------------|--------------------|
| Member Only | \$173.64 | \$159.17 | \$144.70 | \$130.23 | \$115.76 | \$101.29 | \$86.82 | \$72.35 | \$57.88 | \$43.41 |
| Member Plus One Dependent | \$331.44 | \$303.82 | \$276.20 | \$248.58 | \$220.96 | \$193.34 | \$165.72 | \$138.10 | \$110.48 | \$82.86 |
| Member Plus Two or More Dependents | \$523.68 | \$480.04 | \$436.40 | \$392.76 | \$349.12 | \$305.48 | \$261.84 | \$218.20 | \$174.56 | \$130.92 |

PLEASE NOTE: Your contract will renew on 4/1/2012. Applications must be received by the 10th of the month prior to the requested effective date. Applications received after the 10th of the month, will be effective one month later.



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

- Delta Dental PPO Plus Premier*
- Delta Dental PPO*
- DeltaCare*

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 |

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

- Member Only**
 Member Plus One
 Member Plus Family

| COVERED DEPENDENTS List all Covered Dependents below. If additional space is required, attach a list to this form. | | | | | | | | | |
|---|-------|----|---------------|-----|----|-----|---|--|--|
| Last | First | MI | Date of Birth | | | Sex | | | |
| | | | MO | DAY | YR | M | F | | |
| Spouse | | | | | | | | | |
| Dependent | | | | | | | | | |
| Dependent | | | | | | | | | |
| Dependent | | | | | | | | | |
| Dependent | | | | | | | | | |

Dependents covered through age 19. Full-time students covered through age 23.

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

1. Credit Card – Annual premium only

- Visa** **MasterCard**

Card Number _____

Expiration Date _____

Signature _____

2. Paper Check or Money Order – Annual premium only

(Please include your check or money order made payable to Delta Dental of Kentucky with this form.)

3. Bank Draft – Monthly premium only

- A) A **voided check** must accompany this form in order to accurately establish your new withdrawal. The draft process will originate from our office on the 23rd 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 required.
Please review your enrollment form for errors or omissions.***

Please carefully read the Contract Provisions below. Signature required.

KRTA 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 _____

Contract Termination

If you wish to terminate your contract, please sign below and return this form to Delta Dental.

Signature _____ Date _____

Please make a copy for your records and return original with payment to:

***Delta Dental of Kentucky
Attn: KRTA Department
PO Box 242810
Louisville, KY 40224-2810***

SHADED AREA FOR OFFICE USE ONLY

| | | |
|----------------|--------------|--------------|
| Effective Date | Process Date | Processed By |
|----------------|--------------|--------------|

PLAN KRTA3V 2011 MEMBER COPAYMENT SCHEDULE

Benefits are provided for the following services ("covered services"). Covered services must be performed by a network provider or by a network specialist. This is not a contract. Covered services are subject to the limitations, exclusions, and other terms and conditions of your member certificate. No benefits are provided for services received from a provider other than a network provider or for procedures not listed below.

ADA Codes Member Pays

VISITS & DIAGNOSTIC

| | | |
|------|--|------|
| 0120 | Periodic oral evaluation | \$ 0 |
| 0140 | Limited oral evaluation (emergency) – problem focused | 25 |
| 0145 | Oral evaluation for patients under 3 years of age | 0 |
| 0150 | Comprehensive oral evaluation | 0 |
| 0160 | Detailed and extensive oral evaluation – problem focused | 0 |
| 0170 | Re-evaluation – limited, problem-focused | 25 |
| 0180 | Comprehensive periodontal evaluation | 0 |
| 0460 | Pulp vitality tests | 0 |
| 0470 | Diagnostic casts | 0 |

X-RAYS

| | | |
|-----------|--|---|
| 0210 | Full mouth X-rays – complete series (including bitewings (1 per 36 month period) | 0 |
| 0220 | Periapical X-ray | 0 |
| 0230 | Periapical X-ray – each additional film | 0 |
| 0240 | Intraoral, occlusal film | 0 |
| 0270/0272 | Bitewing X-rays (one and two films) | 0 |
| 0273 | Bitewing X-rays (three films) | 0 |
| 0274 | Bitewing X-rays (four films) (1 set per 12 month period) | 0 |
| 0277 | Vertical bitewings (seven to eight films) | 0 |
| 0330 | Panoramic X-ray | 0 |

PROPHYLAXIS & FLUORIDE TREATMENTS

| | | |
|-----------|---|----|
| 1110/1120 | Prophylaxis (teeth cleaning) adult/child (1 per 6 month period) | 0 |
| 1203 | Topical application of fluoride (1 per 6 month period for covered persons to age 19) | 0 |
| 1206 | Topical fluoride varnish (1 per 6 month period for covered persons to age 19) | 0 |
| 1351 | Sealant per tooth through age 15 – occlusal surface permanent molars (Benefits for replacement are disallowed if performed within 3 years of initial placement) | 22 |

SPACE MAINTAINERS*

| | | |
|------|---|-----|
| 1510 | Space maintainer, fixed (unilateral)* | 115 |
| 1515 | Space maintainer, fixed (bilateral)* | 190 |
| 1520 | Space maintainer, removable (unilateral)* | 165 |
| 1525 | Space maintainer, removable (bilateral)* | 220 |
| 1550 | Recementation of space maintainer | 29 |
| 1555 | Removal of fixed space maintainer | 29 |

*Space maintainers are limited to children under 12 years of age.

RESTORATIVE DENTISTRY

Amalgam Restorations – Primary or Permanent Teeth:

| | | |
|------|------------------------------|----|
| 2140 | Amalgam – 1 surface | 47 |
| 2150 | Amalgam – 2 surfaces | 55 |
| 2160 | Amalgam – 3 surfaces | 65 |
| 2161 | Amalgam – 4 or more surfaces | 70 |

Resin Restorations:

| | | |
|------|---|-----|
| 2330 | Resin-based composite – 1 surface, anterior | 50 |
| 2331 | Resin-based composite – 2 surfaces, anterior | 60 |
| 2332 | Resin-based composite – 3 surfaces, anterior | 70 |
| 2335 | Resin-based composite – 4 or more surfaces, anterior or involving incisal angle | 90 |
| 2390 | Resin-based composite crown – anterior | 100 |

ADA Codes

Resin Restorations (continued):

| | | |
|------|---|-------|
| 2391 | Resin-based composite – 1 surface, posterior | \$ 70 |
| 2392 | Resin-based composite – 2 surfaces, posterior | 85 |
| 2393 | Resin-based composite – 3 surfaces, posterior | 95 |
| 2394 | Resin-based composite – 4 or more surfaces | 105 |

Inlay/Onlay Restorations:

| | | |
|-------|--------------------------------------|-----|
| 2510* | Inlay, metallic – 1 surface | 290 |
| 2520* | Inlay, metallic – 2 surfaces | 290 |
| 2530* | Inlay, metallic – 3 or more surfaces | 305 |
| 2542* | Onlay, metallic – 2 surfaces | 290 |
| 2543* | Onlay, metallic – 3 surfaces | 305 |
| 2544* | Onlay, metallic – 4 or more surfaces | 305 |

Crowns:

| | | |
|-------|---|----------|
| 2710 | Crown, resin based composite | 203 |
| 2720* | Crown, resin with high noble metal | 300 |
| 2721 | Crown, resin with predominantly base metal | 261 |
| 2722 | Crown, resin with noble metal | 261 |
| 2740 | Crown, porcelain/ceramic | 400 |
| 2750* | Crown, porcelain fused to high noble | 400 |
| 2751 | Crown, porcelain fused to predominantly base metal | 400 |
| 2752 | Crown, porcelain fused to noble | 400 |
| 2780* | Crown – 3/4 cast high noble metal | 400 |
| 2781 | Crown – 3/4 cast predominantly base metal | 362 |
| 2782 | Crown – 3/4 cast noble metal | 400 |
| 2783 | Crown – 3/4 porcelain/ceramic | 400 |
| 2790* | Crown, full cast high noble metal | 400 |
| 2791 | Crown, full cast predominantly base metal | 362 |
| 2792 | Crown, full cast noble metal | 400 |
| 2794* | Crown – titanium | 400 |
| 2910 | Recement inlay, onlay or partial coverage restoration | 35 |
| 2915 | Recement cast or prefabricated post and core | 44 |
| 2920 | Recement crown | 35 |
| 2930 | Prefabricated stainless steel primary | 105 |
| 2931 | Prefabricated stainless steel permanent | 110 |
| 2932 | Prefabricated resin crown (anterior teeth only) | 126 |
| 2940 | Sedative filling | 36 |
| 2950 | Core build-up, including any pins | 99 |
| 2951 | Pin retention – per tooth, in addition to restoration | 17 |
| 2952* | Post and core, in addition to crown – indirectly fabricated | 120 |
| 2954 | Prefabricated post and core, in addition to crown | 126 |
| 2970 | Temporary crown (fractured tooth) | 78 |
| 2971 | Additional procedures to construct new crown under existing partial denture framework | 60 |
| 2980 | Crown repair | 78 + lab |

*Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Member at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, indirectly fabricated post and cores, inlays and onlays. Crowns limited to 1 per 5 year period. An additional laboratory charge also applies to a titanium crown.

ENDODONTICS

| | | |
|-----------|---|-----|
| 3110/3120 | Pulp capping – direct/indirect (excludes final restoration) | 30 |
| 3220 | Therapeutic pulpotomy (excludes final restoration) | 50 |
| 3221 | Pulpal debridement (primary/perm.) | 34 |
| 3230/3240 | Pulpal therapy (resorbable filling), primary tooth (excludes final restoration) | 75 |
| 3310 | Root canal, anterior (excludes final restoration) | 229 |
| 3320 | Root canal, bicuspid (excludes final restoration) | 285 |
| 3330 | Root canal, molar (excludes final restoration) | 380 |
| 3346 | Retreatment of previous root canal therapy–anterior | 285 |
| 3347 | Retreatment of previous root canal therapy–bicuspid | 330 |
| 3348 | Retreatment of previous root canal therapy–molar | 400 |

(Continued)

DELTACARE PLAN KRТА3V 2011

| ADA Codes | | Member Pays |
|--------------------------------|---|-------------|
| ENDODONTICS (CONTINUED) | | |
| 3410 | Apicoectomy/periradicular surgery, anterior | \$218 |
| 3421 | Apicoectomy/periradicular surgery, bicuspid (1st root) | 209 |
| 3425 | Apicoectomy/periradicular surgery, molar (first root) | 328 |
| 3426 | Apicoectomy/periradicular surgery, each additional root | 201 |
| 3430 | Retrograde filling, per root | 67 |
| 3450 | Root amputation, per root | 132 |

PERIODONTICS

| | | |
|------|--|-----|
| 4210 | Gingivectomy or gingivoplasty, 4 or more contiguous teeth per quadrant | 195 |
| 4211 | Gingivectomy or gingivoplasty, 1 to 3 contiguous teeth or bounded teeth spaces per quadrant | 90 |
| 4240 | Gingival flap procedures, including root planing, 4 or more contiguous teeth | 230 |
| 4241 | Gingival flap procedures, including root planing, 1 to 3 contiguous teeth or bounded teeth spaces per quadrant | 200 |
| 4245 | Apically positioned flap | 219 |
| 4249 | Clinical crown lengthening – hard tissue | 225 |
| 4260 | Osseous surgery, 4 or more contiguous teeth | 420 |
| 4261 | Osseous surgery, 1 to 3 contiguous teeth or bounded teeth spaces per quadrant | 275 |
| 4341 | Periodontal scaling and root planing, 4 or more teeth per quadrant | 85 |
| 4342 | Periodontal scaling and root planing, 1 to 3 teeth per quadrant | 61 |
| 4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis (once in 12 mos.) | 62 |
| 4910 | Periodontal maintenance (following active therapy) | 57 |

PROSTHETICS – REMOVABLE

| | | |
|--|---|----------|
| <i>Includes any adjustments for 6 months</i> | | |
| 5110/5120 | Complete denture, upper or lower | 380 |
| 5130/5140 | Immediate denture, upper or lower | 445 |
| 5211/5212 | Partial denture, resin base, upper or lower (including any conventional clasps, rests and teeth) | 377 |
| 5213/5214 | Partial denture, upper or lower, cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 455 |
| 5225 | Maxillary partial denture – flexible base (including any clasps, rests and teeth) | 448 |
| 5226 | Mandibular partial denture – flexible base (including any clasps, rests and teeth) | 448 |
| 5281 | Removable unilateral partial denture, one piece cast metal (including clasps and teeth) | 290 |
| 5410/5411 | Denture and partial adjustments – upper or lower | 35 |
| 5421/5422 | Adjust partial denture - upper and lower | 35 |
| 5510/5610 5620 | Denture and partial repairs (per repair) | 57 + lab |
| 5520/5640 | Adding or replacing teeth to existing partial/denture (per tooth) | 57 + lab |
| 5630 | Repair or replace broken clasp | 57 + lab |
| 5650/5660 | Add tooth or clasp to existing partial denture | 57 + lab |
| 5670/5671 | Replace all teeth and acrylic on cast metal framework, upper or lower | 260 |
| 5710/5711 | Rebase complete upper or lower denture | 160 |
| 5720/5721 | Rebase upper or lower partial denture | 128 |
| 5730/5731 5740/5741 | Office reline, complete or partial denture | 110 |
| 5750/5751 5760/5761 | Laboratory reline, complete or partial denture | 133 |
| 5850/5851 | Tissue conditioning, upper or lower | 44 |

| ADA Codes | | Member Pays |
|--|---|-------------|
| PROSTHETICS – FIXED (EACH RETAINER AND EACH PONTIC CONSTITUTES A UNIT IN A FIXED PARTIAL DENTURE) | | |
| 6210* | Pontic, cast high noble metal | \$400 |
| 6211 | Pontic, cast predominantly base metal | 380 |
| 6212 | Pontic, cast noble metal | 405 |
| 6240* | Pontic, porcelain fused to high noble metal | 405 |
| 6241 | Pontic, porcelain fused to predominantly base metal | 405 |
| 6242 | Pontic, porcelain fused to noble metal | 405 |
| 6250* | Pontic, resin with high noble metal | 405 |
| 6251 | Pontic, resin with predominantly base metal | 405 |
| 6252 | Pontic, resin with noble metal | 405 |
| 6602* | Inlay cast high noble metal, 2 surfaces | 286 |
| 6603* | Inlay cast high noble metal, 3 or more surfaces | 286 |
| 6604 | Inlay cast predominantly base metal, 2 surfaces | 265 |
| 6605 | Inlay cast predominantly base metal, 3 or more surfaces | 270 |
| 6606 | Inlay cast noble metal, 2 surfaces | 275 |
| 6607 | Inlay cast noble metal, 3 or more surfaces | 285 |
| 6610* | Onlay cast high noble metal, 2 surfaces | 271 |
| 6611* | Onlay cast high noble metal, 3 or more surfaces | 271 |
| 6612 | Onlay cast predominantly base metal, 2 surfaces | 252 |
| 6613 | Onlay cast predominantly base metal, 3 or more surfaces | 252 |
| 6614 | Onlay cast noble metal, 2 surfaces | 262 |
| 6615 | Onlay cast noble metal, 3 or more surfaces | 262 |
| 6720* | Crown, resin with high noble metal | 315 |
| 6721 | Crown, resin with predominantly base metal | 275 |
| 6722 | Crown, resin with noble metal | 275 |
| 6750* | Crown, porcelain fused to high noble metal | 405 |
| 6751 | Crown, porcelain fused to predominantly base metal | 405 |
| 6752 | Crown, porcelain fused to noble metal | 405 |
| 6780* | Crown, 3/4 cast high noble metal | 340 |
| 6781 | Crown, 3/4 cast predominantly base metal | 332 |
| 6782 | Crown, 3/4 cast noble metal | 405 |
| 6790* | Crown, full cast high noble metal | 405 |
| 6791 | Crown, full cast predominantly base metal | 380 |
| 6792 | Crown, full cast noble metal | 405 |
| 6930 | Recement bridge (fixed partial denture) | 45 |
| 6940 | Stress breaker | 135 |
| 6970* | Post & core in addition to fixed partial denture retainer – indirectly fabricated | 142 |
| 6972 | Prefabricated post & core in addition to fixed partial denture retainer | 109 |
| 6973 | Core buildup for retainer, including any pins | 110 |
| 6976 | Each additional indirectly fabricated post – same tooth | 50 |

*Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Member at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, indirectly fabricated post and cores, inlays and onlays. Crowns limited to 1 per 5 year period. An additional laboratory charge also applies to a titanium crown.

ORAL & MAXILLOFACIAL SURGERY

| | | |
|------|---|-----|
| 7111 | Extraction, coronal remnants – deciduous tooth | 32 |
| 7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal); includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary | 44 |
| 7210 | Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, minor smoothing of socket bone and closure | 90 |
| 7220 | Removal of impacted tooth (soft tissue) | 115 |
| 7230 | Removal of impacted tooth (partially bony) | 150 |
| 7240 | Removal of impacted tooth (completely bony) | 160 |
| 7241 | Removal of impacted tooth (completely bony, with unusual surgical complications) | 195 |
| 7250 | Surgical removal of residual tooth roots (cutting procedure) | 119 |

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DELTACARE PLAN KRТА3V 2011

ORAL & MAXILLOFACIAL SURGERY (CONTINUED)

| | | |
|------|--|-------|
| 7286 | Biopsy of oral tissue (soft) | \$ 95 |
| 7310 | Alveoloplasty, with extractions, four or more teeth or tooth spaces, per quadrant | 90 |
| 7311 | Alveoloplasty, with extractions, 1 to 3 teeth or tooth spaces, per quadrant | 90 |
| 7320 | Alveoloplasty, without extractions, four or more teeth or tooth spaces, per quadrant | 111 |
| 7321 | Alveoloplasty, without extractions, 1 to 3 teeth or tooth spaces, per quadrant | 111 |
| 7960 | Frenulectomy – separate procedure | 175 |

MISCELLANEOUS

| | | |
|------|---|----|
| 9110 | Palliative emergency treatment of dental pain (minor procedure) | 35 |
| 9310 | Specialist consultation | 57 |
| 9440 | Office visit, after regularly scheduled hours | 40 |

ORTHODONTIC COVERAGE

MEMBER PAYS

24-month treatment plan including treatment records \$3,800

You may go directly to participating orthodontists for treatment. Coverage is available only in areas where there are network orthodontists.

Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months. Fees for treatment records include X-rays, diagnostic casts and photographs. For treatment plans extending beyond 24 months of active treatment, the patient will be subject to a monthly office visit fee, not to exceed \$75 per month.

SPECIALIST COVERAGE

This plan includes coverage for oral surgery, periodontic, and endodontic specialists. Network specialists are available in most areas we serve. **In order to receive benefits, services must be rendered by a network specialist.**

PREAUTHORIZATION

The following services are subject to review for benefit coverage as stated in your member certificate: crowns, periodontics, partial dentures and bridges. Your dentist must submit a treatment plan for review, prior to services being rendered.

MISSED APPOINTMENTS

DeltaCare plans do not cover missed appointment charges. You should follow your dentist's policy regarding missed appointments.

SECOND OPINIONS

For cases where you feel a second opinion is necessary, contact a Customer Service representative at (800) 955-2030.

OUT-OF-AREA EMERGENCY CARE

If you are 50 miles or more from home, benefits are provided for out-of-area emergency care once per 12-month calendar year. You may seek treatment from any licensed dentist **only for the relief of pain**. Benefits are payable, in accordance with the Member Copayment Schedule, up to a maximum of \$50 per benefit period, less any applicable copayments. To claim these benefits, mail the original receipt and original bill to our office within 60 days of receipt of services.

How to find a Delta Dental participating provider

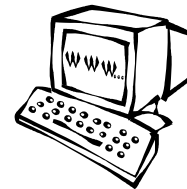
First, determine the Delta Dental plan(s) you are looking at for your dental benefits. You can find the plan name on the highlight sheet found in this packet.

- ▶ **Delta Dental PPO** – In-network benefits are available through providers who participate in the Delta Dental PPO network. Members who choose a Delta Dental PPO network provider have the lowest out of pocket expenses. (See your highlight sheet for specific coverage levels.)
- ▶ **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. Members can choose a provider in either the Delta Dental PPO or Delta Dental Premier networks. Members who choose a Delta Dental PPO network provider have the lowest out of pocket expenses. Delta Dental Premier has the largest number of participating providers in Kentucky. (See your highlight sheet for specific coverage levels.)
- ▶ **DeltaCare** – Benefits are available *only* through providers who participate in the DeltaCare network. (See your benefit summary for specific procedure copayments.)

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.



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 (you may select as many as 5 zip codes) and it will be faxed to you in 5-10 minutes.



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.



Delta Vision Discount Program

EyeMed offers savings to Delta Dental Members



VISION WELLNESS

Regular eye examinations play a crucial role in ensuring healthy vision and overall health.

- An eye examination can not only detect vision problems, but also can detect the early stages of serious health problems such as diabetes and hypertension.
- 1 in 4 children has an undetected vision problem that can interfere with learning, according to the Vision Council of America.
- Undetected eye diseases can lead to worsening eyesight and in some cases irreversible vision loss.

Great Savings— Up to 35% off eyewear

Choose from any available frame including quality name-brand products such as Brooks Brothers®, Anne Klein®, Vogue® and more at provider locations.

With EyeMed Vision Care, Delta Dental members have access to over 30,000 vision care providers nationwide at 16,000 locations including optometrists, ophthalmologists, opticians and the nation's leading optical retailers:



It's easy! To request your discount, simply present your Delta Dental Member ID Card when you arrive at the provider office or location. Your EyeMed provider will take care of the rest!

To learn more about the EyeMed Vision Care Discount Plan or other great discounts available to Delta Dental members, please visit www.eyemedvisioncare.com/deltadental.

Don't have access to the Internet? You can call EyeMed's Customer Care Center toll-free at 1-866-246-9041.

Call today to schedule an appointment!

See Other Side For Details.

Check www.eyemedvisioncare.com/deltadental or call 1-866-246-9041 for EyeMed provider locations.

BENEFIT DESIGN SUMMARY

VISION CARE SERVICES

MEMBER BENEFIT

Exam with Dilation as necessary –

| | |
|---------------------|----------|
| Comprehensive Exam: | \$5 off |
| Contact Lens Exam: | \$10 off |

Prescription Glasses –

The following frame, lenses, and lens options discounts and fees apply only if a complete pair of glasses is purchased in the same transaction. Items purchased separately will be discounted 20% off the retail price.

Standard Plastic Lenses including Standard Scratch

| | |
|----------------|---------------------|
| Single Vision: | Member cost – \$ 75 |
| Bifocal: | Member cost – \$ 95 |
| Trifocal: | Member cost – \$125 |

Frames

| | |
|--|----------------------|
| Any available frame at provider location | 30% off retail price |
|--|----------------------|

Lens Options

| | |
|--|---------------------|
| Standard UV: | Member cost – \$ 15 |
| Standard Tint: | Member cost – \$ 15 |
| Standard Polycarbonate: | Member cost – \$ 40 |
| Standard Antireflective Coating: | Member cost – \$ 45 |
| Standard Progressive (add-on to bifocal) | Member cost – \$ 70 |

Contacts* –

Discount applied to materials only

| | |
|---------------|----------------------|
| Conventional: | 15% off retail price |
|---------------|----------------------|

*After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to you. Details are available at www.eyemedvisioncare.com.

Laser Vision Correction –

| | |
|---------------|---|
| Lasik or PRK: | 15% off retail price or 5% off promotional price |
|---------------|---|

You will receive a 20% discount on items purchased at participating providers not included under plan coverage. 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses. Retail prices may vary by location. Benefits are subject to change without notice.

The following Plan Limitations and Exclusions are not covered under this plan:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Services provided as a result of any Worker's Compensation law.
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount).

IT'S EASY TO UTILIZE YOUR BENEFITS

1. Find an EyeMed participating provider by calling 1-866-246-9041 or accessing their website at www.eyemedvisioncare.com/deltadental. To find a laser vision correction provider, please call 1-877-552-7376.
2. Show the provider your Delta Dental identification card.
3. Your doctor and EyeMed will handle the rest.

QUESTIONS?

If you have questions or need assistance in utilizing benefits, please call the EyeMed Care Center at 1-866-246-9041 or access the EyeMed website at www.eyemedvisioncare.com/deltadental.

ABOUT DELTAVISION

DeltaVision is a discount optical benefit providing a reduced fee on eye exams, prescription lenses, eyeglass frames, and contact lenses. These benefits are extended automatically to those enrolled in all Delta Dental plans. This is not an insurance product. DeltaVision offers a discount from the provider's regular (normal) fee.