We offer two plans certified to meet the requirements of the Affordable Care Act (ACA):

Delta Dental PPO and Delta Dental Premier

Thank you for your interest in the Delta Dental Individual and Family Plan options. You will feel secure to have your dental coverage with the oldest and largest dental benefits company in Kentucky. Our knowledge and focus allow us to present an individual product that will meet your needs.

The plans include the Pediatric Dental Essential Health Benefit (EHB) mandated by the ACA. These benefits are for individuals 20 years of age and under (EHB Eligible Persons). EHB Eligible Persons are also eligible for any benefits under the Basic Plan that are not EHB covered services. The general frequency limitations for Basic Plan covered services do not apply to any of the EHB covered services.

### Highlights of the plans:

#### Delta Dental PPO
- You receive higher benefits for services provided by Delta Dental PPO network dentists. This plan offers the best value for dental services you receive.
- Delta Dental PPO participating providers will not be able to balance bill you over the allowed fee amount.
- Network dentists file all claims for you.
- VSP discount vision benefits are included at no additional cost.
- Amplifon discount hearing-aid benefits are included at no additional cost.

#### Delta Dental Premier
- The Delta Dental Premier network is by far the largest provider network in the state.
- Delta Dental Premier participating providers will not be able to balance bill you over the allowed fee amount.
- Network dentists file all claims for you.
- VSP discount vision benefits are included at no additional cost.
- Amplifon discount hearing-aid benefits are included at no additional cost.
Benefits for individuals 21 years of age or older

<table>
<thead>
<tr>
<th>Preventive and Diagnostic</th>
<th>PPO Dentist Plan Pays</th>
<th>Premier/Nonparticipating Dentist Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams and cleanings (limited to 2 in a benefit period)</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency Palliative Treatment – to temporarily relieve pain</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Brush Biopsy – to detect oral cancer</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Radiographs – X-rays</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Basic Services**

- Minor Restorative – fillings and crown repair 50% 30%
- Stainless Steel Crowns 50% 30%
- Endodontic Services – root canals 50% 30%
- Oral Surgery – excluding any impacted teeth 50% 30%
- Relines and Repairs – to bridges and dentures 50% 30%

**Major Services** - There is a 12-month waiting period on Major Services.

- Major Restorative Services – crowns 50% 30%
- Periodontic Services – to treat gum disease 50% 30%
- Prosthodontic Services* – bridges and dentures 50% 30%

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

- **Policy is a 12-month contract** and may be renewed for another year by paying premiums when due. Your premiums and benefits may change at the end of your contract period as approved by the state. Your contract will not be renewed if: we discontinue our individual insurance product; there is fraud or misrepresentation in your application or claims; or you don’t pay premiums when due. If coverage is not renewed, we will pay all covered claims you have before your coverage ends.
- **Benefit Period:** Calendar year (January through December) regardless of your contract effective date or renewal date.
- **Deductibles:** There is no deductible for Preventive and Diagnostic Services. There is a $50 individual/$150 family deductible per Benefit Period for Basic and Major Services. The $50 individual deductible applies to the $150 family deductible. No individual pays more than $50 in deductibles and the maximum deductible paid under any family contract cannot exceed $150.
- **Plan pays a maximum of $1,000 per member, per Benefit Period for covered services.**
- **Dependents are covered through the end of the Benefit Period in which they turn age 26.**

Essential Health Benefits (EHB)

Benefits for individuals under the age of 21

<table>
<thead>
<tr>
<th>Preventive and Diagnostic</th>
<th>PPO Dentist Plan Pays</th>
<th>Premier/Nonparticipating Dentist Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams, cleansings, fluoride and space maintainers</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency Palliative Treatment – to temporarily relieve pain</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Sealants – to prevent decay to permanent teeth</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Radiographs – X-rays</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Basic Services**

- Minor Restorative – fillings and crown repair 50% 50%
- Endodontic Services – root canals 50% 50%
- Periodontic Services – to treat gum disease 50% 50%
- Oral Surgery – all extractions and dental surgery 50% 50%
- Relines and Repairs – to dentures 50% 50%
- Other Basic Services – misc. services 50% 50%

**Major Services**

- Major Restorative Services – all crowns 50% 50%
- Prosthodontic Services – interim dentures and maxillofacial prosthodontics 50% 50%
- Implant Services 50% 50%

**Orthodontic Services**

- Orthodontic Services – braces when medically necessary 50% 50%

- **Benefit Period:** Calendar year (January through December) regardless of your contract effective date or renewal date.
- **In-Network Out-of-Pocket Maximum for EHB Covered Services** – $350 per Benefit Period if this policy covers one individual under the age of 21, or $700 per Benefit Period if this policy covers two or more individuals under the age of 21. Any Copayments, Deductibles or other out-of-pocket expenses paid by you for In-Network EHB Covered Services provided to EHB Eligible Persons count toward that In-Network Out-of-Pocket Maximum. Once your applicable In-Network Out-of-Pocket Maximum is reached for the Benefit Year, all In-Network EHB Covered Services provided to EHB Eligible Persons will be covered at 100% of the Maximum Approved Fee.
- **Out-of-Network Out-of-Pocket Maximum for EHB Covered Services** – There is no annual Out-of-Pocket Maximum for EHB Covered Services received from Premier and Non-participating (out-of-network) Dentists.
- **Annual and Lifetime Maximum Payments for EHB Covered Services** – There are no annual or lifetime Maximum Payments for all EHB Covered Services provided to individuals under the age of 21.
- **Deductibles for EHB Covered Services** – There is no deductible for Diagnostic and Preventive Services and Orthodontics. $75 deductible for Basic and Major Services per benefit period.
- **Waiting Period for EHB Covered Services** – There are no waiting periods for individuals under the age of 21 seeking EHB Covered Services.
- **Individuals covered through the end of the month in which they turn age 21, then covered on the non-EHB benefits.**

This is not a contract. It is a partial list of benefits and services. For complete details refer to your certificate.
## Benefits for individuals 21 years of age or older

<table>
<thead>
<tr>
<th>Preventive and Diagnostic</th>
<th>Premier Dentist Plan Pays</th>
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<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Basic Services

| Minor Restorative – fillings and crown repair | 50% | 50% |
| Stainless Steel Crowns | 50% | 50% |
| Endodontic Services – root canals | 50% | 50% |
| Oral Surgery – excluding any impacted teeth | 50% | 50% |
| Relines and Repairs – to bridges and dentures | 50% | 50% |

### Major Services - There is a 12-month waiting period on Major Services.

| Major Restorative Services – crowns | 50% | 50% |
| Periodontic Services – to treat gum disease | 50% | 50% |
| Prosthodontic Services* – bridges and dentures | 50% | 50% |

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

- **Policy is a 12-month contract** and may be renewed for another year by paying premiums when due. Your premiums and benefits may change at the end of your contract period as approved by the state. Your contract will not be renewed if: we discontinue our individual insurance product; there is fraud or misrepresentation in your application or claims; or you don’t pay premiums when due. If coverage is not renewed, we will pay all covered claims you have before your coverage ends.
- **Benefit Period:** Calendar year (January through December) regardless of your contract effective date or renewal date.
- **Deductibles:** There is no deductible for Preventive and Diagnostic Services. There is a $50 individual/$150 family deductible for Basic and Major Services. The $50 individual deductible applies to the $150 family deductible. No individual pays more than $50 in deductibles and the maximum deductible paid under any family contract cannot exceed $150.
- **Plan pays a maximum of $1,000 per member, per benefit period for covered services.**
- **Dependents are covered through the end of the benefit period in which they turn age 26.**

## Essential Health Benefits (EHB)

### Benefits for individuals under the age of 21

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</tr>
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<td>Radiographs – X-rays</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Basic Services

| Minor Restorative – fillings and crown repair | 50% | 50% |
| Endodontic Services – root canals | 50% | 50% |
| Periodontic Services – to treat gum disease | 50% | 50% |
| Oral Surgery – all extractions and dental surgery | 50% | 50% |
| Relines and Repairs – to dentures | 50% | 50% |
| Other Basic Services – misc. services | 50% | 50% |

### Major Services

| Major Restorative Services – all crowns | 50% | 50% |
| Prosthodontic Services – interim dentures and maxillofacial prosthodontics | 50% | 50% |
| Implant Services | 50% | 50% |

### Orthodontic Services

| Orthodontic Services – braces when medically necessary | 50% | 50% |

- **Benefit Period:** Calendar year (January through December) regardless of your contract effective date or renewal date.
- **In-Network Out-of-Pocket Maximum for EHB Covered Services** – $350 per Benefit Period if this policy covers one individual under the age of 21, or $700 per Benefit Period if this policy covers two or more individuals under the age of 21. Any Copayments, Deductibles or other out-of-pocket expenses paid by you for In-Network EHB Covered Services provided to EHB Eligible Persons count toward that In-Network Out-of-Pocket Maximum. Once your applicable In-Network Out-of-Pocket Maximum is reached for the Benefit Year, all In-Network EHB Covered Services provided to EHB Eligible Persons will be covered at 100% of the Maximum Approved Fee.
- **Out-of-Network Out-of-Pocket Maximum for EHB Covered Services** – There is no annual Out-of-Pocket Maximum for EHB Covered Services received from Non-participating (out-of-network) Dentists.
- **Annual and Lifetime Maximum Payments for EHB Covered Services** – There are no annual or lifetime Maximum Payments for all EHB Covered Services provided to individuals under the age of 21.
- **Deductibles for EHB Covered Services** – There is no deductible for Diagnostic and Preventive Services and Orthodontics. $25 deductible for Basic and Major Services per benefit period.
- **Waiting Period for EHB Covered Services** – There are no waiting periods for individuals under the age of 21 seeking EHB Covered Services.
- **Individuals covered through the end of the month in which they turn age 21, then covered on the non-EHB benefits.**

This is not a contract. It is a partial list of benefits and services. For complete details refer to your certificate.
“You no longer need to work for a big company to have a good dental plan...thanks to Delta Dental.”

If you have questions regarding these plans, please call:

PlanChoice, Inc.
844-KYDELTA (844-593-3582)
www.kydelta.com

Once enrolled, please call our Customer Service department at 800-971-4108 or visit our website at www.individualaccountmanager.com for benefit information.

Thank you for choosing Delta Dental as your dental benefits carrier!
Rates for effective dates of 1-1-2017 through 12-1-2017

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Delta Dental PPO Monthly Premium</th>
<th>Delta Dental Premier Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$28.24</td>
<td>$33.05</td>
</tr>
<tr>
<td>Single plus Spouse</td>
<td>$56.47</td>
<td>$66.10</td>
</tr>
<tr>
<td>Single plus Child(ren)</td>
<td>$63.02</td>
<td>$72.91</td>
</tr>
<tr>
<td>Family</td>
<td>$98.89</td>
<td>$114.70</td>
</tr>
</tbody>
</table>

Discounted Annual Premium*  
*(Check/money order or credit card)*

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Delta Dental PPO Discounted Annual Premium</th>
<th>Delta Dental Premier Discounted Annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$328.68</td>
<td>$384.72</td>
</tr>
<tr>
<td>Single plus Spouse</td>
<td>$657.36</td>
<td>$769.44</td>
</tr>
<tr>
<td>Single plus Child(ren)</td>
<td>$733.56</td>
<td>$848.76</td>
</tr>
<tr>
<td>Family</td>
<td>$1,151.04</td>
<td>$1,335.00</td>
</tr>
</tbody>
</table>

*If you choose to pay annually, your premium is less than the total premium paid monthly. The annual premium is for 12 months of coverage. Please do not prorate the premium paid.

Applications received by the 25th of the month are effective the 1st of the following month.
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: __________________________
How to find a Delta Dental participating provider:

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. (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.)

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 or www.individualaccountmanager.com) and request the information by city, state, zip code, provider’s name or specialty.

Mobile App
Our mobile app is available for mobile devices using iOS (Apple or Android). To download, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. The dentist search tool makes it easy to search for a Delta Dental Premier or Delta Dental PPO dentist in your area.

Customer Service
You may call a Delta Dental customer service representative at the 1-800-971-4108 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.

Underwritten by Delta Dental of Kentucky, Inc.
* Registered Marks Delta Dental Plans Association
Delta Dental PPO or Delta Dental Premier...

How do I choose which plan is best for me and my family?

Do you have an established relationship with a specific dentist that is important to you and your family?

- **YES**
  - Is your dentist in the Delta Dental PPO network?
    - **YES**: We recommend you select the Delta Dental PPO Plan. Since your dentist is in our network and the premiums are the lowest we offer, this is your best choice. Benefits are reduced if services are received from a non-participating Delta Dental PPO network dentist.
    - **NO**: We recommend you select the Delta Dental Premier Plan. You can go to any licensed dentist with full coverage under the Premier Plan, and with more than 90% of all Kentucky dentists participating in the Premier Plan, there is a good chance you will be protected from balance billing.

- **NO**
  - Is there a Delta Dental PPO general dentist convenient to where you live?
    - **YES**: We recommend you select the Delta Dental PPO Plan since the premiums are the lowest we offer and you can choose a credentialed PPO network dentist convenient to your home. Benefits are reduced if services are received from a non-participating Delta Dental PPO network dentist.
    - **NO**: We recommend you join the Delta Dental Premier Plan since more than 90% of all practicing dentists in Kentucky are in this plan. You should be able to find a dentist convenient to your home. Plus, you can go to any licensed dentist in Kentucky without reduced benefits.

In summary, the Delta Dental PPO plan has the lowest rates, but the Delta Dental Premier plan has the largest selection of dentists.

What is most important to you?

For additional information, call the Delta Dental Customer Service Department at 844-KYDELTA (844-593-3582).
Frequently Asked Questions for the Delta Dental EHB Certified Individual and Family Plans

Q: Does this plan provide the minimum Essential Health Benefits (EHB) for individuals under the age of 21 that is mandated by the Affordable Care Act (ACA)?
A: Yes. Both plans are EHB certified by the state.

Q: What is the cut off for new applications and when is my effective date?
A: Applications received by the 25th of the month are effective the 1st of the following month.

Q: What are my payment options?
A: For monthly bank draft, please complete the enclosed “Did You Know?” authorization form or send a voided check. For monthly credit card, please complete the authorization information on the enrollment form. For annual payment, we will need a check, money order or credit card authorization for the full 12 month premium. Annual credit card payments will be automatically withdrawn from your account at your renewal.

Q: If I want to pay annually, but my effective is any date other than January 1st, do I submit a partial/pro-rated payment?
A: Since your contract is for 12 months of coverage, you will need to submit payment for the full annual amount. Your effective date begins your 12 months of coverage. You will receive information to renew your coverage at the end of your 12 month contract.

Q: Is a deposit needed with the application?
A: No, a deposit is not required.

Q: When is premium drafted for monthly bank draft?
A: Premium is drafted from your checking account between the 4th and the 6th of each month.

Q: Can I choose what day my premium is taken out?
A: We can only draft your checking account between the 4th and the 6th of each month.

Q: Is there an enrollment fee?
A: No, there is no enrollment fee.

Q: Is there a monthly fee in addition to the premium?
A: No, there are no other charges other than the premium.

Q: Is there a network?
A: There is an extensive network of participating providers available with both plan options. Your current provider may already be participating in one of these networks. A sheet on how you can check to see if your provider is participating is included in this packet.

Q: How do I choose which plan is best for me and my family?
A: The Delta Dental PPO plan has the lowest rates and out-of-pocket expenses, but there is limited coverage for services provided by out-of-network dentists. More than, 60% of practicing dentists in Kentucky participate with the PPO plan. With the Delta Dental Premier plan, over 90% of practicing dentists in Kentucky participate, so any member should be able to find a convenient network dentist practice. Under both plans, out-of-network providers can balance bill you for the difference between the Allowable Amount and their submitted charges. A sheet to help you choose which plan best meets your needs is included in this packet.

Q: Is this plan a contract?
A: This plan is a 12 month contract. Your effective date begins your 12 months of coverage. You will receive information to renew your coverage at the end of your 12 month contract.

Q: When can I make changes to my contract?
A: Your plan is a 12 month contract. You can only make changes to your contract at your renewal.

(Continued on back)
Q: **What is my Benefit Period?**
A: Benefits are paid on a calendar year (January through December). The Benefit Period is the time that we pay benefits for Covered Services. Regardless of the effective date of your contract, your Benefit Period will start over January 1st.

Q: **What is the maximum benefit per Benefit Period?**
A: It is $1,000 per covered person, per Benefit Period for individuals age 21 and over. Covered individuals under the age of 21, do not have a maximum benefit per Benefit Period. They have a maximum out-of-pocket cost. Policies with one individual under the age of 21 have a $350 in-network out-of-pocket maximum per Benefit Period. Policies with two or more individuals under the age of 21 have a $700 in-network out-of-pocket maximum per Benefit Period.

Q: **What is the deductible?**
A: For individuals age 21 and over on the PPO or Premier option, the deductible is $50 for single and $150 for family. For individuals under the age of 21 on the PPO or Premier option have a $75 deductible for services in-network or out-of-network.

Q: **What do I pay for covered services?**
A: For individuals age 21 and over, preventive and diagnostic services are covered at 100% in-network; for basic and major services, your responsibility is 50% of the Allowable Amount in-network, after the deductible. For individuals under the age of 21, preventive and diagnostic services are covered at 100% in-network; for basic and major services, your responsibility is 50% of the Allowable Amount in-network up to the out-of-pocket maximum.

Q: **Are there any waiting periods?**
A: For individuals age 21 and over, preventive, diagnostic and basic services are available upon your effective date. There is a 12 month waiting period on major services and requires 12 months of continuous coverage before these services are available. However, if you’re Delta Dental group coverage is ending, you may be eligible to have your waiting period waived. Proof of prior coverage is required. For individuals under the age of 21, there is no waiting period.

Q: **Is there a minimum or maximum age?**
A: Anyone can enroll, regardless of age. Individuals under the age of 21 receive the EHB certified benefits. Individuals age 21 and over receive the non-EHB benefits.

Q: **Are full time students covered?**
A: All dependents, regardless of student status, are covered until the end of the contract year in which they turn 26.

Q: **My child needs braces. Would that be covered on this plan?**
A: For individuals age 21 and over, there is no orthodontic coverage. For individuals under the age of 21, there is medically necessary orthodontic coverage. Cosmetic orthodontic services are not covered.

Q: **Are veneers or implants covered?**
A: Veneers and implants are not covered for individuals age 21 and over. For individuals under the age of 21, implants are covered at 50%, subject to the deductible.

Q: **Is information/enrollment available online?**
A: Enrollment information and online enrollment is available at www.kydelta.com.

Q: **Once I have submitted my application, what is the next step?**
A: Soon after you have enrolled, you will receive a member packet from Delta Dental that includes your identification card and detailed benefit information.

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*If you have additional questions please call:*

PlanChoice, Inc.
13257 O'Bannon Station Way
Louisville, KY 40223
844-KYDELTA (844-593-3582) • Fax: 502-459-3388
deltadental@planchoice.com • www.kydelta.com

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*Please note:* This is not a contract. It is a partial list of benefits and services. *For complete details refer to your certificate.*
Individual and Family Plan Enrollment Form

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

- [ ] Delta Dental PPO
- [ ] Delta Dental Premier

Requested Effective Date ____________________

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

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

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Name – First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Date of Birth</th>
<th>Home Address – Number and Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>M or F</td>
<td>MM DD YY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Email Address

Phone Number ( )

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

- [ ] Single contract
- [ ] Single plus Spouse/Domestic Partner
- [ ] Single plus Child(ren)
- [ ] Family

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

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>SSN (Required)</th>
<th>Date of Birth</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

Have you had prior coverage through a Delta Dental plan within the last 60 days?

- [ ] No
- [ ] Yes – Please provide proof of prior Delta Dental 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 _________________________

   Signature _____________________________

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

2. Paper Check or Money Order –
   - Annual premium only

   Please include your check or money order with this form.

3. Bank Draft – Monthly premium only

   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 from our office between the 4th and the 6th of each month and should reach your account for processing within three working days. First month premium not required.

   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 ___________________________________

You can enroll online at www.kydelta.com

or

Make a copy for your records and return original with payment, if applicable, to:

Delta Dental of Kentucky

c/o PlanChoice

13257 O’Bannon Station Way

Louisville, KY 40223

You may email your enrollment form to kydelta@planchoice.com or fax to 502-459-3388.

**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.)

<table>
<thead>
<tr>
<th>Agent Name (printed)</th>
<th>Agent Phone Number</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Agent Email</th>
<th>Agent Signature</th>
<th>Date</th>
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</table>

Underwritten by Delta Dental of Kentucky, Inc.
Your hearing health care program - for life
The following program is brought to you by Delta Dental of Kentucky

Amplifon Hearing Health Care Overview

Custom hearing solutions - we find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers.

Risk-free 60-day trial - 100% money-back guarantee.

Hearing aid low price guarantee - if you find the same product at a lower price, bring us the local quote and we’ll not only match it, we’ll beat it by 5%!

Continuous Care - one year free follow-up, two years of free batteries, and a three-year warranty.

Don’t delay - call to schedule your appointment today!

1.877.703.3505
www.amplifonusa.com/deltadentalky

Accessing your benefits is as easy as...

1
Call Amplifon at 1.877.703.3505 and a Patient Care Advocate will assist you in finding a hearing care provider near you.

Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.

Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

Call 1.877.703.3505 today!

Amplifon ID Card

Keep this card for future access to:
• Discounted hearing testing
• Low price guarantee
• 60-day risk-free trial period
• 2 years batteries with purchase

To activate your benefit, call 1.877.703.3505 today!

*This is not health insurance.

HearPO has changed its name to Amplifon Hearing Health Care.

Special money saving offer!

Call today for your FREE hearing screening appointment!
Please bring this offer with you to your appointment.

Call 1.877.703.3505 today!

This is not a medical exam and is only intended to assist with amplification selection.
VSP Vision Savings Pass is a discount vision program that offers immediate savings on eye care and eyewear. This is not an insurance plan.

### See the Savings
- Access to discounts through a trusted, private-practice VSP doctor
- One rate of $50 for an eye exam¹
- Special pricing on complete pairs of glasses and sunglasses
- 15% savings on a contact lens exam²
- Unlimited use on materials throughout the year
- Exclusive Member Extras, like rebates and special offers

### Unlimited Annual Material Use³
Your VSP Vision Savings Pass can be used as often as you like throughout the year. With the best choices in eyewear, we make it easy to find the perfect frame that's right for you, your family, and your budget. Choose from great brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more.⁴

<table>
<thead>
<tr>
<th>Service</th>
<th>Reduced prices and savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellvision Exam®</td>
<td>• $50 with purchase of a complete pair of prescription glasses.</td>
</tr>
<tr>
<td></td>
<td>• 20% off without purchase.</td>
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<tr>
<td></td>
<td>• Once every calendar year.</td>
</tr>
<tr>
<td>Retinal Screening</td>
<td>• Guaranteed pricing with Wellvision Exam, not to exceed $39.</td>
</tr>
<tr>
<td>Lenses</td>
<td>With purchase of a complete pair of prescription glasses:</td>
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<tr>
<td></td>
<td>• Single vision $40</td>
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<tr>
<td></td>
<td>• Lined bifocals $60</td>
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<tr>
<td></td>
<td>• Lined trifocals $75</td>
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<tr>
<td></td>
<td>• Polycarbonate for children $0</td>
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<tr>
<td>Lens Enhancements</td>
<td>• Average savings of 20-25% on lens enhancements such as progressive, scratch-resistant, and anti-reflective coatings.</td>
</tr>
<tr>
<td>Frames</td>
<td>• 25% savings when a complete pair of prescription glasses is purchased.</td>
</tr>
<tr>
<td>Sunglasses</td>
<td>• 20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last Wellvision Exam.</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>• 15% savings on contact lens exam (fitting and evaluation).</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.</td>
</tr>
</tbody>
</table>

1. This cost is only available with the purchase of a complete pair of prescription glasses; otherwise, you'll receive 20% off an eye exam only.
2. Applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost.
3. Unlimited use is for materials only. An eye exam is limited to once a year per member.
4. Brands subject to change.