Dear KRTA member:

Thank you for considering Delta Dental of Kentucky for your dental insurance needs. You can select the Delta Dental PPO™ plan, Delta Dental PPO Plus Premier™ Plan, or the DeltaCare® plan (available to KY residents only). You can also purchase the DeltaVision® plan with one of the Delta Dental plans and receive a rate discount.

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

- Delta Dental overview (provides comparison of the PPO, PPO Plus Premier and DeltaCare benefits)
- DeltaVision plan overview
- A rate sheet that gives the monthly and annual prices of the options available
- Enrollment form
- Healthy Mouth, Healthy Body program overview
- Healthy Mouth, Healthy Body enrollment form
- Automatic Debit form for monthly payment
- Copayment Schedule for the DeltaCare (DHMO plan) (Available to KY residents only)

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

Sincerely,

Delta Dental of Kentucky

DELTA DENTAL®

KRTA
KENTUCKY RETIRED TEACHERS ASSOCIATION

KRTA
Benefit Plan Options

	Option A		Option B	Option C
	Delta Dental PPO™ Participating Dentist	Non-Participating Dentist	Delta Dental PPO Plus Premier™	DeltaCare®
Preventive and Diagnostic (excluded from the benefit maximum)				
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**				
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	No Deductible
Benefit Period Maximum (Diagnostic & Preventive services are excluded from the maximum)	$1500		$1500	No Maximum

Dependents covered up to the end of the year they turn 23.

* Option A: Members who choose a Delta Dental PPO network provider have the lowest out of pocket expenses and cannot be balance billed. When services are received from an out-of-network dentist (non-participating dentist), Delta Dental's Non-participating Dentist Fee may be less than what the dentist charges and you will be responsible for the difference. Dentists are allowed to unbundle services and fees, and balance bill patients. You may also be responsible for filing your own claims.
* Option B: The Delta Dental PPO Plus Premier 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.
* Option C: DeltaCare is a DHMO plan. Members agree to choose a dentist in the DeltaCare Network.

** Credit provided with proof of 12 months of prior dental coverage.

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

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. 10/2021

DELTA DENTAL®

VSP® Vision Care

KRTA DeltaVision®

You'll see the difference with DeltaVision®

3 in 4
adults need vision correction.1

1 in 4
children need vision correction.1

Only 1 in 5
Americans get an annual medical exam.2

Personalized Care. DeltaVision members receive quality care that focuses on their eyes and overall wellness. Our eye care provider will look for vision problems and signs of other health conditions.

Eyewear. Choose eyewear that's right for you and your budget. From classic styles to the latest designer fashions, there are hundreds of options for DeltaVision members.

Value and Savings. DeltaVision members receive great benefits on exams and eyewear at an affordable price.

Enroll Today!

deltadentalky.com/KRTA | (800) 955-2030

Sources: 1. Vision Council, VisionWatch December 2014; 2. American Journal of Preventative Medicine 2012, 42, Issue 2:164-173.

DELTA DENTAL

vsp Vision care for life

DeltaVision® by Delta Dental of Kentucky
administered by VSP®

KRTA DeltaVision

Benefit	Description	Copay
WellVision Exam		
Exams 1 exam every 12 months	Comprehensive eye exam to ensure overall visual wellness	$10
Prescription Glasses		$25
Frames 1 pair every 24 months	$130 Frame Allowance (including Walmart/Sam's Club) 20% savings on amount over allowance $70 Costco frame allowance	Included in Prescription Glasses Copay
Lenses 1 pair every 12 months	Single vision, lined bifocal and lined trifocal lenses Polycarbonate lenses for children	Included in Prescription Glasses Copay
Covered Lens Enhancements	Standard Progressive Lenses	$0
Optional Lens Enhancements	Standard Anti-Reflective Coating Premium Progressive Lenses Custom Progressive Lenses Average savings of 20-25% on other lens enhancements	$41 $95 - $105 $150 - $175
Contact Lenses - instead of glasses		
Contacts every 12 months	$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	up to $60
Extra Savings		
Featured Frames	$150 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 copay on routine retinal screening as an enhancement to a WellVision Exam	
Laser Vision Correction	Average 15%-20% discount	
Additional Programs		
Included	Primary Eyecare, Eye Health Management (including Diabetic Exam Reminder Letters)	

Your coverage with Out-of-Network Providers		
Exam - up to $45 Frame - up to $70 Single Vision Lenses - up to $30	Lined Bifocal Lenses - up to $50 Lined Trifocal Lenses - up to $65 Lenticular Lenses - up to $100	Progressive Lenses - up to $50 Contacts - up to $105 Necessary Contact Lenses - up to $210

Delta Dental of Kentucky 800-955-2030 | **VSP** 800-877-7195
(Please contact DDKY for eligibility before contacting VSP Member Services)

VSP Choice Network
100,000 Access Points • In-network with Costco, Walmart/Sam's Club

Rev. 5/2022

KRTA
Individual and Family Plan Rate Sheet

Rates for effective dates of 7-1-2022 through 6-30-2023

Monthly Premium Payment Option

	Option A	Option AV	Option B	Option BV	Option C	Option CV
	Delta Dental PPO™	Delta Dental PPO ™ with DeltaVision®	Delta Dental PPO Plus Premier®	Delta Dental PPO Plus Premier® with DeltaVision®	DeltaCare®	DeltaCare® with DeltaVision®
Member Only	$36.60	$48.29	$38.25	$49.94	$16.20	$27.89
Member plus One Dependent	$70.25	$87.20	$73.46	$90.41	$30.93	$47.88
Member plus Two or more Dependents	$120.77	$151.17	$126.23	$156.63	$48.87	$79.27

Paid on a monthly basis by credit card or bank draft

Annual Premium Payment Option

	Option A	Option AV	Option B	Option BV	Option C	Option CV
	Delta Dental PPO™	Delta Dental PPO ™ with DeltaVision®	Delta Dental PPO Plus Premier®	Delta Dental PPO Plus Premier® with DeltaVision®	DeltaCare®	DeltaCare® with DeltaVision®
Member Only	$439.20	$579.48	$459.00	$599.28	$194.40	$334.68
Member plus One Dependent	$843.00	$1,046.40	$881.52	$1,084.92	$371.16	$574.56
Member plus Two or more Dependents	$1,449.24	$1,814.04	$1,514.76	$1,879.56	$586.44	$951.24

Paid on an annual basis by credit card or bank draft

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

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.

DELTA DENTAL®

KRTA Enrollment/Renewal Form

KRTA KENTUCKY RETIRED TEACHERS ASSOCIATION

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

- ❑ Option A - Delta Dental PPO
- ❑ Option AV - Delta Dental PPO with DeltaVision®
- ❑ Option B - Delta Dental PPO Plus Premier
- ❑ Option BV - Delta Dental PPO Plus Premier with DeltaVision®
- ❑ Option C - DeltaCare
- ❑ Option CV - DeltaCare with DeltaVision®

Please complete the information below.

Social Security Number	Name – Last First	Email Address	Home Phone ( )

Sex (Circle one) M or F	Date of Birth MO DAY YR	Home Address – Number and Street	City	State	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	SSN	Date of Birth MO	DAY	YR	Sex M	F
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						

Dependents covered through the end of the benefit year in which they turn age 23.

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

1. ❑ Credit Card – ❑ Annual ❑ SemiAnnual ❑ Quarterly ❑ Monthly
   ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

   Card Number _____

   Expiration Date _____

   Signature _____

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

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

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

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

Please carefully read the Contract Provisions below. Signature required.

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 _____

You can enroll online at deltadentalky.com/KRTA,

by phone at 1-800-955-2030

or, by mail:

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

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

SHADED AREA FOR OFFICE USE ONLY

Effective Date	Process Date	Processed By

DELTA DENTAL®

Delta Dental of Kentucky

Healthy Mouth, Healthy Body Program

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

Enhanced coverage for at-risk conditions

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

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

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

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

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

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

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

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

Questions?

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

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

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

Rev. 11/2022

Healthy Mouth, Healthy Body
Enrollment Form

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

ENROLLING IS AS EASY AS IMPROVING YOUR SMILE.

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

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

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

Enrollee name: _____

Subscriber name: _____

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

Group name: _____

Condition (please check one):

- ☐ Pregnancy - Due date: _____
- ☐ Diabetes - Diagnosis date: _____

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

Dentist signature: _____ Date: _____

- ☐ Renal failure/dialysis - Diagnosis date: _____
- ☐ HIV Positive - Diagnosis date: _____
- ☐ Dementia - Diagnosis date: _____
- ☐ Stem Cell Transplant - Date: _____
- ☐ Chemotherapy/Radiation - Start date: _____
- ☐ Orthodontic Treatment - Start Date: _____
- ☐ Infective endocarditis - Diagnosis date: _____

Enrollee signature: _____

Physician name: _____

Physician signature: _____ Date: _____

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

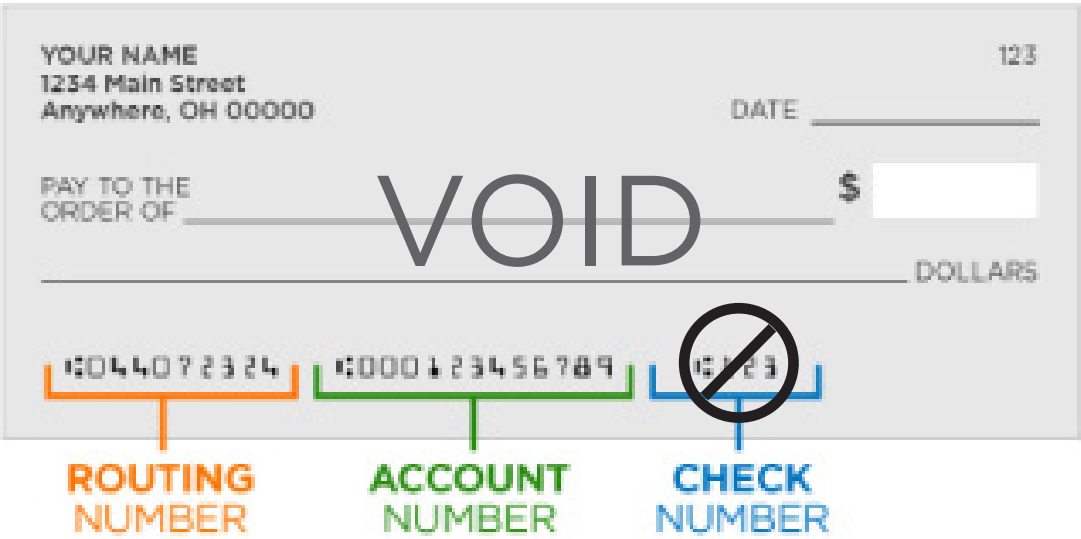
Delta Dental of Kentucky has provided more than $20 million to Non-profits across Kentucky since 2003.

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:_____

DeltaCare
Exclusive Provider Option

DELTA DENTAL®

Must be a KY resident to enroll

PLAN 20173A
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	28
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	28
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 60 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 (1 per 60 month period)	0
PROPHYLAXIS & FLUORIDE TREATMENTS		
1110/1120	Prophylaxis (teeth cleaning) adult/child (2 per 12 month period)	0
1206	Topical fluoride varnish (1 per 6 month period for covered persons to age 19)	0
1208	Topical application of fluoride (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)	24
SPACE MAINTAINERS*		
1510	Space maintainer, fixed (unilateral)*	130
1515	Space maintainer, fixed (bilateral)*	211
1520	Space maintainer, removable (unilateral)*	174
1525	Space maintainer, removable (bilateral)*	233
1550	Recementation of space maintainer	33
1555	Removal of fixed space maintainer	33

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

ADA Codes		Member Pays
RESTORATIVE DENTISTRY		
Amalgam Restorations – Primary or Permanent Teeth:		
2140	Amalgam – 1 surface	49
2150	Amalgam – 2 surfaces	59
2160	Amalgam – 3 surfaces	71
2161	Amalgam – 4 or more surfaces	77
Resin Restorations:		
2330	Resin-based composite – 1 surface, anterior	55
2331	Resin-based composite – 2 surfaces, anterior	67
2332	Resin-based composite – 3 surfaces, anterior	79
2335	Resin-based composite – 4 or more surfaces, anterior or involving incisal angle	102
2390	Resin-based composite crown – anterior	122
Resin Restorations (continued):		
2391	Resin-based composite – 1 surface, posterior	$ 77
2392	Resin-based composite – 2 surfaces, posterior	98
2393	Resin-based composite – 3 surfaces, posterior	118
2394	Resin-based composite – 4 or more surfaces	122
Inlay/Onlay Restorations:		
2510*	Inlay, metallic – 1 surface	324
2520*	Inlay, metallic – 2 surfaces	324
2530*	Inlay, metallic – 3 or more surfaces	336
2542*	Onlay, metallic – 2 surfaces	324
2543*	Onlay, metallic – 3 surfaces	336
2544*	Onlay, metallic – 4 or more surfaces	336
Crowns:		
2710	Crown, resin based composite	219
2720*	Crown, resin with high noble metal	335
2721	Crown, resin with predominantly base metal	293
2722	Crown, resin with noble metal	293
2740	Crown, porcelain/ceramic	448
2750*	Crown, porcelain fused to high noble	448
2751	Crown, porcelain fused to predominantly base metal	448
2752	Crown, porcelain fused to noble	448
2780*	Crown – 3/4 cast high noble metal	448
2781	Crown – 3/4 cast predominantly base metal	402
2782	Crown – 3/4 cast noble metal	448
2783	Crown – 3/4 porcelain/ceramic	448
2790*	Crown, full cast high noble metal	448
2791	Crown, full cast predominantly base metal	402
2792	Crown, full cast noble metal	448
2794*	Crown – titanium	448
2910	Recement inlay, onlay or partial coverage restoration	43
2915	Recement cast or prefabricated post and core	45
2920	Recement crown	40
2930	Prefabricated stainless steel primary	119
2931	Prefabricated stainless steel permanent	122
2932	Prefabricated resin crown (anterior teeth only)	134
2940	Sedative filling	39
2950	Core build-up, including any pins	118
2951	Pin retention – per tooth, in addition to restoration	19
2952*	Post and core, in addition to crown – indirectly fabricated	153
2954	Prefabricated post and core, in addition to crown	147
2971	Additional procedures to construct new crown under existing partial denture framework	73
2980	Crown repair	92 + 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.

ADA Codes		Member Pays
ENDODONTICS		
3110/3120	Pulp capping – direct/indirect (excludes final restoration)	35
3220	Therapeutic pulpotomy (excludes final restoration)	65
3221	Pulpal debridement (primary/perm.)	47
3230/3240	Pulpal therapy (resorbable filling), primary tooth (excludes final restoration)	92
3310	Root canal, anterior (excludes final restoration)	255
3320	Root canal, bicuspid (excludes final restoration)	315
3330	Root canal, molar (excludes final restoration)	415
3346	Retreatment of previous root canal therapy–anterior	319
3347	Retreatment of previous root canal therapy–bicuspid	365
3348	Retreatment of previous root canal therapy–molar	442

(Continued)

DELTACARE PLAN 20173A

ADA Codes		Member Pays
ENDODONTICS (CONTINUED)		
3410	Apicoectomy/periradicular surgery, anterior	$245
3421	Apicoectomy/periradicular surgery, bicuspid (1st root)	236
3425	Apicoectomy/periradicular surgery, molar (first root)	348
3426	Apicoectomy/periradicular surgery, each additional root	216
3430	Retrograde filling, per root	82
3450	Root amputation, per root	158
PERIODONTICS		
4210	Gingivectomy or gingivoplasty, 4 or more contiguous teeth per quadrant	216
4211	Gingivectomy or gingivoplasty, 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	102
4240	Gingival flap procedures, including root planing, 4 or more contiguous teeth	253
4241	Gingival flap procedures, including root planing, 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	217
4245	Apically positioned flap	247
4249	Clinical crown lengthening – hard tissue	252
4260	Osseous surgery, 4 or more contiguous teeth	453
4261	Osseous surgery, 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	304
4341	Periodontal scaling and root planing, 4 or more teeth per quadrant	102
4342	Periodontal scaling and root planing, 1 to 3 teeth per quadrant	71
4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	74
4910	Periodontal maintenance (following active therapy)	69
PROSTHETICS – REMOVABLE		
Includes any adjustments for 6 months		
5110/5120	Complete denture, upper or lower	422
5130/5140	Immediate denture, upper or lower	487
5211/5212	Partial denture, resin base, upper or lower (including any conventional clasps, rests and teeth)	416
5213/5214	Partial denture, upper or lower, cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	499
5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	496
5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	496
5281	Removable unilateral partial denture, one piece cast metal (including clasps and teeth)	328
5410/5411	Denture and partial adjustments – upper or lower	41
5421/5422	Adjust partial denture - upper and lower	46
5510/5610 5620	Denture and partial repairs (per repair)	65 + lab
5520/5640	Adding or replacing teeth to existing partial/denture (per tooth)	65 + lab
5630	Repair or replace broken clasp	65 + lab
5650/5660	Add tooth or clasp to existing partial denture	65 + lab
5670/5671	Replace all teeth and acrylic on cast metal framework, upper or lower	285
5710/5711	Rebase complete upper or lower denture	180
5720/5721	Rebase upper or lower partial denture	145
5730/5731 5740/5741	Office reline, complete or partial denture	120
5750/5751 5760/5761	Laboratory reline, complete or partial denture	165
5850/5851	Tissue conditioning, upper or lower	58

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	$435
6211	Pontic, cast predominantly base metal	422
6212	Pontic, cast noble metal	448
6240*	Pontic, porcelain fused to high noble metal	448
6241	Pontic, porcelain fused to predominantly base metal	448
6242	Pontic, porcelain fused to noble metal	448
6245	Pontic, porcelain/ceramic	448
6250*	Pontic, resin with high noble metal	448
6251	Pontic, resin with predominantly base metal	448
6252	Pontic, resin with noble metal	448
6602*	Inlay cast high noble metal, 2 surfaces	317
6603*	Inlay cast high noble metal, 3 or more surfaces	317
6604	Inlay cast predominantly base metal, 2 surfaces	295
6605	Inlay cast predominantly base metal, 3 or more surfaces	295
6606	Inlay cast noble metal, 2 surfaces	305
6607	Inlay cast noble metal, 3 or more surfaces	316
6610*	Onlay cast high noble metal, 2 surfaces	301
6611*	Onlay cast high noble metal, 3 or more surfaces	301
6612	Onlay cast predominantly base metal, 2 surfaces	281
6613	Onlay cast predominantly base metal, 3 or more surfaces	281
6614	Onlay cast noble metal, 2 surfaces	292
6615	Onlay cast noble metal, 3 or more surfaces	292
6720*	Crown, resin with high noble metal	335
6721	Crown, resin with predominantly base metal	293
6722	Crown, resin with noble metal	293
6740	Crown, porcelain/ceramic	448
6750*	Crown, porcelain fused to high noble metal	448
6751	Crown, porcelain fused to predominantly base metal	448
6752	Crown, porcelain fused to noble metal	448
6780*	Crown, $^{3}/_{4}$ cast high noble metal	376
6781	Crown, $^{3}/_{4}$ cast predominantly base metal	367
6782	Crown, $^{3}/_{4}$ cast noble metal	448
6790*	Crown, full cast high noble metal	448
6791	Crown, full cast predominantly base metal	409
6792	Crown, full cast noble metal	448
6930	Recement bridge (fixed partial denture)	57
6940	Stress breaker	156

*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	38
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	57
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	104
7220	Removal of impacted tooth (soft tissue)	132
7230	Removal of impacted tooth (partially bony)	173
7240	Removal of impacted tooth (completely bony)	183
7241	Removal of impacted tooth (completely bony, with unusual surgical complications)	206

(Continued)

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ORAL & MAXILLOFACIAL SURGERY (CONTINUED)		
7250	Surgical removal of residual tooth roots (cutting procedure)	$135
7286	Biopsy of oral tissue (soft)	111
7310	Alveoloplasty, with extractions, four or more teeth or tooth spaces, per quadrant	98
7311	Alveoloplasty, with extractions, 1 to 3 teeth or tooth spaces, per quadrant	93
7320	Alveoloplasty, without extractions, four or more teeth or tooth spaces, per quadrant	131
7321	Alveoloplasty, without extractions, 1 to 3 teeth or tooth spaces, per quadrant	131
7960	Frenulectomy – separate procedure	185
MISCELLANEOUS		
9110	Palliative emergency treatment of dental pain (minor procedure)	42
9310	Specialist consultation	60
9440	Office visit, after regularly scheduled hours	44

ORTHODONTIC COVERAGE	**MEMBER PAYS**
24-month treatment plan including treatment records	$4,100

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.

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.

DELTA DENTAL®

Delta Dental of Kentucky

PPO Plus Premier™ Plan Network Savings

Save Money and Stay in Network

With a PPO Plus Premier dental plan, visiting a Delta Dental PPO™ dentist provides the most significant discounts resulting in lowest out-of-pocket costs. In-network PPO dentists have agreed to accept lower fees as full payment for covered services. However, if a dentist doesn't participate in Delta Dental PPO, you can still save money with a Delta Dental Premier® participating dentist. Like our PPO dentists, Delta Dental Premier dentists agree to accept Delta Dental's fee determination as full payment for covered services.

DELTA DENTAL NETWORKS		
YOUR PLAN →	**Delta Dental PPO**	• Most significant network discounts • More than 112,000[1] participating providers nationwide • No balance billing on covered services • Providers file claims for you
	Delta Dental Premier	• More than 153,000[1] participating providers nationwide • No balance billing on covered services • Providers file claims for you
OUT-OF-NETWORK	**Out-of-network**	• May be balance billed • May not receive discounts • May need to file your own claims

[1]*National network statistics: Delta Dental Plans Association March 2021*

Examples of how it works:

As shown below, staying in network can help save you on out-of-pocket costs.*

		DELTA DENTAL PPO NETWORK DENTIST	DELTA DENTAL PREMIER NETWORK DENTIST	OUT OF NETWORK DENTIST
COMPOSITE FILLING (D2392) *May be subject to deductible*	Submitted fee:	$176.00	$176.00	$176.00
	Maximum allowed fee:	$124.00	$143.00	$87.00
	Coverage level:	80%	60%	60%
	Amount Delta Dental pays:	$99.20	$85.80	$52.20
	AMOUNT YOU PAY:	**$24.80**	**$57.20**	**$123.80**
CROWN (D2740) *May be subject to deductible*	Submitted fee:	$952.00	$952.00	$952.00
	Maximum allowed fee:	$660.00	$813.00	$462.00
	Coverage level:	50%	40%	40%
	Amount Delta Dental pays:	$330.00	$325.20	$184.80
	AMOUNT YOU PAY:	**$330.00**	**$487.80**	**$767.20**

**Payment examples shown above are illustrative only. Fees and reimbursements can vary by location and provider. Benefit coverages, levels and deductibles may vary by client. They do, however, represent how payment is determined.*

Members can get estimated cost ranges for common dental services using Delta Dental's mobile app. The app also provides the ability to search for a Delta Dental PPO or Delta Dental Premier dentist in their area. The Delta Dental mobile app is available for mobile devices using iOS (Apple) or Android.

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. 10/2022

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.

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

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

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

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

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