



**Turn in your form at  
the Whitley County  
Board Central office.**

## ***PPO Plus Premier Program***

Delta Dental has simplified the decision making process and is now offering one plan with the same benefits as the previous two PPO and Premier product offerings. Members will enjoy access to both networks of dentists. For new enrollment or changes, please complete the following form. If you are currently enrolled in a Delta Dental Plan you **DO NOT** have to complete a new application.

### **Monthly Rates:**

Employee:	\$19.46
Employee + Spouse:	\$39.69
Employee + 1:	\$39.69
Family:	\$73.94

**WHITLEY COUNTY BOARD OF EDUCATION**  
**VOLUNTARY BENEFIT SELECTION FORM**

Employee Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Location: \_\_\_\_\_  
 Marital Status:  Married  Divorced  Single  Legally Separated  Widowed

All premiums are listed as monthly rates.

**DENTAL PLAN – DELTA DENTAL**

Your dental plan will continue to be offered through Delta Dental of Kentucky. This year you will have 3 ways to access the Delta Dental Network through just one plan and one set of rates. You will have access to the PPO Network, the Premier Network and Out of Network dentists, at a lesser benefit. Please review the dental materials and decide what level of coverage you wish to enroll in. Mark your selection below and be sure to complete the dependent information section included in this form.

I wish to drop / decline dental coverage at this time.

**DEPENDENT INFORMATION**

Please list all dependents you wish to cover, add or terminate on your dental plan in the boxes below. Please mark the "Enroll" box if you are adding or covering a dependent. If you would like to remove a dependent from dental or vision coverage, please make note below. If no information is provided below and you are currently enrolled, all benefits will remain exactly the same. If no information is provided below and you are enrolling for the first time, your coverage will be for single coverage only.

	Dependent Name	Birthday	SS#	Enroll Dental
Spouse				<input type="checkbox"/>
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>

\_\_\_\_\_  
 Employee signature Date



**Delta Dental of Kentucky  
Delta Dental PPO plus Premier  
Summary of Dental Plan Benefits**

Group Name: WHITLEY COUNTY BOARD OF EDUCATION

Group Number: DU7693-4001

Benefit Year: October 1 through September 30

Covered Services –

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Non-participating Dentist Plan Pays*
<b>Diagnostic &amp; Preventive</b>			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
<b>Basic Services</b>			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
<b>Major Services</b>			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
<b>Orthodontic Services</b>			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Dependent Children to the end of the month of age 19		

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per benefit year. Limited oral evaluations for a specific problem or complaint are also payable twice per benefit year.
- Prophylaxes (cleanings) are payable twice per benefit year. Two additional periodontal maintenance procedures are payable per benefit year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Fluoride treatments are payable once per benefit year for people up to age 19.
- Bitewing X-rays are payable once per Benefit Year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per two-year period for first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.

Customer Service Toll-Free Number: 800-955-2030  
<https://www.DeltaDentalKY.com>

- The initial installation of any prosthodontic service is not a Covered Service to replace missing teeth that were lost before coverage began.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

**Deductible – Delta Dental PPO Dentist** - \$25 Deductible per person total per Benefit Year limited to a maximum Deductible of \$75 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

**Delta Dental Premier Dentist or Nonparticipating Dentist** - \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

**Maximum Payment** – \$1,000 per person total per Benefit Year on all services, except cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth). \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

**Dependent Age Limit** – Dependents are covered up to age 26.

**Waiting Period** – There is a 12-month waiting period for certain services. Major Restorative Services, Relines and Adjustments, Fixed Prosthodontic Repair, Prosthodontic Services, and Orthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months.

**Eligible People** – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

**This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflict with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages above are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.\***

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**Delta Dental of Kentucky**  
Renewal Rates for WHITLEY COUNTY BOARD OF EDUCATION #DU7693  
Effective October 1, 2019

<b>Rates</b>		
Rates per subscriber per month	Current Rate(s)	Renewal Rate(s)
	October 1, 2018 through September 30, 2019	October 1, 2019 through September 30, 2020
Subscriber only	\$18.80	\$19.46
Subscriber with one dependent	\$38.35	\$39.69
Subscriber with two or more dependents	\$71.44	\$73.94

**Rating Requirements**

Tied to medical: No

Subscribers and eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, they may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Dependents may only enroll if the Subscriber is enrolled (except under COBRA) and must be enrolled in the same plan as the Subscriber. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

**Rating Assumptions**

Rates do not include any applicable claims taxes. The rates are valid only for the effective date noted above and are guaranteed for a one year contract.

Self-billing is not allowed and you agree to pay as invoiced each month.

Subscriber materials which are produced by Delta Dental will be updated and provided when plan changes apply and are always available to view or print at <https://www.DeltaDentalKY.com>.

Printed dentist directories are not included. You can find participating dentists on our website at <https://www.DeltaDentalKY.com>.

The plan specifications are subject to Delta Dental's standard exclusions and limitations, including:

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- Prophylaxes (cleanings) are payable twice per benefit year. Two additional periodontal maintenance procedures are payable per benefit year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
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