

We've Got You Covered!

Individual and Family Dental Plans – EHB Certified



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.
- EyeMed 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.
- EyeMed discount vision benefits are included at no additional cost.
- Amplifon discount hearing-aid benefits are included at no additional cost.

Delta Dental PPO Benefits Including EHB Standard Plan

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

	PPO Dentist Plan Pays	Premier/Nonparticipating Dentist Plan Pays
Preventive and Diagnostic		
Exams and cleanings (limited to 2 in a benefit period)	100%	80%
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%
Brush Biopsy – to detect oral cancer	100%	80%
Radiographs – X-rays	100%	80%
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%
<p>*Replacement of teeth missing prior to the effective date of this plan is not covered.</p> <ul style="list-style-type: none"> 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

	PPO Dentist Plan Pays	Premier/Nonparticipating Dentist Plan Pays
Preventive and Diagnostic		
Exams, cleanings, fluoride and space maintainers	100%	80%
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%
Sealants – to prevent decay to permanent teeth	100%	80%
Radiographs – X-rays	100%	80%
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%
Orthodontic Services		
Orthodontic Services – braces when medically necessary	50%	50%
<ul style="list-style-type: none"> 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. 		

Delta Dental Premier Benefits Including EHB Standard Plan

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

	Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays
Preventive and Diagnostic		
Exams and cleanings (limited to 2 in a benefit period)	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%
Radiographs – X-rays	100%	100%
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%
<p>*Replacement of teeth missing prior to the effective date of this plan is not covered.</p> <ul style="list-style-type: none"> 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

	Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays
Preventive and Diagnostic		
Exams, cleanings, fluoride and space maintainers	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%
Sealants – to prevent decay to permanent teeth	100%	100%
Radiographs – X-rays	100%	100%
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%
Orthodontic Services		
Orthodontic Services – braces when medically necessary	50%	50%
<ul style="list-style-type: none"> 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. \$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. 		

"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 contact:

Jason Young
(859) 263-2301
jason@vfgbenefits.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 1-1-2016 through 12-1-2016

**Monthly Premium
(Bank draft or credit card)**

Contract Type	Delta Dental PPO Monthly Premium	Delta Dental Premier Monthly Premium
Single	\$28.24	\$33.05
Single plus Spouse	\$56.47	\$66.10
Single plus Child(ren)	\$63.02	\$72.91
Family	\$98.89	\$114.70

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

Contract Type	Delta Dental PPO Discounted Annual Premium	Delta Dental Premier Discounted Annual Premium
Single	\$328.68	\$384.72
Single plus Spouse	\$657.36	\$769.44
Single plus Child(ren)	\$733.56	\$848.76
Family	\$1,151.04	\$1,335.00

****If you choose to pay annually, your premium is less than the total premium paid monthly.***

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

How to find a Delta Dental participating provider

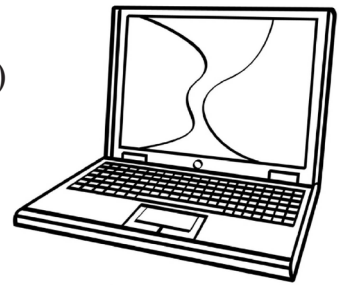
First, determine the Delta Dental plan(s) you are looking at for your dental benefits.

- ▶ **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.

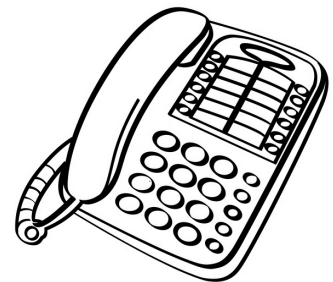


Mobile App

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.



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: Is a deposit needed with the application?

A: 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: There is no enrollment fee.

Q: Is there a monthly fee in addition to the premium?

A: 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. About 60% of practicing dentists in Kentucky participate with this 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.

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. For effective dates of 2/1 through 12/1, your initial Benefit Period will be less than 12 months and start over the January of the following year. If your coverage ends earlier, the Benefit Period ends at the same time.

(Continued on back)

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: Full-time students 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 or implants are not covered.

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.

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.

If you have additional questions please call:

Jason Young
VFG Benefit Solutions
(859) 263-2301 (Office)
(859) 263-2302 (Fax)
jason@vfgbenefits.com
www.vfgbenefits.com

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



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 join 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 Jason Young and VFG Benefit Solutions, (859) 263-2301**



Individual and Family Plan – EHB Certified 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.

Social Security Number		Name – First		Middle	Last		
Gender M or F	Date of Birth MM DD YY	Home Address – Number and Street			City	State KY	Zip
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.

First	Middle	Last	SSN (Required)	Date of Birth			Gender	
				MM	DD	YY	M	F
Spouse/Domestic Partner								
Dependent								
Dependent								
Dependent								
Dependent								

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

Have you had prior 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 vfgbenefits.com

or

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

**Delta Dental of Kentucky
c/o Jason Young, VFG Benefit Solutions
131 Prosperous Place, Suite 14A
Lexington, KY 40509**

You may email your enrollment form to jason@vfgbenefits.com or fax to (859) 263-2302.

Delta Dental of Kentucky reserves the right to assign effective dates.

FOR AGENT USE ONLY (IF YOU DO NOT HAVE AN AGENT REPRESENTING YOU, PLEASE LEAVE BLANK.)

Agent Name (printed)	
Jason Young	
Agent Email	Agent Phone Number
jason@vfgbenefits.com	(859) 263-2301
Agent Signature	Date

SHADED AREA BELOW FOR OFFICE USE ONLY

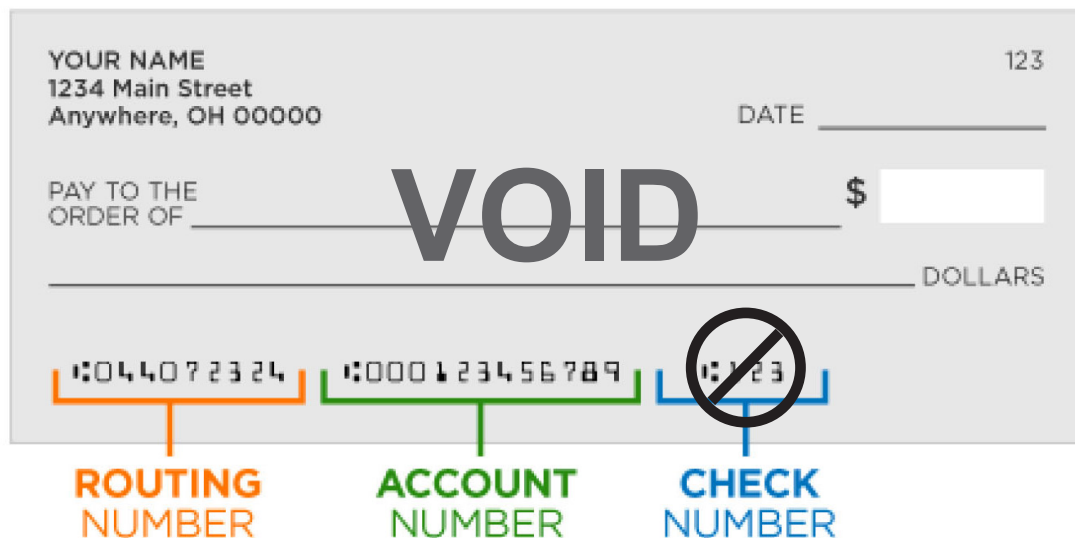
Effective Date	Process Date	Processed By
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DID YOU KNOW?

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: _____



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!

1.888.832.1867

www.amplifonusa.com/deltadentalky

Accessing your benefits is as easy as...

- 1** Call Amplifon at **1.888.832.1867** and a Patient Care Advocate will assist you in finding a hearing care provider near you.
- 2** Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
- 3** Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.



©Registered Marks Delta Dental Plans Association
©2015 Amplifon Hearing Health Care, Corp.
2591MISC/DDKY

HearPO has changed its name to Amplifon Hearing Health Care.



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 **1.888.832.1867** today!

*This is not health insurance.

Special money saving offer!



Call today for your **FREE** hearing screening appointment!

Please bring this offer with you to your appointment.

Call **1.888.832.1867** today!

Hurry! Offer expires on March 31st, 2016!

This is not a medical exam and is only intended to assist with amplification selection.



See better – live better

Delta Dental Vision provided by EyeMed Vision Care

Your eyes say a lot about you – from your emotions to vision and your overall health. And, when you're proactive about protecting your eyes, the impact is clear.

Regular eye exams not only correct vision problems, they also can reveal early warning signs of more serious health conditions such as hypertension, cardiovascular disease and diabetes. So, schedule exams annually and you'll be set on a path to better health.

Keep on saving

You can use your EyeMed discount as often as you like, all year long, on nearly all your vision care purchases at EyeMed's participating providers.

Visit eyemed.com to learn more

Need to locate a provider? Want to learn about vision wellness? Visit eyemedvisioncare.com/deltadental.



Locate a provider

You love choices – and so do we. That's why our network has thousands of independent doctors and retail providers.



Schedule an appointment

Call ahead or stop by one of the many providers that offer walk-ins. Most also have evening and weekend hours to fit any schedule.



Show your ID card

When you arrive, let the provider know you have an EyeMed discount through Delta Dental.

Please note your discount cannot be combined with any other discounts, coupons or promotional offers.

DELTA DENTAL

Member/Patient Services:
1.866.246.9041
ACCESS DISCOUNT PLAN
DELTA DENTAL
Discount Plan#: 9231093

Signature: _____

This is not insurance.
Dependents are eligible.



Please detach carefully at perforation and keep card in your wallet.

Delta Dental

Discount plan
Access network
Discounted exam and a defined materials discount

Vision care services	Member cost
Exam and dilation as necessary	\$5 off routine exam \$10 off contact lens exam
Complete pair of glasses purchase*: Frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard plastic lenses: Single Vision\$50 Bifocal\$70 Trifocal\$105	
Frames	35% off retail price
Lens options: UV treatment\$15 Tint (solid and gradient)\$15 Standard plastic scratch coating\$15 Standard polycarbonate\$40 Standard progressive lens (Add-on to bifocal)\$65 Standard anti-reflective coating\$45 Other add-ons and services20% off retail price	
Contact lens materials: (Discount applied to materials only) Disposable0% off retail price Conventional15% off retail price	
Laser vision correction**: LASIK or PRK15% off retail price or 5% off promotional price	
Frequency: ExaminationUnlimited FrameUnlimited LensesUnlimited Contact lensesUnlimited	

THIS IS NOT INSURANCE

*Items purchased separately will be discounted 20% off of the retail price.

**Since LASIK and PRK vision corrections are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your location. For a location near you and the discount authorization, please call 1.877.5LASER6.

Member will receive a 20% discount on those items purchased at participating providers that are not specifically covered by this discount. The 20% off discount does not apply to EyeMed providers' professional services or contact lenses. Retail prices may vary by location. All discounts cannot be combined with any other discounts or promotional offers.

This discount design is offered with the EyeMed Access panel of providers.



**EyeMed Member/
Patient Services:**
 Visit eyemed.com or call
 the number on the front
 of this card.
**EyeMed Doctors/
Providers Only:**
 Visit eyemed.com to
 receive plan information
 or authorization online
 or call 1.800.521.3605.








Limitations/Exclusions:

- 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
- Discount is not available on those frames where the manufacturer prohibits a discount

Visit eyemedvisioncare.com/deltadental for more information or to locate a provider near you.