Dear IBEW 369 Member:

Welcome to Delta Dental of Kentucky!

We are excited about our partnership with the International Brotherhood of Electrical Workers Local 369 for your dental and vision benefit needs.

The Delta Dental PPO™ dental plan offers you lower rates and a network of over 1,400 participating dentists throughout Kentucky. A DeltaVision® plan, administered by VSP, will also be available for purchase with or without the dental plan.

The following enclosed materials will help further explain the dental and vision options:

- IBEW Local 369 Dental Plan Benefit Summary
- IBEW Local 369 Vision Plan Benefit Summary
- Rate Sheet with Monthly Premium options
- How to find participating Dental and Vision providers
- IBEW Local 369 Dental/Vision Enrollment Form
- Bank Draft Enrollment

You can enroll in two ways:

1. **Call Nelson Insurance at 502-736-7000 and enroll over the phone**
2. **Visit ky.deltadental.com/IBEW to enroll online**
3. **Complete the enclosed paper application and return to:**
   Delta Dental of Kentucky, Inc.
   ATTN: IPU
   PO Box 242810
   Louisville, KY 40224

If you have questions after reviewing this information, please call **502-736-7000**.

Delta Dental of Kentucky is looking forward to serving you.

Sincerely,

Delta Dental of Kentucky

IBEW Local 369
Delta Dental Plan Option

What the plan pays: This is 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 PPO™	
	Network *(Percent of Allowable Amount)*	**Out-of-Network** *(Percent of Allowable Amount)*
Preventive & Diagnostic		
▸ Exams (initial, periodic, and emergency; limited to 2 in a benefit period)	100%	80%
▸ Bitewing x-rays (limited to 1 in a benefit period)	100%	80%
▸ Full-mouth or panoramic (limited to 1 in a 5 year period)	100%	80%
▸ Cleanings (limited to 2 in a benefit period)	100%	80%
▸ Pulp Vitality Test	100%	80%
▸ Emergency Treatment (relief of pain)	100%	80%
Minor Services		
▸ Routine Fillings	80%	60%
▸ Stainless Steel Crowns	80%	60%
▸ Sedative Filling (relief of pain)	80%	60%
▸ Pin Retention	80%	60%
▸ Crown Repair	80%	60%
▸ Simple denture repairs to an existing denture or partial	80%	60%
▸ Oral Surgery	80%	60%
Major Services*		
▸ Crowns (permanent; limited to once per tooth in 5 years)	50%	50%
▸ Recement Crown	50%	50%
▸ Crown Build-up	50%	50%
▸ Root Canal and Pulp Therapy (excluding final restoration)	50%	50%
▸ Periodontal Procedures	50%	50%
▸ Dentures (complete and partial)*	50%	50%
▸ Denture repairs for adding a tooth or clasp to an existing denture or partial*	50%	50%
▸ Bridges*	50%	50%
Orthodontics Services*	50%	50%

To enroll, please complete the enrollment form and include payment in the envelope provided.

There is a 12-month waiting period on Major and Orthodontic Services. Replacement of teeth missing prior to the effective date of this plan is not covered.
Deductibles: No deductible for Preventive & Diagnostic Services. $50 individual/$150 family deductible per year for Minor and Major Services.
Plan pays a maximum of $1,000 per member, per year for covered services. Only the services listed above will be covered. Plan pays a lifetime of $1,000 for orthodontic services.
Dependents covered through age 26 (non-orthodontics). Dependents covered through age 19 for orthodontics.
This is not a contract. Covered services are subject to the limitations, exclusions, and other terms and conditions of the member certificate. A complete description of covered services can be found in the member's certificate booklet.

Delta Dental of Kentucky
ky.deltadental.com | 800-955-2030

® Registered Mark of Delta Dental Plans Association
Underwritten by Delta Dental of Kentucky, Inc.

DELTA DENTAL®

VSP® Vision care for life

IBEW 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 eyecare 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!

ky.deltadental.com/IBEW | (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

IBEW DeltaVision®

Benefit	Description	Copay
WellVision Exam		
Exams 1 exam every 12 months	Comprehensive eye exam to ensure overall visual wellness	$20
Prescription Glasses		$20
Frames 1 pair every 24 months	$120 allowance for wide selection of frames 20% savings on amount over 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
Optional Lens Enhancements	Standard Anti-Reflective Coating Standard, Premium, Custom Progressive Lenses Photochromic Lenses Scratch -resistant coating Average savings of 25-30% on other lens enhancements	$41 $55 - $175 $70 - $82 $17
Contact Lenses - instead of glasses		
Contacts every 12 months	$120 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	up to $60
Extra Savings		
Featured Frames	$140 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	
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

VSP Choice Network
38,000 preferred providers - 91,000 Access Points

DELTA DENTAL®

IBEW Local 369
Rate Sheet

Rates for effective dates of 11-1-2019 through 10-1-2020

Monthly Premium
(Bank Draft or Credit Card)

Contract Type	Delta Dental PPO Plus DeltaVision Monthly Premium	Delta Dental PPO Only Monthly Premium	DeltaVision Only Monthly Premium
Employee only	$29.40	$24.94	$9.24
Employee plus Spouse	$65.78	$56.88	$9.24
Employee plus Child(ren)	$57.42	$47.90	$9.24
Family	$90.06	$80.82	$9.24

Annual Premium
(Check, Money Order, or Credit Card)

Contract Type	Delta Dental PPO Plus DeltaVision Annual Premium	Delta Dental PPO Only Annual Premium	DeltaVision Only Annual Premium
Employee only	$352.80	$299.28	$110.88
Employee plus Spouse	$789.36	$682.56	$110.88
Employee plus Child(ren)	$689.04	$574.80	$110.88
Family	$1,080.72	$969.84	$110.88

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.

IBEW 9/17 Rev. 9/19

® Registered Marks Delta Dental Plans Association

DELTA DENTAL®

Delta Dental of Kentucky
Find a Dental or Vision Provider

How to find a Delta Dental participating provider:

First, determine the Delta Dental plan(s) you are looking at for your dental benefits and then search using the methods below:

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.)

Delta Dental PPO Plus Premier™ – In-network benefits are available through providers who participate in the Delta Dental PPO or Delta Dental Premier network. (See your benefit summary for specific coverage levels by network.)

DeltaCare® USA – Benefits are only available through providers who participate in the DeltaCare network.

Internet
Visit ky.deltadental.com and request the information by city, state, zip code, provider's name or specialty.

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.

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.

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.

Customer Service
Call VSP customer service representatives at 800-877-7195 and ask if your provider is participating in the VSP Choice Network.

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.

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.

®Registered Mark of Delta Dental Plans Association

DELTA DENTAL®

IBEW Local 369 Enrollment Form

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

☐ **Delta Dental PPO™ Dental Coverage with DeltaVision® Included**

☐ **Delta Dental PPO Dental Coverage Only**

☐ **DeltaVision Only**

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

Social Security Number	Name – Last	First	MI	Home Phone ( )	
Sex (Circle one) M or F	Date of Birth MO DAY YR	Home Address – Number and Street	City	State KY	Zip
Email Address			Phone Number		

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

❑ **Employee only** ❑ **Employee plus Spouse** ❑ **Employee plus Child(ren)** ❑ **Family**

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

Last	First	MI	Date of Birth MO	DAY	YR	Sex M	F
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

Dependents covered through age 26.

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 in the **1st 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 required. Please review your enrollment form for errors or omissions.

® Registered Marks Delta Dental Plans Association

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 ______________________________

Call 502-736-7000 to enroll over the phone

or

Complete this enrollment form and mail to:

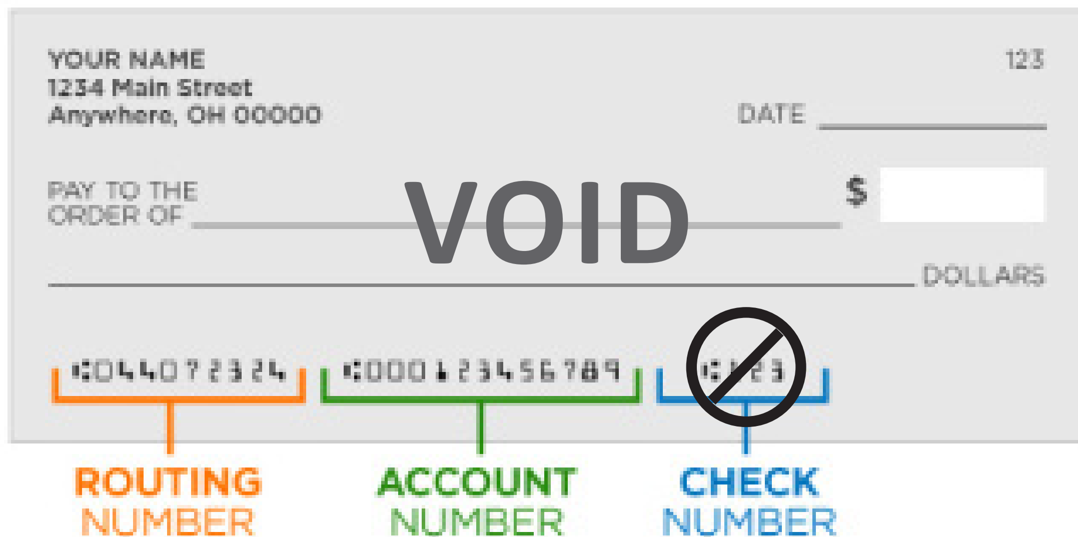
Delta Dental of Kentucky, Inc.
ATTN: IPU
PO Box 242810
Louisville, KY 40224

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: _______________________