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 Delta Dental PPO™ Basic plan. 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 PPO Basic 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

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

# KRTA
# Benefit Plan Options

| | Option A - PPO<br>Delta Dental PPO™ Participating Dentist (Non-participating Dentist) | Option B - PPO+<br>Delta Dental PPO Plus Premier™ | Option C - PPO Basic<br>Delta Dental PPO™ Participating Dentist (Non-participating Dentist) |
|---|---|---|---|
| **Preventive and Diagnostic (Deductible does not apply)** | | | |
| Oral examination (limited to 2 per calendar year) | 100% (75%) | 100% | 100% (75%) |
| Emergency Exam | 100% (75%) | 100% | 100% (75%) |
| Palliative emergency treatment | 100% (75%) | 100% | 100% (75%) |
| Periapical, bitewing, panoramic or complete series x-ray | 100% (75%) | 100% | 100% (75%) |
| Topical fluoride application (up to age 19) | 100% (75%) | 100% | 100% (75%) |
| Routine cleanings | 100% (75%) | 100% | 100% (75%) |
| Sealants (up to age 16) | 100% (75%) | 100% | 100% (75%) |
| Space maintainers (up to age 11) | 100% (75%) | 100% | 100% (75%) |
| **Minor Services** | | | |
| Routine Fillings (including composites) | 50% (25%) | 50% | Not Covered |
| Simple extractions | 50% (25%) | 50% | Not Covered |
| Periodontic services | 50% (25%) | 50% | Not Covered |
| **Major Services**** | | | |
| Inlays or crowns | 50% (25%) | 25% | Not Covered |
| Prosthetic services (bridges, dentures and partials) | 50% (25%) | 25% | Not Covered |
| Root canal therapy | 50% (25%) | 25% | Not Covered |
| Oral surgery | 50% (25%) | 25% | Not Covered |
| Simple denture repair | 50% (25%) | 25% | Not Covered |
| Implants | 50% (25%) | 25% | Not Covered |
| | | | |
| Deductibles | $50 Individual<br>$150 Family | $50 Individual<br>$150 Family | $0 Individual<br>$0 Family |
| Benefit Period Maximum<br>(Diagnostic & Preventive services are excluded from the maximum) | $1,500 | $1,500 | N/A |

Dependents covered up to the end of the year they turn 26.

* Option A & C: 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.

** There is a 12 month waiting period for all Major Services. A credit to waive the waiting period can be applied with proof of prior dental coverage. Prior dental coverage must be for 12 months with no lapse and no more than 60 days since policy termed.

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 | ky.deltadental.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**<br>1 exam every 12 months | Comprehensive eye exam to ensure overall visual wellness | $10 |
| **Prescription Glasses** | | $25 |
| **Frames**<br>1 pair every 24 months | $130 Frame Allowance (including Walmart/Sam's Club)<br>20% savings on amount over allowance<br>$70 Costco frame allowance | Included in Prescription Glasses Copay |
| **Lenses**<br>1 pair every 12 months | Single vision, lined bifocal and lined trifocal lenses<br>Polycarbonate lenses for children | Included in Prescription Glasses Copay |
| **Covered Lens Enhancements** | Standard Progressive Lenses | $0 |
| **Optional Lens Enhancements** | Standard Anti-Reflective Coating<br>Premium Progressive Lenses<br>Custom Progressive Lenses<br>Average savings of 20-25% on other lens enhancements | $41<br>$95 - $105<br>$150 - $175 |
| **Contact Lenses - instead of glasses** | | |
| **Contacts**<br>every 12 months | $130 allowance for contacts; copay does not apply<br>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<br>Frame - up to $70<br>Single Vision Lenses - up to $30 | Lined Bifocal Lenses - up to $50<br>Lined Trifocal Lenses - up to $65<br>Lenticular Lenses - up to $100 | Progressive Lenses - up to $50<br>Contacts - up to $105<br>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 7-1-2024 through 6-30-2025***

## 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® | Delta Dental PPO™ Basic | Delta Dental PPO™ Basic with DeltaVision |
| **Member Only** | $36.60 | $48.29 | $38.25 | $49.94 | $18.46 | $30.15 |
| **Member plus One Dependent** | $70.25 | $87.20 | $73.46 | $90.41 | $35.44 | $52.39 |
| **Member plus Two or more Dependents** | $120.77 | $151.17 | $126.23 | $156.63 | $60.93 | $91.33 |

***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® | Delta Dental PPO™ Basic | Delta Dental PPO™ Basic with DeltaVision |
| **Member Only** | $439.20 | $579.48 | $459.00 | $599.28 | $221.52 | $361.80 |
| **Member plus One Dependent** | $843.00 | $1,046.40 | $881.52 | $1,084.92 | $425.28 | $628.68 |
| **Member plus Two or more Dependents** | $1,449.24 | $1,814.04 | $1,514.76 | $1,879.56 | $731.16 | $1,095.96 |

***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 | ky.deltadental.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

KENTUCKY RETIRED TEACHERS ASSOCIATION

Requested Effective Date: _____

## 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 - Delta Dental PPO Basic
- ❑ Option CV - Delta Dental PPO Basic 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 26.

## 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**

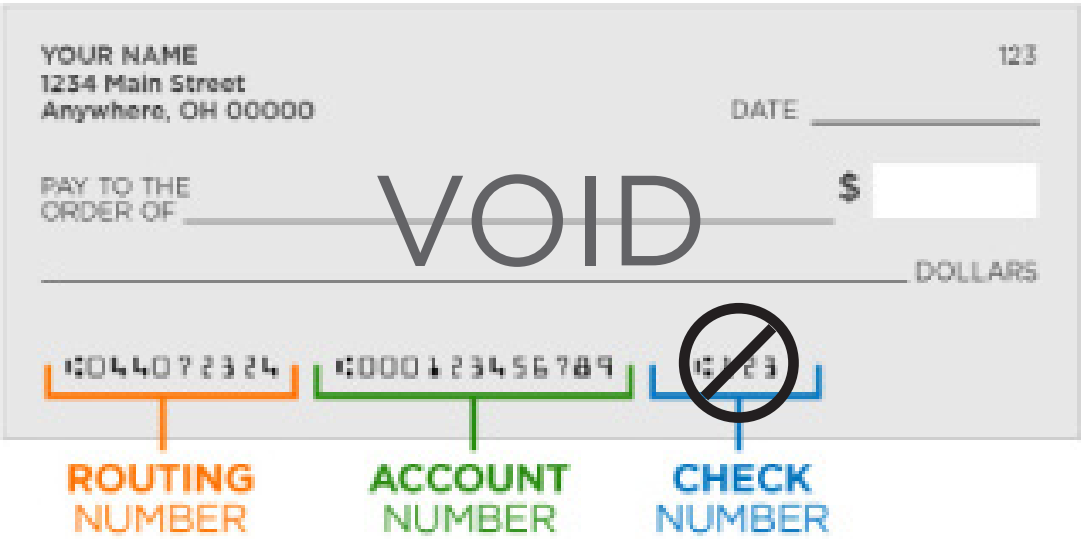
*Delta Dental of Kentucky has provided more than $20 million to Non-profits across Kentucky since 2003.*

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:_____

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** | **Delta Dental PPO** | • Most significant network discounts<br>• More than 112,000[1] participating providers nationwide<br>• No balance billing on covered services<br>• Providers file claims for you |
| *YOUR PLAN* → | **Delta Dental Premier** | • More than 153,000[1] participating providers nationwide<br>• No balance billing on covered services<br>• Providers file claims for you |
| **OUT-OF-NETWORK** | **Out-of-network** | • May be balance billed<br>• May not receive discounts<br>• 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.*

DELTA DENTAL®

# 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**

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


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!