

Delta Dental Premier

Eastern Kentucky University DeltaPremier Dental Program <i>Benefit Period - January 1, 2009 through December 31, 2009</i>				
	Option 1	Option 2		
Deductibles	<i>Dependents covered to age 19, full-time students to age 24.</i>			
Individual	\$50	\$50		
Family	\$150	\$150		
Maximum Benefits per Covered Person each Benefit Period	\$1,500	\$1,500		
Ortho Lifetime Maximum	No Coverage	\$1,000		
Waiting Period	<i>Replacement of teeth missing prior to the effective date is not covered</i>			
New Enrollees	None	6-months - Major & Ortho Services		
Prior Coverage (12months)	None	None		
Covered Services	Reimbursement Amounts			
Preventative	Option 1	Option 2		
Oral Examination	100% of the Allowable Amount	100% of the Allowable Amount		
Palliative Emergency Treatment				
Periapical, Bitewing, Panoramic or Complete Series X-ray				
Topical Fluoride Application				
Prophylaxis			Deductible Does Not Apply (limits may apply)	Deductible Does Not Apply (limits may apply)
Sealants				
Space Maintainers				
Minor Services	Option 1	Option 2		
Routine Fillings	80% of the Allowable Amount	80% of the Allowable Amount		
Simple Extractions				
Root Canal Therapy				
Simple Denture Repair			Subject to Deductible	Subject to Deductible
Oral Surgery				
Major Surgery	Option 1	Option 2		
Inlays or Crowns	Periodontic Services are covered at 80%; All other services are not covered	50% of the Allowable Amount		
Prosthetic Services				
Periodontic Services		Subject to Deductible		
Orthodontic Services	Option 1	Option 2		
Diagnosis & Treatment Plan	Not Covered	50% of the Allowable Amount		
Minor Treatment for Tooth Guidance				
		Deductible Does Not Apply		
		\$1000		
		Lifetime Maximum for Covered Dependents Under Age 19		

	Monthly Cost	(20 Pays)	(24 Pays)
Employee Only	\$19.71	\$11.83	\$9.86
Employee+Spouse	\$40.18	\$24.11	\$20.09
Employee+Child(ren)	\$37.91	\$22.75	\$18.96
Employee+Family	\$62.33	\$37.40	\$31.17

	Option 2 Monthly Cost	Faculty (20 Pays)	Semi-Mo. (24 Pays)
Employee Only	\$31.53	\$18.92	\$15.77
Employee+Spouse	\$61.76	\$37.06	\$30.88
Employee+Child(ren)	\$67.13	\$40.28	\$33.57
Employee+Family	\$107.76	\$64.66	\$53.88

*bi-weekly payrolls can only be deducted 24 pay periods

This dental program should reduce the financial burden of the rising cost of dental care. It is designed to help cover the cost of quality dental treatment by combining the positive aspects of preventive dentistry with the convenience of prepayment.

NOTE: Dentists who have signed participating agreements with Delta Dental Plan of Kentucky agree to accept the Allowable Amount as payment in full for Covered Services as these terms are defined in the Certificate of Coverage. Each Covered Person is responsible for the amount of Coinsurance, Deductible, and charges for non-covered services.

Dentists who have not signed a participation agreement may bill you directly for any amount in excess of the Delta Dental Allowable Amount.

Certain procedures require pre-authorization and/or are subject to limitations.