

**Dental Insurance Premium Cost**  
**City of Wichita**  
**2015**

<b><u>Plan</u></b>	<b><u>Preferred</u></b> Total Monthly Premium	<b><u>Traditional</u></b> Total Monthly Premium
Single	\$23.30	\$29.12
Single +1	\$41.34	\$55.02
Family	\$69.54	\$89.72

Dependent children may stay on your dental insurance through age 26, regardless of student status. If your dependent has already been removed from dental insurance due to the previous age limit, employees must fill out the enrollment form during Open Enrollment to re-enroll him or her. No dependents will be reinstated automatically.

Employees enrolled in Dental Insurance should check with their provider to ensure they accept the Dental Plan that you have selected.

Reminder: Employees have **30** days from a related qualifying event to make changes to their enrollment. The changes must be in writing.

## Summary of Dental Plan Benefits

CITY OF WICHITA

Group #399

Effective for January 1, 2015

### Maximum Contract Benefit Per Person:

The Maximum Benefit for all Covered Services for each Enrollee in any one Contract Year is: One Thousand Dollars (\$1,000.00).

The Maximum Benefit for Orthodontic Services for each Enrollee is: One Thousand Dollars (\$1,000.00) during such person's lifetime.

Payment for the Orthodontic Services shall not be included in determining the Maximum Benefit for each Contract Year.

### Deductible Limitations:

Coverage for diagnostic and preventive services is not subject to any deductible amount. For all other covered benefits, the Contract Year deductible is:

\$50 x 3

### Dependent Ages:

Dependents are covered to age twenty-six (26).

\* Benefits will increase from the Base Level to the Incentive Level if the member receives an exam and/or cleaning at least one (1) time in twelve (12) months. Benefits will increase to the Incentive Level ninety (90) days after a cleaning and/or exam. Benefits for new members will begin at the Incentive Level. After twelve (12) months, benefit levels will be determined by the date of the last Diagnostic or Preventive treatment.

### Monthly Rates:

Employee:	\$29.12
Employee+1:	\$55.02
Family:	\$89.72

\*Using a non-participating provider may result in higher out of pocket expenses. Refer to your benefit booklet for further information.

Benefit % Paid			
Base Level	Incentive Level	*Delta Dental PPO/Premier	
100%	100%		<b><u>DIAGNOSTIC &amp; PREVENTIVE</u></b> (Not subject to deductible)
		<b>Diagnostic:</b>	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> <li>* <u>Oral examinations</u> – once (1) each six (6) months.</li> <li>* <u>Diagnostic x-rays</u> – bitewings once (1) each six (6) months for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over.</li> <li>* <u>Full mouth x-rays or panoramic x-rays</u> – once (1) each five (5) years.</li> </ul>
100%	100%	<b>Preventive:</b>	Provides for the following: <ul style="list-style-type: none"> <li>* <u>Prophylaxis</u> (Cleanings) - once (1) each six (6) months.</li> <li>* <u>Topical Fluoride</u> – once (1) each six (6) months for dependent children under age nineteen (19).</li> <li>* <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars.</li> <li>* <u>Sealants</u> – once (1) per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.</li> </ul>
			<b><u>BASIC</u></b> (Subject to Deductible)
60%	80%	<b>Ancillary:</b>	Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
60%	80%	<b>Oral Surgery:</b>	Provides for extractions and other oral surgery including pre and post-operative care.
60%	80%	<b>Regular Restorative:</b>	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
60%	80%	<b>Endodontics:</b>	Includes procedures for root canal treatments and root canal fillings.
60%	80%	<b>Periodontics:</b>	a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis. b. Surgical periodontal procedures.
			<b><u>MAJOR</u></b> (Subject to Deductible)
40%	50%	<b>Special Restorative:</b>	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
40%	50%	<b>Prosthodontics:</b>	Includes bridges, partial and complete dentures, including repairs and adjustments.
			<b><u>ORTHODONTICS</u></b> (Subject to Deductible)
50%	50%	<b>Orthodontics:</b>	Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age nineteen (19).

*This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Please refer to the Description of Dental Care Coverage for complete coverage information, including exclusions and limitations. Coverage as described in the employer group's Agreement to Provide Dental Benefits (contract) is binding on all parties and supersedes all other written or oral communications.*



## Welcome to Delta Dental of Kansas



With Delta Dental of Kansas you receive the expertise of the largest, most experienced dental benefits carrier in the nation, paired with our unparalleled customer service. Together with your employer, we have designed a dental benefit plan to help protect the oral health of you and your covered dependents. Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to your overall well-being.

### Network Strength

You are free to go to any dentist of your choice; however, there may be a difference in the amount of payment if the dentist is not a Delta Dental participating dentist. It is to your advantage to choose a **Delta Dental PPO** or **Delta Dental Premier** dentist. Since nearly 4 out of 5 dentists nationwide contract with Delta Dental, the chances are excellent your dentist is already a member. If you have any questions about whether your dentist participates with Delta Dental, contact Customer Service at **(316) 264-4511** or toll-free at **(800) 234-3375**. You may also locate a dentist using the 'Locate a Dentist' link at [www.deltadentalks.com](http://www.deltadentalks.com).

### Website Capabilities

From our website, [www.deltadentalks.com](http://www.deltadentalks.com), you can:

- Locate a participating **Delta Dental PPO** or **Delta Dental Premier** dentist anywhere in the United States
  - Go to [www.deltadentalks.com](http://www.deltadentalks.com)
  - Click on 'Subscribers' across the top of the page
  - Under 'Locate a Dentist', click on 'Dentist Search' then 'Find a Dentist'
  - #1 - 'Product Selection', click on '**Delta Dental PPO**' or '**Delta Dental Premier**'
  - #2 - 'Your Location', type in either your city and state OR your zip code
  - You may also sort the number of results, enter your dentist's name or choose by specialty
  - Click on 'Search for a Dentist'
- Check your eligibility and plan information
- Print an ID card
- Check claim status
- Estimate your out-of-pocket dental care costs with the Flexible Spending Account Estimator
- Sign-up to receive your Explanation of Benefits electronically
- Learn about oral health and wellness

# Enrollment/Change Form

**Check One:**

- New Application for Coverage
- Change Authorization
- Waiver of Coverage (complete Section (6) ONLY)

**Section 1: EMPLOYEE INFORMATION** (Please Type or Print Legibly)

Add <input type="checkbox"/>	Social Security / ID Number:	Group Number: <b>399</b>	Employer/Group Name: (Please do not abbreviate) <b>CITY OF WICHITA-TRADITIONAL</b>		
Terminate <input type="checkbox"/>	Employee Name: (First, Middle Initial, Last)				
Home Address:		City:	State:	Zip Code:	Birth Date: (mm/dd/yy)
Single <input type="checkbox"/>	Hire Date: (mm/dd/yy)	Effective Date: (mm/dd/yy)	Type of Medical Coverage:	Medical Carrier and Address:	
Married <input type="checkbox"/>	Single <input type="checkbox"/> Family <input type="checkbox"/>				

**Section 2: DEPENDENT INFORMATION** (List ONLY eligible family members to be enrolled (affected by change))

Action:	Effective Date:	Spouse Name: (First, Middle Initial, Last)	Birth Date:
Add <input type="checkbox"/>	(mm/dd/yy)		
Terminate <input type="checkbox"/>			

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:

Action:	Effective Date:	Dependent Name: (First, Middle Initial) (Last Name, if different)	Male	Female	Birth Date:
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Add <input type="checkbox"/>	(mm/dd/yy)		<input type="checkbox"/>	<input type="checkbox"/>	
Terminate <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	

**Section 3: OTHER INSURANCE INFORMATION** (Complete ONLY if requesting coverage for dependent(s))

Are your dependents covered by another <u>dental</u> plan? <input type="radio"/> Yes <input type="radio"/> No Are your dependents covered by another <u>medical</u> plan? <input type="radio"/> Yes <input type="radio"/> No If YES, please provide spouse's Social Security #: _____ Spouse's employer: _____	Spouse Children	Dental Carrier: _____ Address: _____ Medical Carrier: _____ Address: _____
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**Section 4: CHANGES** (Please mark all appropriate boxes that apply to change(s) you wish to make)

**DELTA DENTAL OF KANSAS MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT**

DATE OF EVENT: \_\_\_\_\_

Name Change: From: \_\_\_\_\_ To: \_\_\_\_\_

Marriage  Divorce  Other: \_\_\_\_\_  Adoption/Legal Custody of Child

**Section 5: SIGNATURE / AUTHORIZATION**

I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.  
 Authorization/Signature for Enrollment/Change[s]: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 6: WAIVER OF COVERAGE** (Complete ONLY if you or your family are not enrolling for benefits)

This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer and I have decided that:

Do not want dental coverage for myself because \_\_\_\_\_

Do not want dental coverage for my spouse and/or my children \_\_\_\_\_

I understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Employee Name: (First, Middle Initial, Last) \_\_\_\_\_ Social Security #: \_\_\_\_\_