Fire Chief
Jon L. Troutman

Shepherdsville Fire Department
634 Conestoga Parkway
Shepherdsville, KY 40165

Mayor
Jose' Cubero

READ ENTIRELY BEFORE CONTINUING

Candidate,

Congratulations on taking the first step in the 2023 Shepherdsville Fire Department Recruit Firefighter Hiring Process. Please follow the following instructions when completing your application packet. Failure to follow the instructions will result in a candidate being disqualified from the process. All applications must be turned in by May 5th at 12:00 p.m. at 634 Conestoga Parkway, Shepherdsville, KY 40165. No applications will be accepted after this time. Testing will be conducted on May 13th, 2023 and interviews to follow on May 24th- May 26th, 2023. You will be notified by email at a later date, with information regarding the testing location and time and information regarding interviews. All correspondence to follow will be communicated through email. Please make sure when completing the application package to write legibly, failure to do so may result in failed communication.

Minimum Requirements

Must be 18 years of age at time of application submittance

Must poses a High School Diploma or equivalent (GED)

Must poses a valid Drivers License

Must not be convicted of a felony

Continues on page 2

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Items to be submitted in application packet:

City of Shepherdsville Employment Application- Please fill in all boxes in blue or black ink. If there is a box that is not applicable to you, please note this by simply putting "N/A". Any items left blank will be cause for disqualification. Candidates must complete the employment application in its entirety and must be legible.

KY State Police Request for Conviction Records- DO NOT SELF SUBMIT! Please fill out the form and return with the rest of the packet.

Color Copy of High School Diploma or GED- COLOR COPY,

*If you are scheduled to graduate in May or June of 2023 and have not received a copy of your diploma please note that one the **Packet Completion Checklist**. You will be required to provide a copy of your diploma by June 8th 2023

Color Copy of Drivers License- COLOR COPY

If Applicable- Color copy of CPAT Card

If Applicable- Copy of DD214 if prior military

Personal References Sheet- Must be completed with 5 personal references

Uniform Sizing Sheet- Please complete all sections

Packet Completion Checklist- Check all boxes of Items submitted and Initial

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Continues on page 3

Items and Information to keep

Anthem Blue View Vision Insurance- Information and coverage subject to change

Delta Dental Coverage- Information and coverage subject to change

City of Shepherdsville Kentucky League of Cities Health, Dental, Vision Information

IMPORTANT INFORMATION

In accordance to KRS 95A.040 all candidates must obtain a Candidate Physical Ability Testing Card, commonly known as "CPAT Card" prior to employment. Each candidate will be required to have this completed by June 8th, 2023. Listed below are several options and contacts for scheduling the CPAT.

Rick Larkins (859) 753-7282 or fccpat@kctcs.edu

April 11-12 in Paris, KY, May 9-10 in Burlington, KY, June 6-7 in Louisville, KY.

*It is advised to schedule and attempt the CPAT as soon as possible. Spots do fill up quickly. There are no cost associated with this test.

Outside state options

CPAT - Candidate Physical Ability Testing - Emergency Services Education Center (wayne.k12.in.us) * May be cost associated with any out of state CPAT Testing

Continues on page 4

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Additional information- Candidates wishing to prepare for the written may visit FPSI.com and purchase a Candidate Orientation Guide for the Firefighter Aptitude and Characteristics Test (FACT) for $15. The guide is optional, but it is a great preparatory tool that has an overview of the whole test, practice test questions with an answer key, test taking tips and more.

The written examination will be composed of 110 questions from the FACT and 85 questions from the Work Styles Inventory (WSI). This test is designed to gauge general aptitude as well as personal characteristics for working in the fire service environment.

Again, the Shepherdsville Fire Department would like to thank you and wish you good luck in the as you advance through the process.

CITY OF SHEPHERDSVILLE

634 Conestoga Parkway
P.O. Box 400
Shepherdsville KY 40165

Employment Application

APPLICANT INFORMATION

Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date Available	Social Security No.	Desired Salary	
Position Applied for		Full-time or Part-time?	

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Are you at least 18 years of age? YES ☐ NO ☐

Have you ever been convicted of a felony? YES ☐ NO ☐ If yes, explain

Have you ever worked for the City of Shepherdsville? YES ☐ NO ☐ If yes, where and when

EDUCATION

High School		Address			
From	To	Did you graduate?	YES ☐	NO ☐	Degree
College		Address			
From	To	Did you graduate?	YES ☐	NO ☐	Degree
Other		Address			
From	To	Did you graduate?	YES ☐	NO ☐	Degree

List any special skills or licenses you have:

REFERENCES

Please list three professional references.

Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	

PREVIOUS EMPLOYMENT

Company		Phone ( )
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐
Company		Phone ( )
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐
Company		Phone ( )
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐

MILITARY SERVICE

Branch	From To
Rank at Discharge	Type of Discharge
If other than honorable, explain	

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature	Date

Reference Sheet

List 5 personal references that are not related to you.

Name _____

Phone Number _____

Name _____

Phone Number _____

Name _____

Phone Number _____

Name _____

Phone Number _____

Name _____

Phone Number _____

REQUEST FOR CONVICTION RECORDS
FIRE DEPARTMENT, AMBULANCE SERVICE, RESCUE SQUAD

Pursuant to KRS 17.167, Request is made for any record of conviction found in the files of the Kentucky centralized criminal history record information system regarding the person identified herein. This information shall be released to:

Shepherdsville Fire Department 634 Conestoga Parkway Shepherdsville, KY 40165
Organization Name and Address

ACKNOWLEDGEMENT BY APPLICANT

I have applied for employment or a volunteer position with one of the following organizations: a paid or volunteer fire department (certified by the Commission on Fire Protection Personnel Standards and Education), an ambulance service (licensed by the Commonwealth of Kentucky), or a rescue squad (officially affiliated with a local disaster and emergency services organization or with the Division of Emergency Management). I am requesting that the Kentucky State Police provide the employer with any record of conviction found in the files of the Kentucky centralized criminal history record information system. I know that I have the right to inspect my criminal history record and to request correction of any inaccurate information. If I do not exercise that right, I agree to hold harmless the Kentucky State Police and any Kentucky State Police employee(s) from any claim for damages arising from the dissemination of inaccurate information.

I have applied for a position with the above stated organization.

APPLICANT INFORMATION (PLEASE PRINT)

NAME: _____ _____ _____ _____
First Middle Last Maiden

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

SEX: _____ RACE: _____ DATE OF BIRTH: ___/___/___ SOC SEC NO: _____

_____ _____ _____ _____
Signature Date Signature Date

INSTRUCTIONS:

The Requesting Agency must confirm that all application information is completed accurately and legibly.

Requests should be accompanied by two, self-addressed stamped envelopes—one bearing the name and address of the requesting agency and the other bearing the name and address of the applicant.

RETURN THIS FORM TO:

Kentucky State Police
Criminal Identifications and Records Branch
Criminal History Dissemination Section
1266 Louisville Road
Frankfort, KY 40601

Uniform Sizing Sheet

List the size needed.

T-Shirt _____

Sweatshirt _____

Sweatpants _____

Gym Shorts _____

Fitted Hat _____

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Application Completion Checklist

- City of Shepherdsville Employment Application _____
- KY State Police Request for Conviction Records _____
- Color Copy of High School Diploma or GED _____
- Graduate of 2023, Diploma to be presented by June 8th in order to proceed in the process _____
- Color Copy of Drivers License _____
- Personal References Sheet _____
- Uniform Sizing Sheet _____
- If Applicable- Color Copy of CPAT Card _____
- If Applicable- Copy of DD214 (prior military) _____

I _____ , understand that as part of the Shepherdsville Fire Department 2023 Recruit Hiring Process, it is my responsibility to schedule and complete the Candidate Physical Ability Test (CPAT) by June 8th in order to be considered for the position of Recruit Firefighter.

Payscale

Shepherdsville Fire Department

	FIREFIGHTER/EMT-B	Column1	FIREFIGHTER/EMT-A	Column2	FIREFIGHTER/Paramedic	Column3
Recruit	14.85	51,816.96				
2 Years	15.15	52,805.38	15.90	55,311.36	18.40	63,631.36
4 YEARS	15.45	53,813.56	16.22	56,369.66	18.77	64,856.06
6YEARS	15.76	54,841.91	16.54	57,449.13	19.14	66,105.26
8 YEARS	16.07	55,890.82	16.87	58,550.19	19.53	67,379.44
10 YEARS	16.40	56,960.72	17.21	59,673.27	19.92	68,679.11
12YEARS	16.72	58,052.01	17.55	60,818.82	20.32	70,004.77
14 YEARS	17.06	59,165.12	17.91	61,987.27	20.72	71,356.94
16 YEARS	17.40	60,300.50	18.26	63,179.09	21.14	72,736.16
18 YEARS	17.75	61,458.59	18.63	64,394.75	21.56	74,142.96
20 YEARS	18.10	62,639.84	19.00	65,634.72	21.99	75,577.89

City of Shepherdsville

RATES EFFECTIVE: 07/01/22 - 06/30/23
BENEFIT PLAN YEAR: 07/01/22 - 06/30/23
Group: W31747

Kentucky League of Cities

ANTHEM	Plan: HRACA03T1
	IN - NETWORK
Deductible	
Single / Family	$2,500 / $5,000
Employer Funded HRA	$1,250 / $2,500
Employee Pays	$1,250 / $2,500
Coinsurance	0%
Out-of-Pocket Maximum (Includes deductible)	
Single/Family	$4,000 / $8,000
Physician Copay	
Preferred PCP (Primary Care Physician)	$10
PCP (Primary Care Physician)	$20
SCP (Special Care Physician)	$50
Urgent Care	0%
Emergency Room	0%
Deductible Type	Non - Embedded
PRESCRIPTION DRUG PLAN	**Level 1 / Preferred In-Network Provider**
Retail (30 day supply) (Tier 1 / Tier 2 / Tier 3 / Tier 4)	$10 / $35 / $75 / 25% w/$350 Max
Mail Order (90 day supply) (Tier 1 / Tier 2 / Tier 3 / Tier 4)	$25 / $105 / $225 / 25% w/$350 Max
PRESCRIPTION DRUG PLAN	**Level 2 / Non-Preferred In-Network Provider**
Retail (30 day supply) (Tier 1 / Tier 2 / Tier 3 / Tier 4)	$20 / $45 / $85 / 25% w/$450 Max

July 1, 2022 - June 30, 2023 Monthly Premium Details

ANTHEM HRACA03T1	Monthly Premium	Employee Contribution Monthly	City Contribution Monthly	Bi-weekly Deduction
Employee	$ 489.76	$ -	$ 489.76	$ -
Employee / Spouse	$ 1,013.76	$ 52.40	$ 961.36	$ 26.20
Employee / Child(ren)	$ 870.85	$ 38.11	$ 832.74	$ 19.05
Family	$ 1,537.77	$ 104.80	$ 1,432.97	$ 52.40

ANTHEM Health HRA Contributions (Funded by Employer)	
Employee (HRA $ is prorated for any enrollment effective after 07/01/22).	$ 1,250.00
Employee/Spouse, Employee/Child(ren), Family (HRA $ is prorated for any enrollment effective after 07/01/22).	$ 2,500.00

DELTA DENTAL Option 5 Group No. M00106	Monthly Premium	Employee Contribution Monthly	City Contribution Monthly	Bi-weekly Deduction
Employee	$ 23.06	$ -	$ 23.06	$ -
Employee / Spouse	$ 45.69	$ 22.63	$ 23.06	$ 11.32
Employee / Child(ren)	$ 52.20	$ 29.14	$ 23.06	$ 14.57
Family	$ 82.68	$ 59.62	$ 23.06	$ 29.81

ANTHEM Blue View Vision Option 26	Monthly Premium	Employee Contribution Monthly	City Contribution Monthly	Bi-weekly Deduction
Employee	$ 7.02	$ -	$ 7.02	$ -
Employee / Spouse	$ 12.19	$ 5.17	$ 7.02	$ 2.59
Employee / Child(ren)	$ 12.82	$ 5.80	$ 7.02	$ 2.90
Family	$ 19.55	$ 12.53	$ 7.02	$ 6.27

Blue View Vision℠

Option 26

Anthem BlueCross BlueShield

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor.** You may also call member services for assistance at **1-866-723-0515.**

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $42 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $45 allowance	Once every 24 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses: o Single vision lenses o Bifocal lenses o Trifocal lenses	 $20 copay $20 copay $20 copay	 Up to $40 allowance Up to $60 allowance Up to $80 allowance	Once every 12 months
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
o Transitions Lenses (for a child under age 19) o Standard polycarbonate (for a child under age 19) o Factory scratch coating	$0 copay $0 copay $0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
o Elective conventional (non-disposable) OR o Elective disposable OR o Non-elective (medically necessary)	$130 allowance, then 15% off any remaining balance $130 allowance *(no additional discount)* Covered in full	Up to $105 allowance Up to $105 allowance Up to $210 allowance	Once every 12 months

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	○ Transitions lenses (Adults)
	○ Standard Polycarbonate (Adults)
	○ Tint (Solid and Gradient)
	○ UV Coating
	○ Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	○ Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	○ Other Add-ons
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	○ Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	○ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:

GLASSES.COM · contactsdirect · LensCrafters · Pearle Vision · Optical · Sears Optical · JCPenney | optical

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

DELTA DENTAL

Delta Dental of Kentucky
Delta Dental PPO plus Premier
Summary of Dental Plan Benefits

Group Name: KY League of Cities Option 5
Group Number: M00106
Benefit Year: January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Denture Repair – repairs to complete or partial dentures	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Fixed Prosthodontic Repair – to bridges	50%	50%	50%
Implant Repair – implant maintenance, repair, and removal	50%	50%	50%
Relines and Rebase – to dentures	50%	50%	50%
Adjustments to Dentures – adjustments to complete or partial dentures	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Dependent children to the end of the month of age 19		

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

Customer Service Toll-Free Number: (800) 955-2030
www.DeltaDentalKY.com

Effective 7/1/2019

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Fluoride treatments are payable once per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per two-year period for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Deductible – $25 Deductible per person total per Benefit Year limited to a maximum Deductible of $75 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

Waiting Periods-There is a 12-month waiting period for certain services. Major Restorative Services, Relines and Adjustments, Fixed Prosthodontic Repair, Prosthodontic Services, and Orthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months.

Maximum Payment – $1,500 per person total per Benefit Year on all services, except cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth). $1,500 per person total per lifetime on cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

Dependent Age Limit – Dependents are covered up to age 26.

Eligible People – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

Rates

Employee $22.61 Employee + Spouse $44.80 Employee + Child(ren) $51.17 Family $81.06

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflict with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages above are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Customer Service Toll-Free Number: (800) 955-2030
www.DeltaDentalKY.com