



DELTA DENTAL OF OKLAHOMA

2023
**FEDERALLY
COMPLIANT
DENTAL PLANS**

Checklist for New Groups

2023

When enrolling in a new group, there are several key areas essential in providing a smooth implementation. In order to better serve our clients, we have developed a checklist to aid in the process of enrolling and setting up new groups.

- Application for Group Contract completed in its entirety and signed by the person authorized to contract for the group.
- Individual enrollment form completed and signed by each employee enrolling in the dental plan. For more information on approved enrollment methods, please contact Sales@DeltaDentalOK.org.

Please mail new group submissions to:
Delta Dental of Oklahoma
Attention: Sales
P.O. Box 54709
Oklahoma City, Oklahoma 73154-1709

or send an email to:

Sales@DeltaDentalOK.org

Federally Compliant Dental Plans

Federally Compliant Plans for Groups

2023

Delta Dental PPO-Plus Premier Federally Compliant Dental plans⁺ – For the 2023 plan year, Delta Dental has two Federally Compliant Plans designed to meet ACA Pediatric Dental Essential Health Benefit standards. Our plans include the Delta Dental PPO and Premier networks for maximum network access.

Plan Information	Low Option	High Option
Annual Maximum Benefit: applies to covered persons age 19 or older	\$1,500	\$1,500
Annual Maximum Out-of-Pocket: for one covered person <u>to age 19</u>	\$375	\$375
Annual Maximum Out-of-Pocket: for two or more covered persons <u>to age 19</u>	\$750	\$750
Annual Deductible	\$75 per person	\$50 per person

Co-Insurance – The percentage Delta Dental will pay for covered services

Plan Information	Co-Insurance – Low Option	Co-Insurance – High Option
Preventive & Diagnostic Services	100% \$75 Annual Deductible applies	100% <u>No</u> Deductible
Basic Services*: Six (6) month specific benefit waiting period applies to covered persons age 19 or older	60% \$75 Annual Deductible applies	80% \$50 Annual Deductible applies
Major Services*: Twelve (12) month specific benefit waiting period applies to covered persons age 19 or older	50% \$75 Annual Deductible applies	50% \$50 Annual Deductible applies
Medically Necessary Orthodontic Services** applies to covered persons to age 19 only	50% <u>No</u> Deductible	50% <u>No</u> Deductible

⁺A minimum of two (2) enrolled individuals per plan required for participation in FCP plans.

- Processing policies, limitations and exclusions will apply for medically necessary procedures. Dependent children are eligible for coverage to age 26.
- Deductibles and Co-Insurance will apply to Maximum Out-of-Pocket.
- Maximum Out-of-Pocket does **not** apply to out-of-network services.

* **Medically Necessary Extractions** – The surgical or non-surgical removal/extraction of third molars must be medically necessary.

** **Medically Necessary** – Orthodontic treatment and/or services are only covered with orthognathic surgery cases or certain designated syndromes or genetic disorders such as cleft palate. Benefits are only allowed for medically necessary orthodontic services to help correct severe handicapped malocclusions caused by cranio-facial orthopedic deformities involving teeth.

Coverage Type	Monthly Rates Low Option	Monthly Rates High Option
Individual Only	\$26.00	\$52.00
Individual + Spouse (Couple)	\$52.00	\$104.00
Individual + 1 Dependent	\$52.00	\$104.00
Individual + 2 Dependents	\$78.00	\$156.00
Individual + 3 or more Dependents	\$104.00	\$208.00
Individual + Spouse + 1 Dependent (Family/Couple +1)	\$78.00	\$156.00
Individual + Spouse + 2 Dependents (Family/Couple +2)	\$104.00	\$208.00
Individual + Spouse + 3 or more Dependents (Family/Couple +3)	\$130.00	\$260.00

Delta Dental Program of Benefits for PPO – Plus Premier Federally Compliant Plans

Delta Dental of Oklahoma's benefits consist of Preventative & Diagnostic, Basic Services, Major Services and Medically Necessary Orthodontic services. The benefits listed below are not a complete list and do not contain any limitations. Limitations to benefits can be found in the Summary Plan Description:

Preventive & Diagnostic Services (Class I Benefits):

- Oral evaluation
- Routine prophylaxis, including cleaning and polishing
- Bite-wing and periapical x-rays
- Full-mouth x-rays
- Topical application of fluoride for eligible children
- Topical application of sealants, for eligible children only, limited to permanent first and second molars free of caries and restorations on the occlusal surface

Basic Services (Class II Benefits):

- Amalgam and composite fillings
- Stainless steel crowns, for eligible children only, when the natural teeth cannot be restored with another filling material
- Endodontics – includes pulpal therapy and root canal treatment
- Oral Surgery – non-surgical extractions; medically necessary, non-prophylactic (diseased) third molar non-surgical extractions; incision and drainage of abscess; and other coverall oral surgery procedures
- Periodontics – procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, root planning and scaling
- Anesthesia – Nitrous oxide/analgesia benefits are limited to invasive procedures (procedures that penetrate the hard or soft tissue). Nitrous oxide/analgesia is not payable with evaluations and cleanings

Major Services (Class III Benefits):

- Major Services – provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material
- Prosthodontics – procedures for constructions of fixed bridges, partial dentures and complete dentures
- Oral Surgery Services – Surgical extractions; medically necessary, non-prophylactic (diseased) third molar extractions; and other oral surgical procedures
- Occlusal guards are a benefit by report, for eligible children only, when used to prevent the destructive force of bruxism for periodontal purposes. This is a benefit if the eligible child has periodontal coverage and has had periodontal therapy or is undergoing therapy

Medically Necessary Orthodontics (Class IV Benefits):

- Orthodontic Benefits are available only with orthognathic surgery cases or certain designated syndromes or genetic disorders such as cleft palate. Benefits are only allowed for medically necessary orthodontic services to help correct severe handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth.



APPLICATION FOR GROUP CONTRACT
Delta Dental of Oklahoma – Federally Compliant Plans (FCPs)
For Plan Year 2023

This Application for Group Contract is hereby made a part of the Plan Agreement and is subject to all terms and conditions of said Agreement. This Application for Group Contract will not be accepted unless **signed and completed in its entirety**.

Step 1 – PLAN EFFECTIVE DATE: (Month) _____ 01, 2023

Step 2 – EMPLOYER INFORMATION

Legal Business Name (as it should appear on Summary Plan Description and Plan Agreement)

DBA (if applicable)

Billing/Mailing Address

City State Zip

Physical Oklahoma Address (if different from the billing/ mailing address)

City State Zip

Telephone Number

Nature of Business

Federal Tax ID Number SIC Code

ERISA Exempt: No Yes (exemption typically only applies to government employers/entities or religious institutions)

Step 3 – ELIGIBILITY AND ENROLLMENT: A minimum of two (2) enrolled individuals per plan required for participation in FCP plans.

Total Number Eligible Employees: _____

Employees are eligible for coverage on (select one):

- The date of hire The first of the month following the date of hire
- The _____ day of continuous full-time employment*
- The first of the month following _____ days of continuous full-time employment*

Is the following included with this application? (select all that apply): Enrollment Forms Electronic Enrollment Data

* Cannot exceed 90 days between first day of full-time employment and coverage start date.



Step 4 – EMPLOYER CONTRIBUTION

Employer contributes to the employee cost of the plan (select one): None A portion All

Step 5 – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

Please provide a minimum of two (2) authorized group contacts. A valid email address is required for each contact as our Federally Compliant plans are administered electronically. Enter the information for each contact that is to receive access through Online Resources, Delta Dental of Oklahoma’s (DDOK) secure benefits administration portal for eligibility maintenance, invoice reporting and payment.

Contact Type:

- **Primary Contact** – Authorized contact for all aspects of plan administration and recipient of essential plan correspondence, including plan documents, renewals, CDT changes, billing/delinquency notices, etc.
- **Secondary Contact** – Authorized contact for plan administration and recipient of plan correspondence in the event the Primary Contact cannot be contacted
- **Executive** – Authorized contact for all aspects of plan administration; should have access to billing and eligibility online.
- **Billing** – Authorized contact for billing inquiries; should have access to view and pay invoices online
- **Eligibility** – Authorized contact for eligibility and enrollment inquiries; should have access to enrollment online as indicated (view only or modify)

Eligibility Access:

- **View only** – Contact should have read-only access to online eligibility
- **Modify** – Contact should have ability to make changes through online eligibility

Primary Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify
Secondary Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify
Additional Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify
Additional Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify

An authorized representative for the Employer must approve access to information on this account for the person(s) named above, and for receipt of the monthly billing from Delta Dental via the above selected option. Further, the authorized representative for the Employer must submit written notification to Delta Dental of Oklahoma if a user’s access to Online Resources needs to be terminated or access should be provided to additional persons. A Group Change Form is available on Online Resources and the authorized representative for the Employer may submit completed forms to ClientRelations@DeltaDentalOK.org.



Step 6 – FULLY INSURED PLAN OPTIONS AND PLAN SELECTION (select all that apply)

Plan Year: Calendar

MONTHLY RATES FOR <i>COMBINED</i> PLANS	<input type="checkbox"/> Low Option	<input type="checkbox"/> High Option
Ages 0 – 20 (Per Covered Person)	\$26.00	\$52.00
Ages 21 and older (Per Covered Person)	\$26.00	\$52.00

BENEFITS SUMMARY

		Low Options	High Options	
Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%	100%	
	Class II – Basic Services	60%	80%	
	Class III – Major Services	50%	50%	
	Class IV – Orthodontic Services*	50%	50%	
	Classes I, II and III Services Only	\$75 per Person	n/a	
Deductible per Plan Year – <i>Combined Low</i>	Classes II and II Services Only	n/a	\$50 per Person	
Deductible per Plan Year – <i>Combined High</i>				
Plan Maximum Year Benefit Payment – <i>for covered persons age 19 and older only</i>	Classes I, II and III Services Combined	\$1,500	\$1,500	
	Plan Benefit waiting Period(s) – <i>for covered persons age 19 and older only</i>	Class II Services	6 Months	6 Months
	Class III Services	12 Months	12 Months	
Maximum Out-of-pocket Cost Per Benefit Plan Year – <i>for covered persons to age 19</i>	One Covered Person	\$350	\$350	
	Two or more Covered Persons	\$700	\$700	

*Medically Necessary Only for Covered Person(s) to age 19

Step 7 – THIRD PARTY ADMINISTRATORS

Third party administrators (TPA) listed in this section are authorized contacts for communication and processing of the below specified service(s) provided on behalf of the employer group.

EDI/Eligibility _____

COBRA Administrator _____

FSA Administrator _____

Other _____

Step 8 – PAYMENT OPTIONS

Designated Billing Contact(s) will be setup with monthly E-Bill reminders. Billing contact(s) may either log into Online Resources to view and pay invoice(s) or establish a monthly automatic draft. To set up automatic draft for the fifth (5th) day of each month*, please complete the information below. **A voided check must be attached to this authorization form.**

Financial Institution _____ Branch _____

Branch Address _____ City _____ State _____ Zip _____

Branch Telephone _____

Account Type (select one): Checking Savings

I (We) _____ hereby authorize Delta Dental of Oklahoma and the financial institution named above to begin deductions of company dental premium from the account I have indicated herein on the fifth (5th) day of each month.* I understand that company eligibility can be placed on hold for a rejected draft.

Signature**: _____ Date: _____

*If the fifth (5th) day of the month is on a weekend or a holiday, Delta Dental of Oklahoma will debit the specified account on the next business day.

**Signature must be that of an authorized signer on the bank account.



Step 9 – PRODUCER/AGENT INFORMATION

Agency	Five (5) Digit Agency Number	Telephone
City	State	Zip
Producer/Agent Name	Email Address	Online Resources ID
Producer/Agent Assistant Name	Email Address	Online Resources ID
Second Servicing Producer/Agent Name	Email Address	Online Resources ID

Producer/Agent Fee Payment Options, if applicable: EFT to Producer EFT to Agency

Step 10 – ACKNOWLEDGEMENT AND SIGNATURES

Delta Dental has not reviewed the employer’s request for plan coverage nor designed the group plan to meet any federal requirements for Discriminatory Employee Benefit Plans. Said plan may not be in compliance with criteria established for Discriminatory Employee Benefit Plans and employer holds Delta Dental Plan of Oklahoma harmless if said plan fails to meet any such requirements.

By executing this Application For Group Contract, I hereby acknowledge all Federally Compliant employer plan documents and communications, including but limited to enrollee packets, group supplies, billing statements, and notices of renewal, delinquency and/or termination shall be provided electronically, and hereby consent to such delivery/administration. I understand such consent to electronic delivery/administration may be declined initially, or may be rescinded in the future by providing Delta Dental of Oklahoma written notice of such intent. Rescission effective date will be at least 30 days after written notice is received by Delta Dental of Oklahoma. I acknowledge failure to consent initially to electronic delivery/administration of the Federally Compliant group dental plan, or future rescission of consent to such, shall result in a \$15.00 monthly paper delivery/administration fee, which shall be included in the monthly billing statements and payable under the same terms and conditions as the monthly premiums.

All information above is true and correct to the best of my knowledge. I have reviewed and accept the benefits and eligibility requirements as stated in this Application for Group Contract. **Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Employer’s Authorized Signature	Title	Date
Producer/Agent Signature		Date

New Group Kit

The new group kit will be emailed to the designated Primary Contact and Producer upon completion of new group implementation. The new group kit contains a welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.



PPO – Plus Premier Federally Compliant Plans Enrollment Form

Delta Dental of Oklahoma | DeltaDentalOK.org
For Plan Year 2023

Employee Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____

Social Security Number _____ Email _____

Employer _____ Group/Subgroup Number _____ Location Code _____

Each covered Person's Social Security Number (SSN) MUST be provided. Please include yourself if applying for coverage under this plan.

Covered Person Name _____ SSN _____ Date of Birth _____

Covered Person Name _____ SSN _____ Date of Birth _____

Covered Person Name _____ SSN _____ Date of Birth _____

Covered Person Name _____ SSN _____ Date of Birth _____

Covered Person Name _____ SSN _____ Date of Birth _____

Covered Person Name _____ SSN _____ Date of Birth _____

PROGRAM SELECTION (choose High OR Low plan)

<input type="checkbox"/> Federally Compliant Plan – High	
Program Types (choose one)	Your Cost Per Person
<input type="checkbox"/> Ages 0 - 20	\$52.00 per month
<input type="checkbox"/> Ages 21 and older	\$52.00 per month
<input type="checkbox"/> Federally Compliant Plan – Low	
Program Types (choose one)	Your Cost Per Person
<input type="checkbox"/> Ages 0 - 20	\$26.00 per month
<input type="checkbox"/> Ages 21 and older	\$26.00 per month

ENROLLMENT/ELIGIBILITY UPDATE INFORMATION

Eligibility Date _____

Effective Date of Update/Change/Termination _____

Dependents eligible for coverage after group's waiting period has been met.

Change in status for: Subscriber
 Spouse Dependent(s)

Reason for change: Name Change New Address
 Marriage Divorce Adoption/Guardianship*
 Other: _____ *Legal documents must be submitted for update/change

Termination of Coverage Date _____

Group/Subgroup Transfer
From Group/Subgroup Number _____ To Group/Subgroup Number _____

DELTA DENTAL SUBMISSION INFORMATION

Mail to: Delta Dental of Oklahoma
Attn: Client Relations
PO Box 54709
Oklahoma City, OK 73154

Fax to: 405-607-2136

Email to: ClientRelations@DeltaDentalOK.org

Warning: Any person who knowingly and with intent to injure, defraud or deceive an insurer, provides false information herein and makes any claim for the proceeds of and insurance policy containing any false, incomplete, or misleading information is guilty of a felony. By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma, and acknowledge I have read the privacy policy on the back of this form.

Applicant Signature: _____ Date: _____



Privacy Policy

Delta Dental of Oklahoma

All companies part of the Delta Dental of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality. For this reason and in compliance with the Gramm-Leach-Bliley Act of 1999, Delta Dental has developed a Privacy Policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental has which may contain your confidential information. Financial companies are able to choose how they share your personal information; however Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

Information We Collect – We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, check, credit or debit card payments, insurance claims, and our website. We also collect your personal information from other companies. The types of personal information we collect and share depend on the product or service you have with us. This information can include your name, address, social security number, date of birth, transaction and claim history, medical information, and checking account information.

Utilization Of Information – Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business in order to provide our Customers with services and products. These functions include processing your requests, claims and transactions, maintaining your account(s), providing information about new products, responding to court orders and legal investigations, reporting to credit bureaus, and to comply with Federal and State Laws. The information Delta Dental uses to provide a service cannot be restricted by our Customers. However, Delta Dental is able to limit this information on your behalf under HIPAA.

Federal law gives consumers the right to limit information sharing in relation to affiliates' everyday business purposes, information about your creditworthiness, affiliates using your information to market to you, and non-affiliates using your information to market to you. In addition, state laws and other individual companies may give you additional rights to limit sharing.

Delta Dental does not have any affiliates, nor do we share information with non-affiliates for marketing purposes. When you are no longer our Customer, we will continue to share your information as described in this notice.

Our Security - To protect your personal information from unauthorized access and use, we maintain physical, electronic, and procedural safeguards that comply with Federal Law, including computer safeguards and secured files and buildings. We consider nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process.

While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers. Therefore, our Customer's confidential information is protected.

If the group plan is terminated or you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at 800-522-0188 (Toll Free) or 405-607-2100 (OKC Metro).

Under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.

SPOTLIGHT

Time to Focus on Your Smile

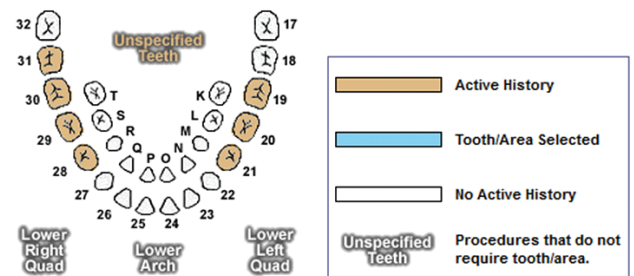
SPOTLIGHT

is **Delta Dental of Oklahoma's** online health services site where subscribers can securely access real-time information regarding their benefits plan.

Maximize your dental benefits:

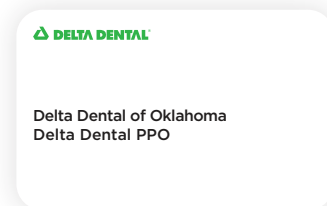
- 🦷 Find a dentist
- 🦷 View benefits
- 🦷 Track claim status
- 🦷 Access Explanation of Benefits
- 🦷 Secure messaging with our Customer Service team

🦷 My Mouth Chart



An individual tooth-by-tooth illustration of recent dental treatment.

🦷 Electronic ID Card



When you bring your own ID Card, you will have the peace of mind that your claims will be paid appropriately.

Visit DeltaDentalOK.org/Spotlight to register and to opt out of receiving paper statements today!



DELTA DENTAL.ORG