



DELTA DENTAL OF OKLAHOMA

2024
**FEDERALLY
COMPLIANT
DENTAL PLANS**

Checklist for New Groups

2024

When establishing a new group, there are several essential documents necessary for an efficient implementation. To better serve our clients, DDOK has developed a checklist for Federally Compliant Plan setup and initial enrollment process.

Application for Group Contract

- | | |
|---|---|
| <input type="checkbox"/> Step 1: Plan Effective Date | <input type="checkbox"/> Step 6: Plan Options and Plan Selection |
| <input type="checkbox"/> Step 2: Employer Information | <input type="checkbox"/> Step 7: Third Party Administrators |
| <input type="checkbox"/> Step 3: Eligibility and Enrollment | <input type="checkbox"/> Step 8: Billing and Payment Options |
| <input type="checkbox"/> Step 4: Employer Contribution | <input type="checkbox"/> Step 9: Producer/Agent Information |
| <input type="checkbox"/> Step 5: Contact Information/OR Access | <input type="checkbox"/> Step 10: Acknowledgement and Signatures |

***Please note:** Incomplete and/or inaccurate applications will result in processing delays. Please ensure the application is completed in its entirety and signed by the person authorized to contract for the group and, if applicable, producer.*

Initial Enrollment (select one):

- [Enrollment Forms](#) completed and signed by each employee
- Completed [One-time Load Spreadsheet](#)
- Not required for EDI and/or Online Resources enrollment options

Send completed application, enrollment documents and other supporting materials to Sales@DeltaDentalOK.org or by mail to:

Delta Dental of Oklahoma
Attention: Sales
P.O. Box 54709
Oklahoma City, Oklahoma 73154-1709

Federally Compliant Dental Plans

Federally Compliant Plans for Groups

2024

Delta Dental PPO-Plus Premier Federally Compliant Dental plans* – For the 2024 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	\$30.00	\$60.00
Individual + Spouse (Couple)	\$60.00	\$120.00
Individual + 1 Dependent	\$60.00	\$120.00
Individual + 2 Dependents	\$90.00	\$180.00
Individual + 3 or more Dependents	\$120.00	\$240.00
Individual + Spouse + 1 Dependent (Family/Couple +1)	\$90.00	\$180.00
Individual + Spouse + 2 Dependents (Family/Couple +2)	\$120.00	\$240.00
Individual + Spouse + 3 or more Dependents (Family/Couple +3)	\$150.00	\$300.00

If you, or someone you're helping, has questions about Delta Dental PPO Plus Premier - Federally Compliant Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-522-0188.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental PPO Plus Premier - Federally Compliant Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-522-0188.

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 2024

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, 2024

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, with a valid email address for each. 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. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation, one (1) containing the User ID and another containing the temporary password.

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): Billing Eligibility Executive Eligibility Access (select one): View only Modify

Secondary Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): View only Modify

Additional Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): View only Modify

Additional Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): View only 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 PLANS</i>	<input type="checkbox"/> Low Option	<input type="checkbox"/> High Option
Ages 0 – 20 (Per Covered Person)	\$30.00	\$60.00
Ages 21 and older (Per Covered Person)	\$30.00	\$60.00

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	\$375	\$375	
	Two or more Covered Persons	\$750	\$750	

*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 to conduct the specified business service(s) below on behalf of the employer group. The Employer authorizes DDOK to communicate and transact with the TPA, as needed, to fulfill applicable transactions and/or reporting.

EDI/Eligibility^o _____

COBRA Administrator^o _____

Flexible Spending Arrangement (FSA) Administrator _____

Other^o _____

^oTPAs acknowledging PHI/PII will be shared between the TPA and DDOK.

I authorize DDOK to disclose Protected Health Information (PHI) and Personally Identifiable Information (PII), as defined in the Health Information Portability and Accountability Act of 1996, to the TPA listed above. I will maintain a signed Business Associate Agreement (BAA) for the above TPA authorization types identified as TPA(s) that acknowledge PHI/PII will be shared between the TPA and DDOK. At any time, DDOK reserves the right to request a copy of the signed agreement between the TPA and the Group listed on this application.

Authorized Group Contact Name (please print or type) _____ Title _____

Authorized Group Contact Signature _____ Date _____



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† _____

†If already assigned by DDOK



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 2024

Employee Name

Date of Birth

Mailing Address

City

State

Zip

Social Security Number

Email

Grid for Social Security Number and 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

PROGRAM SELECTION (choose High OR Low plan)

Federally Compliant Plan – High

Program Types (choose one) | Your Cost Per Person

Ages 0 - 20 | \$60.00 per month

Ages 21 and older | \$60.00 per month

Federally Compliant Plan – Low

Program Types (choose one) | Your Cost Per Person

Ages 0 - 20 | \$30.00 per month

Ages 21 and older | \$30.00 per month

ENROLLMENT/ELIGIBILITY UPDATE INFORMATION

Eligibility Date

Grid for Eligibility Date

Effective Date of Update/Change/Termination

Grid for Effective Date

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

Grid for Termination of Coverage Date

Group/Subgroup Transfer

From Group/Subgroup Number | To Group/Subgroup Number

Grid for Group/Subgroup Transfer

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 checking this box as the enrollee, you confirm explicit consent regarding Delta Dental of Oklahoma's collection, use, disclosure, maintenance, storage, and disposal of Customer Protected Health Information and Personally Identifiable Information as described in the enrollment form's Privacy Policy online at DeltaDentalOK.org/PrivacyPolicyGroup, or by mail upon request, and Delta Dental of Oklahoma's Notice of Privacy Practices available at DeltaDentalOK.org/HIPAANotice, or by mail upon request.

Applicant Signature: _____ Date: _____

SPOTLIGHT

Time to Focus on Your Smile

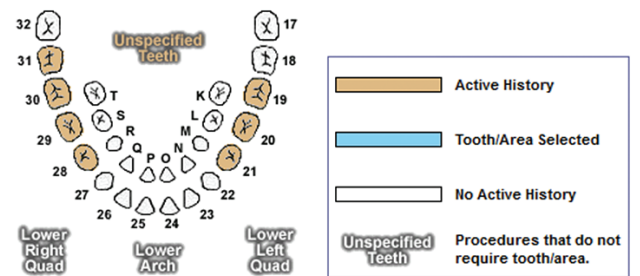
SPOTLIGHT

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:

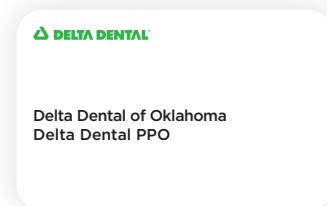
- 🦷 Find a dentist
- 🦷 View benefits
- 🦷 Track claim status
- 🦷 Access Explanation of Benefits
- 🦷 Secure messaging with our Customer Service team

🦷 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!

If you, or someone you're helping, has questions about Delta Dental Federally Compliant Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-522-0188.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental Federally Compliant Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-522-0188.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về de Delta Dental Federally Compliant Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-522-0188.

如果您，或是您正在協助的對象，有關於[插入 SBM 項目的名稱 de Delta Dental Federally Compliant Plans 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 800-522-0188]。

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 de Delta Dental Federally Compliant Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 800-522-0188로 전화하십시오.

Falls Sie oder jemand, dem Sie helfen, Fragen zum de Delta Dental Federally Compliant Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-522-0188 an.

فلديك الحق في الحصول على المساعدة والمعلومات (الضرورية بلغتك من دون اية تكلفة) للتحدث مع مترجم اتصل ب 0188-522-800

သင့်ို့မဟုတ် ငှာသူတို့ နှင့်ဆိုင်ရန် de Delta Dental Federally Compliant Plans ငှာသူတို့ ကို ဖိနှိပ်ခြင်း ရသလာပါက ကုန်စရံသတို့ ဝေးရန်လသုတ် မသမသာသာစကား ဖင အကူအညီရယူ သူ ဝူငှာ။ စကား ပန် ငှာ ဝေးလာသူပါက 800-522-0188 သသုတ် ဝေးငှာသုတ်ပါ။

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog de Delta Dental Federally Compliant Plans, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-522-0188.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa de Delta Dental Federally Compliant Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-522-0188.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de de Delta Dental Federally Compliant Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-522-0188.

ຖ້າທ່ານ, ຫຼື ອົງ ນັບ ທ່ານ ກ່າວ ັ ງຊ່ວຍເຫຼືອ, ມີ ອ່າ ຖາມ ກ່ຽວ ັ ບ ດe Delta Dental Federally Compliant Plans, ທ່ານ ມີ ສິ ດທ ັ ຈະ ໄດ້ ຮ ັ ບ ການ ຊ່ວຍເຫຼືອ ອດລະຂ ັ ັ

ມູນຂ່າວສານທ່ ເປ ັ ນພາສາຂອງທ່ານບ ັ ັ ມ ອ່າໃຊ້ ຈ່າຍ. ການໂອ ັ ມ ັ ັ

ບນາຍພາສາ, ໃຫ້ ໂທຫາ 800-522-0188.

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ de Delta Dental Federally Compliant Plans คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับสำม โทร 800-522-0188

کے بارے میں، تو اپ دونوں کو اپنی زبنا میں مفت مدد اور معلومات de Delta Dental Federally Compliant Plans اگر آپ کسی کو مدد دے رہے ہیں اور آپ دونوں کو سوال حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے 0188-522-800 فون کریں۔

hA ṣCS Ṛ CLṠṠJ Dđ YG ḂḡS ṚḡE ḢS Ṛ ṠṠṠṠJAG ḡḡ, ḡḡḡ ṠṠṠḡḡ ḂD ṠṠḡCET de Delta Dental Federally Compliant Plans. DLḡAḡ ṠṠḡ DLḡSWJ RCḡḡ Zđ RCZ Ḃḡḡ CS ṚḡS CSWḡ Ḃḡḡ ḡ ḡḡ ḡ ḡḡḡḡ Eḡ Zđ ḡEGWJ hḡRḡ ḡRT. DLḡWJḡḡ ḡḡḡḡḡ ḡCS Ṛ, ḡWZḡ ḡ ḡḡḡ ḂD 800-522-0188.

داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به ، de Delta Dental Federally Compliant Plans اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد [طور رایگان دریافت نمایی 0188-522-800 تماس حاصل نمایی



DELTA DENTAL.ORG