DELTA DENTAL

PPO – Point of Service
Retiree Conversion Program

2025

Delta Dental of Oklahoma's Retiree Conversion Program provides individuals the opportunity to retain quality dental benefits upon retirement at a reasonable cost. Our Point of Service program provides access to two dental networks – the **Delta Dental PPO** network and the **Delta Dental Premier** network.

To find a participating dentist, visit DeltaDentalOK.org and select 'Find a Dentist' under the 'For Members' section, or call our Customer Service Department at 405-607-2100 (OKC Metro) or 800-522-0188 (Toll Free).

Monthly Rates	
Retiree Only	$51.00
Retiree + 1 Dependent (spouse or one child)	$92.00
Retiree + Family	$174.00

Plan Information	
Maximum Calendar Year Benefit Payment	$1,000 per person
Calendar Year Deductible	$50 per person (Class II and Class III only)
Covered Services and Co-payments	Refer to Delta Dental PPO – Point of Service Summary of Benefits

- The maximum benefit payment for covered Class I, Class II and Class III services combined is $1,000 per each enrolled person each calendar year.
- Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will not reduce your Annual Maximum Benefit Per Person for Class I, II and III services combined.
- A $50 deductible applies to each enrolled person each calendar year for covered Class II and Class III services. Deductible can be met in Class II or Class III services, or in any combination of Class II and Class III services. Deductible **does not** apply to Class I services.

Note: *Although deductible and maximum benefit payments are based on the calendar year (January 1 – December 31 annually), all policy limitations that relate to the frequency of covered dental procedures are measured in consecutive-month periods.*

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Summary of Benefits

Percentages listed are the portion of the dentist's fee that Delta Dental of Oklahoma (DDOK) will pay toward covered services after any applicable deductible has been met, subject to the maximum allowable charge or the prevailing fee, as determined by DDOK, and the annual maximum benefit payment.

Covered Services and Co-Payments	PPO Network	Premier Network	Out-of-Network
Diagnostic and Preventive Services (Class I Benefits): ▪ Oral evaluation ▪ Routine prophylaxis, including cleaning and polishing ▪ Periodontal maintenance procedures (D4910) following active therapy ▪ X-rays ▪ Space maintainers to replace prematurely lost teeth for eligible dependent children (not for orthodontic purposes) ▪ Topical application of fluoride (for eligible dependent children only) ▪ Minor emergency (palliative) treatment for relief of pain	**100%**	**90%**	**70%**
Basic Services (Class II Benefits): ▪ Amalgam and composite fillings ▪ Stainless steel crowns (for eligible dependent children only) when the natural teeth cannot be restored with another filling material ▪ Endodontics – includes pulpal therapy and root canal treatment ▪ Oral Surgery – procedures for extractions and other oral surgery ▪ Periodontics – procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, excluding periodontal maintenance following active therapy (D4910) and scaling in the presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation (D4346) which are payable as Class I services	**80%**	**70%**	**40%**
Major Services (Class III Benefits): ▪ Crowns – provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material ▪ Prosthodontic – procedures for construction of fixed partial dentures (bridges), removable partial dentures, complete dentures; and/or adjustment or repair of an existing prosthodontic device	**50%**	**40%**	**20%**

Note: *Covered services indicated above are subject to limitations (e.g., patient age, frequency of procedure) or excluded in certain instances.*

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Eligibility/Underwriting Requirements

- To be eligible for coverage under the Retiree Conversion Program, the retiring employee must: (a) be enrolled as an eligible participant in his or her employer's active group dental plan with Delta Dental of Oklahoma (DDOK) at the time of retirement; and, (b) convert to the individual policy at the time of retirement or at the end of the retiree's COBRA coverage period if COBRA coverage is elected at the time of retirement. Coverage will be effective the first of the month coinciding with or next following the retiree's eligibility date. *Note: The Retiree Conversion Enrollment Form must be received by DDOK within 30 days of the conversion effective date.*
- Eligible dependents may also be covered under the retiree's individual policy provided: (a) the retiring employee has family coverage at the time of retirement or at the end of the retiree's COBRA coverage period if COBRA coverage is elected at the time of retirement; and, (b) covered dependents are converted to the individual policy at the same time the retiree converts. Any eligible dependent(s) acquired by the retiree after the conversion effective date may be added to the retiree's individual policy provided a Retiree Conversion Enrollment Form is received by DDOK within 30 days of the date the retiree acquires the new dependent(s).
- The retiree must make his or her policy type and payment elections at the time of conversion to the individual policy. Changes in policy type and/or payment election can only be made effective January 1 each year.
- Rates are guaranteed from the initial effective date of the retiree's individual policy through December 31 of the same calendar year. Thereafter, rates are subject to change January 1 each year, but are guaranteed for 12-month periods commencing January 1 and continuing through December 31 each year.

- I understand my Individual Dental Policy and all communications and notices (renewal, delinquency, and/or termination) shall be provided electronically, and hereby consent to such delivery/administration. Further, I understand my consent to the electronic delivery/administration may be declined initially, or may be rescinded in the future by providing Delta Dental of Oklahoma with written notice of intent to rescind such consent at least 30 days prior to the rescission effective date. I further understand and agree that declining consent to electronic delivery/administration of my Individual Dental Policy and benefits thereunder initially, or future rescission of such consent, shall result in a paper delivery/administration fee in the amount of $15.00 per month, which shall be added to the monthly automatic draft of my designated personal bank account or payable by personal check or money order if paying annual premium in full.

DELTA DENTAL®

RETIREE CONVERSION ENROLLMENT FORM

Delta Dental of Oklahoma | PPO – Point of Service Plan

Retiree Information

Name		**Date of Retirement**
Mailing Address		**Date of Birth**
City	**State**	**Zip**
Social Security Number	**Email**	
Home Phone Number	**Mobile Phone Number**	

Plan Selection and Dependent Enrollment

Plan Type (select one): Retiree Retiree + 1 (spouse or one child) Retiree + Family

List all dependents to be enrolled (complete for spouse and/or all dependent children under 23 years of age)

Spouse Name	**Date of Birth**
Dependent Child Name	**Date of Birth**
Dependent Child Name	**Date of Birth**
Dependent Child Name	**Date of Birth**
Dependent Child Name	**Date of Birth**

Billing and Payment

Automatic Draft† Options (select one): Monthly* | Annual**

Financial Institution	**Branch**
Account Number	**Bank Routing Number**

Type of Account (select one): Checking Savings

†To set up automatic draft, **a voided check must be attached to this enrollment form in the space provided on the next page.**

*Initial premium will be drafted from your account immediately upon approval of this application. Subsequent drafts will be made on the fifth (5th) of each month and applied to that month's premium.

**Initial premium will be drafted from your account immediately upon approval of this application. Subsequent annual drafts will be made on December 20th each year and applied to the next year's premium.

Termination Requirement: Please note that you must provide a minimum of 30 days written notice to Delta Dental of Oklahoma prior to requested termination date.

ATTACH VOIDED CHECK HERE

Acknowledgement, Authorization and Signature

Warning: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Acknowledgement and Authorization: By clicking the submit button, I agree to continue coverage as provided in the Individual Policy issued by Delta Dental of Oklahoma and acknowledge I have read the Privacy Policy. To cover the cost of my dental benefits for which I have made request, and for which I am or may become insured, I hereby authorize Delta Dental to draft my designated account until further notice. I understand and agree that failure to make funds available in sufficient amounts to cover the cost of my dental benefits for which I have made request shall result in the termination of my coverage effective on the paid-through date reflected in DDOK records at the time of such failure. I understand my Individual Dental Policy and all communications and notices (renewal, delinquency, and/or termination) shall be provided electronically, and hereby consent to such delivery/administration. Further, I understand my consent to the electronic delivery/administration may be declined initially, or may be rescinded in the future by providing Delta Dental of Oklahoma with written notice of intent to rescind such consent at least 30 days prior to the rescission effective date. I further understand and agree that declining consent to electronic delivery/administration of my Individual Dental Policy and benefits thereunder initially, or future rescission of such consent, shall result in a paper delivery/administration fee in the amount of $15.00 per month, which shall be added to the monthly automatic draft of my designated personal bank account or payable by personal check or money order if paying annual premium in full.

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/PrivacyPolicyIndividual, or by mail upon request, and Delta Dental of Oklahoma's Notice of Privacy Practices available at DeltaDentalOK.org/HIPAANoticeIndividual, or by mail upon request.

Retiree's Signature: _____ **Date:** _____

Submission Information

Email to: INDY@DeltaDentalOK.org

Mail to: Delta Dental of Oklahoma
Attn: Individual and Family Services
PO Box 54709
Oklahoma City, OK 73154

Broker/Agent Code (five or six digits)
