



DELTA DENTAL OF OKLAHOMA

2023

SELF-FUNDED GROUPS

Administrative Services Only (ASO)

Implementation Checklist for Administrative Services Agreement

2023

When establishing a new Administrative Services Only (ASO) plan, there are several essential documents necessary for an efficient implementation. To better serve our clients, DDOK has developed a checklist for the ASO plan setup and initial enrollment process.

- ☐ Application for Administrative Services Agreement
 - ☐ **Step 1:** Plan Effective Date
 - ☐ **Step 2:** Employer Information
 - ☐ **Step 3:** Eligibility and Enrollment
 - ☐ **Step 4:** Employer Contribution
 - ☐ **Step 5:** Plan Options and Plan Selection
 - ☐ **Step 6:** Reimbursement Schedules and Payment Options
Authorized Bank Signature Required
 - ☐ **Step 7:** Third Party Administrators
Authorized Group Signature Required
 - ☐ **Step 8:** Producer/Agent Information
 - ☐ **Step 9:** Documents and Fulfillment
 - ☐ **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.

- ☐ Statement of HIPAA Certification – Completed and signed by Chief Privacy Officer
- ☐ Plan Certification of HIPAA Compliance – Completed and signed by Chief Privacy Officer
- ☐ 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
- ☐ ASO Contact List (if needed for additional contacts)

Send completed application, enrollment documents and HIPAA certifications electronically to Sales@DeltaDentalOK.org or by mail to:

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

APPLICATION FOR ADMINISTRATIVE SERVICES AGREEMENT

Delta Dental of Oklahoma – Self-Funded Plans

For Plan Year 2023

This Application for Group Contract is hereby made a part of the Administrative Services Only 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: _____ 01, 2023

Step 2 – EMPLOYER INFORMATION

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

DBA (if applicable)

Billing/Mailing Address	City	State	Zip
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Physical Oklahoma Address (if different from billing address)	City	State	Zip
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Telephone Number	Nature of Business
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Federal Tax ID Number	SIC Code
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ERISA Exempt: ☐ No ☐ Yes (exemption typically only applies to government employers/entities or religious institutions)

Form 5500 information required? ☐ No ☐ Yes If Yes, reporting timeframe required: _____

Include subrogation language: ☐ No ☐ Yes – ASA ☐ Yes – SPD

Please provide a minimum of two (2) authorized group contacts, with a valid email address for each. Enter the information for each contact who is to receive access through Online Resources, Delta Dental of Oklahoma's (DDOK) secure benefits administration portal for eligibility maintenance, as well as enrollment and claims reporting. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation, one (1) containing the User ID and the other containing the temporary password.

Contact Type:

- **Primary Contact** – Authorized contact for all aspects of plan administration and recipient of essential plan correspondence, including contact changes, plan documents, renewals, CDT changes and billing/delinquency notices.
- **Secondary Contact** – Authorized contact for plan administration and recipient of plan correspondence in the event the Primary Contact cannot be contacted. Authorized to submit regular updates to contact list.
- **Group/All** – Authorized group contact for all aspects of plan administration and recipient of plan correspondence.
- **Group/Eligibility** – Authorized group contact for eligibility/enrollment administration. Authorized to submit and receive eligibility/enrollment additions, modifications, terminations and/or reports.
- **Group/Billing** – Authorized group contact for billing/payment administration. Authorized to submit and receive billing/payment correspondence and/or reports.

Access Status:

- **All PHI/PII** – Authorized contact for all aspects of plan administration, including but not limited to billing, eligibility, claims and reporting inquiries.
- **Eligibility Only** – Authorized contact for eligibility and enrollment reporting and inquiries.
- **COBRA Eligibility Only** – Authorized contact for COBRA eligibility and enrollment reporting and inquiries.
- **Contact Change Authority** – Authorized contact for group contact additions, changes and/or removals.
- **Ebill** – Authorized contact for electronic billing (Ebill) correspondence.
- **ASO Reporting** – Authorized contact to receive all ASO reporting, including but not limited to eligibility/enrollment and claims.

Online Resources Access:

- **Read Eligibility** – Contact should have read-only access to online eligibility.
- **Modify Eligibility** – Contact should have ability to make changes through online eligibility.
- **Claims** – Contact should have ability to view/download online claims reports.

Additional contacts can be added, if necessary. Please include the name, title, email, telephone and contact type designation for each on the Authorized Contact List for Administrative Services Only Plans and submit with the application. An authorized representative for the Employer approves the individuals/entities listed below and attached to access the indicated Protected Health Information and/or Personally Identifiable Information at Delta Dental of Oklahoma. As an authorized representative, I will notify Delta Dental of Oklahoma immediately in the event of termination of access of any of the individuals/entities listed below or attached. I acknowledge requests for updates to this form must be made in writing to ClientRelations@DeltaDentalOK.org.

Primary Group Contact	Title	Organization (if different than group)
Email	Telephone	
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA		
Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting		
Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Secondary Contact	Title	Organization (if different than group)
Email	Telephone	
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA		
Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting		
Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Additional Contact	Title	Organization (if different than group)
Email	Telephone	
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA		
Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting		
Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Additional Contact	Title	Organization (if different than group)
Email	Telephone	
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA		
Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting		
Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Additional Contact	Title	Organization (if different than group)
Email	Telephone	
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA		
Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting		
Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Step 3 – ELIGIBILITY AND ENROLLMENT

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

Employees become ineligible for coverage on (select one):

- ☐ Date of termination ☐ End of month ☐ End of pay period ☐ 30 days after termination

Dependents reaching the age limitation become ineligible for coverage on (select one):

- ☐ Date threshold is exceeded ☐ End of month threshold is exceeded ☐ End of year threshold is exceeded

Domestic Partnership (select one): ☐ Eligible ☐ Not Eligible ☐ Limited Eligibility based on State Law

Retirees (select one): ☐ Covered by Group Plan ☐ DDOK Retiree Conversion Plan (Documentation in New Group Kit) ☐ Not Applicable

Enrollment/Eligibility Processing

Initial Implementation (select one): ☐ EDI File ☐ One-Time Load ☐ Online Resources ☐ Enrollment Forms

Ongoing Maintenance (select applicable): ☐ EDI File ☐ Online Resources ☐ Enrollment Forms

Subscriber Identification Number (select one): ☐ SSN ☐ Alternate Identification Numbers (Alt IDs)

Note: Implementation of Alternate Identification Numbers (Alt IDs) requires 90 days for testing and must meet Delta Dental of Oklahoma's requirements.

Step 4 – EMPLOYER CONTRIBUTION Employer contributes _____% OR \$_____ to employee cost of plan.

Step 5 – PLAN OPTIONS AND PLAN SELECTION (select all that apply)

Benefits Summary: Please indicate the applicable benefits information below by placing a checkmark in the appropriate box(es) and/or completing those areas requiring information, based on proposed benefits plan.

Plan Options:

- ☐ Single Option
☐ Dual Option
☐ Triple Option

Plan Types:

- ☐ Delta Dental PPO – Plus Premier ☐ Delta Dental PPO
☐ Delta Dental PPO – Plus Premier "Elite" ☐ Delta Dental PPO – Preventive Plus
☐ Delta Dental PPO – Point of Service ☐ Delta Dental PPO – Choice Advantage
☐ Delta Dental PPO – Point of Service Advantage

Account Structure (select one): ☐ One Subgroup per Plan Option ☐ Other (Details Attached)

Processing Policy: ☐ DDOK Standard ☐ Current Carrier Match* ☐ Other*

*Benefit breakdown required

Health through Oral Wellness® (HOW®): ☐ Accepted ☐ Declined

Covered Services and Plan Co-Payment:

	PPO Network	Premier Network	Out-of-Network
<input type="checkbox"/> Class I – Preventive and Diagnostic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class II – Basic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class III – Major Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class IV – Orthodontic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Dependent Children Only <input type="checkbox"/> Family			

Deductible(s) and Maximum(s): Plan Year Deductible(s) and Maximum(s) renew _____ 1, each year.

Plan Year Deductible Per Person: _____ Maximum Plan Year Deductible Per Family: _____

Maximum Plan Year Benefit Payment: _____ ☐ Excluding Orthodontics ☐ Including Orthodontics

Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will reduce Annual Maximum Plan Year Benefit (select one): ☐ Yes ☐ No

Maximum Lifetime Orthodontic Benefit Payment, if applicable: _____

Maximum Dependent Age: _____

Additional Benefit Information, if applicable: _____

Step 6 – REIMBURSEMENT SCHEDULES AND PAYMENT OPTIONS

Claims reimbursement schedule is weekly and Administrative Fee payment schedule is monthly, unless otherwise approved and agreed upon in writing with the signed proposal and receipt of Operating Fund Deposit. Designated Contact(s) will receive claims/administrative fee invoices via email from Accounting@DeltaDentalOK.org according to this schedule.

Claims Reimbursement (select one): ☐ Automatic Draft ☐ Wire Transfer

Indicate alternate frequency and deposit amount here (if applicable): _____

Administrative Fees (please indicate the appropriate fee structure): ☐ Per Employee Per Month \$ _____ ☐ Percent of Paid Claims _____ %

Administrative Fee Payment (select one): ☐ Automatic Draft[†] ☐ Wire Transfer ☐ Check

[†]To set up automatic draft for claims and/or administrative fees, please complete the information below. Drafts occur a minimum of two (2) days after the claims and/or administrative fee invoices are issued. **A voided check must be attached to this authorization form.**

Financial Institution _____		Branch _____	
Branch Address _____	City _____	State _____	Zip _____
Branch Telephone _____	Select One: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		

I (We) _____ hereby authorize Delta Dental of Oklahoma and the financial institution named above to begin deductions of company claims reimbursements and/or administrative fees from the account I have indicated herein. I understand that company claims can be placed on hold for a rejected draft.

Signature**: _____ Date: _____

*If the date claims and/or administrative fee invoices are issued falls on 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 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. **All TPAs must also be listed on the 'Authorized Contact List for Administrative Services Only Plans' as a TPA, with access type designated.**

EDI/Eligibility[°] _____

COBRA Administrator[°] _____

Flexible Spending Arrangement (FSA) Administrator: _____

Other[°] _____

I authorize Delta Dental of Oklahoma (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), where applicable[°], with the above identified TPA(s) that acknowledges 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) _____	Title _____
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Authorized Group Contact Signature _____	Date _____
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Step 8 – PRODUCER/AGENT INFORMATION

Agency	Five 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 Delta Dental of Oklahoma.

Producer Commission (as approved and noted on signed proposal; select one):

☐ Per Employee Per Month \$ _____ ☐ Percent of Paid Claims _____% ☐ No Commission

Step 9 – DOCUMENTS AND FULFILLMENT

New Group Kit

All self-funded employer plan documents, enrollee packets and group supplies will be provided electronically. The new group kit will be emailed to the designated Primary Contact and Producer upon completion of new group implementation and contains welcome letter, Administrative Services Agreement, Summary Plan Description*, electronic identification cards and, if applicable, Retiree Conversion materials.

*Summary Plan Description (SPD) written by:

☐ Delta Dental of Oklahoma ☐ Group (please provide a copy of the current dental benefits SPD for DDOK records)

New Enrollee Packet

Initial Implementation (select one)

☐ Electronic to Group ☐ Mail to Group ☐ Mail to Subscriber

Ongoing Maintenance (select one)

☐ Electronic to Group ☐ Mail to Group

Step 10 – ACKNOWLEDGEMENT AND SIGNATURES

Though providing certain administrative services to the employer, Delta Dental has not reviewed the employer's group plan coverage nor designed the employer's group plan to meet any federal requirements that may apply for Discriminatory Employee Benefit Plans. Said self-funded group plan may not be in compliance with criteria established for such Discriminatory Employee Benefit Plans and employer holds Delta Dental Plan of Oklahoma harmless if said plan fails to meet any such requirements.

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 Administrative Services Agreement. **Be advised:** 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
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Producer/Agent Signature	Date
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Statement of HIPAA Certification for Administrative Services Agreement

DELTA DENTAL OF OKLAHOMA

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and amendments thereto regarding the Privacy and Security of Protected Health Information and Electronic Protected Health Information (collectively "PHI"), which is to include Genetic Information as defined by the Genetic Information Nondiscrimination Act (GINA) §105(a) and corresponding federal regulations, _____ the "Plan Sponsor", at _____ [Address], hereby makes the following certification to **Delta Dental of Oklahoma (DDOK)** as to its compliance with the rules and regulations governing PHI in relation to, _____ [Name of Plan] otherwise known as "The Plan".

1. The Plan Sponsor will NOT use or further disclose PHI other than as permitted or required by the Plan documents, or as required by law.
2. The Plan Sponsor ensures that every agent, including any subcontractor, to whom the Plan Sponsor provides PHI, is bound by the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.
3. The Plan Sponsor will NOT use or disclose PHI for employment-related actions and decisions or in connection with any other benefits or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan and to DDOK any use or disclosure of the PHI that is inconsistent with the uses and disclosures provided for in the Plan documents, of which it becomes aware.
5. The Plan Sponsor will ensure that each participant, dependent, personal representative or enrollee will have access to his/her PHI maintained by the Plan Sponsor.
6. The Plan Sponsor will ensure that each participant, dependent, personal representative or enrollee will have the ability to amend or incorporate any amendments to his/her PHI, if said amendment is proper according to the Plan's HIPAA compliance documents and/or HIPAA itself.
7. The Plan Sponsor will ensure that PHI and its disclosure and use is appropriately maintained in a manner consistent with the Plan documents and rules governing HIPAA, so that an accounting may be provided to the individual.
8. The Plan Sponsor will make available to the Secretary of the Department of Health and Human Services, and other regulatory agencies having the appropriate authority, the Plan and Plan Sponsor internal practices, books, and records relating to the use and disclosure of PHI received from DDOK, for the purpose of determining compliance by DDOK with HIPAA.
9. If feasible, upon the termination of the plan, or any arrangement with DDOK, the Plan Sponsor will return or destroy all PHI received from DDOK that the Plan Sponsor continues to maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further use and disclosure to those purposes that make the return or destruction of the PHI infeasible.

The person signing this Certification has the authority, on behalf of the Plan Sponsor to make the affirmations of compliance found in this certification and will hold DDOK harmless in the event any of the compliance statements are found to be incorrect, have been inappropriately implemented, or have been violated by Plan Sponsor.

Chief Privacy Officer Signature

Date

Typed or Printed Name

Delta Dental Group Number

Please complete, sign and date this Certification, and return one (1) original to Delta Dental of Oklahoma.

Confidentiality Notice: This documentation may contain personal, confidential and privileged information that is otherwise protected by law. If you are not the intended recipient, do not read, copy, distribute, use or disclose any of the information or documentation to other parties. If you have received this document in error, please notify the Delta Dental of Oklahoma Compliance Department at Compliance@DeltaDentalOK.org, (800) 522-0188 or (405) 607-2100 and destroy all documents received in error.

Certification of HIPAA Compliance for Administrative Services Agreement

DELTA DENTAL OF OKLAHOMA

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and amendments thereto regarding the Privacy and Security of Protected Health Information and Electronic Protected Health Information (collectively "PHI"), which includes genetic information as defined by the Genetic Information Nondiscrimination Act (GINA) §105(a) and corresponding federal regulations, the _____ [Name of Plan], otherwise known as "The Plan", hereby certifies its compliance to **Delta Dental of Oklahoma (DDOK)** with the rules and regulations governing PHI as follows:

1. The Plan and the Plan Sponsor have created an adequate separation between the Plan and the Plan Sponsor that is compliant with the rules and regulations governing HIPAA.
2. The Plan documents include a description of those employees or classes of employees or other persons under the control of the Plan Sponsor to be given access to the PHI to be disclosed, provided that any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, must be included in this description.
3. The Plan documents adequately restrict access to and use by the employees and other persons for plan administration functions that the Plan Sponsor performs for the Plan.
4. The Plan documents provide an effective mechanism for resolving issues of noncompliance by Plan Sponsor personnel or others having access to Plan participant's PHI.
5. The Plan documents DO NOT permit DDOK to disclose PHI to the Plan Sponsor except as permitted.
6. The Plan documents prohibit the disclosure of PHI to the Plan Sponsor otherwise permitted by these policies and procedures, unless these disclosures are made part of the Notice of Privacy Practices of the Plan.
7. The Plan documents prohibit any disclosure or use of PHI by the Plan Sponsor for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
8. The Plan documents of the Plan have been amended to incorporate provisions to require the Plan Sponsor to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
9. Any agent, including a subcontractor, to whom the Plan provides PHI, agrees to implement reasonable and appropriate security measures to protect the PHI.
10. The Plan will promptly report to Delta Dental of Oklahoma any security incident of which it becomes aware.

Plan Sponsor (Name of Company)

Date

Chief Privacy Officer Signature

Delta Dental Group Number

[Address]

Please complete, sign and date this Certification, and return one (1) original to Delta Dental of Oklahoma.

Confidentiality Notice: This documentation may contain personal, confidential and privileged information that is otherwise protected by law. If you are not the intended recipient, do not read, copy, distribute, use or disclose any of the information or documentation to other parties. If you have received this document in error, please notify the Delta Dental of Oklahoma Compliance Department at Compliance@DeltaDentalOK.org, (800) 522-0188 or (405) 607-2100 and destroy all documents received in error.



<input type="checkbox"/> DELTA DENTAL PPO - PROTECTIVE PLUS	<input type="checkbox"/> DELTA DENTAL PREMIER
<input type="checkbox"/> DELTA DENTAL PPO	<input type="checkbox"/> DELTA DENTAL PREMIER - CHOICE
<input type="checkbox"/> DELTA DENTAL PPO - PLUS PREMIER	<input type="checkbox"/> DELTA DENTAL PPO - CHOICE
<input type="checkbox"/> DELTA DENTAL PPO - PLUS PREMIER "ELITE"	<input type="checkbox"/> DELTA DENTAL PPO - CHOICE ADVANTAGE
	<input type="checkbox"/> DELTA DENTAL PPO - POINT OF SERVICE

GROUP#/SUBGROUP#	LOCATION CODE
<div style="display: flex; justify-content: space-around;"> <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div></div> </div>	<div style="display: flex; justify-content: space-around;"> <div><div></div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div><div></div></div> </div>

[illegible]

Enrollment/Eligibility Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: <div style="display: flex; justify-content: space-between; width: 150px;"> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> <div>-</div> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> <div>-</div> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div> </div>	
TYPE OF ENROLLMENT/ELIGIBILITY UPDATE: <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> NEW ENROLLMENT</div> <div><input type="checkbox"/> REINSTATEMENT</div> <div><input type="checkbox"/> OPEN ENROLLMENT</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div><input type="checkbox"/> COBRA ELECTION</div> <div><input type="checkbox"/> TERMINATION OF BENEFITS</div> <div><input type="checkbox"/> DECLINE</div> </div> <div style="margin-top: 10px;"> <input type="checkbox"/> TERMINATION OF EMPLOYMENT AS OF ____ - ____ - ____ </div>	<div style="margin-bottom: 10px;"> <input type="checkbox"/> CHANGE IN CURRENT ENROLLMENT STATUS FOR: <input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENTS </div> REASON FOR CHANGE: <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div><input type="checkbox"/> DIVORCE</div> <div><input type="checkbox"/> MARRIAGE</div> <div><input type="checkbox"/> NAME CHANGE</div> <div><input type="checkbox"/> LEGAL GUARDIANSHIP</div> </div> <div> <input type="checkbox"/> ADOPTION <input type="checkbox"/> OTHER _____ </div>
GROUP TRANSFER-GROUP#/SUBGROUP# <div style="display: flex; justify-content: space-around; width: 100%;"> <div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="margin-left: 20px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> </div>	TO: GROUP#/SUBGROUP# <div style="display: flex; justify-content: space-around; width: 100%;"> <div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="margin-left: 20px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> </div>

Dependent Enrollment/Eligibility Update Information: <i>(please complete for spouse and/or dependent children for enrollment/eligibility update)</i>												
SPOUSE NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]								
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				

Subscriber's
Signature: _____ Date: _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or updating/changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the primary subscriber. Please print clearly in ink.

Full-Time Hire Date: The date you were hired with your employer.

Coverage Effective Date: The date Delta Dental coverage takes effect for you (and/or your dependents, if enrolled).

Status Definitions (Please select only one status)

Active You are an eligible subscriber.

Retiree You are retired and your employer continues to provide you with dental benefits.

COBRA You are no longer an active subscriber but you have continued coverage under COBRA. Please check with your human resources or personnel department for information regarding COBRA.

Surviving Dep. The surviving spouse or child of a deceased subscriber to whom the employer continues to provide benefits other than under provisions of COBRA.

Enrollment/Eligibility Update Information - This section should only be completed if you are: (1) enrolling yourself or a family member for the first time or (2) if your benefits were terminated and are not being reinstated or (3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your eligible dependents.

Reinstatement: Check for reinstatement coverage for yourself or your eligible dependents.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: Must be completed when you are transferring from one subgroup to another. (All dependents will transfer)

Dependent Enrollment/Eligibility Update Information - This section should be completed when: (1) enrolling dependents or (2) if you are submitting updates/changes to Delta Dental enrollment. (Please include both first and last names of any individuals for whom you are enrolling or submitting an update or change).

* Disabled: Your permanently disabled dependent child. (Requires submission of medical statement)

Delta Dental of Oklahoma Privacy Policy

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.

Authorized Contact List for Administrative Services Only Plans

DELTA DENTAL OF OKLAHOMA

Group/Plan Name: _____

Group Number: _____

Please enter the information for each contact who is to receive access through Online Resources, Delta Dental of Oklahoma's (DDOK) secure benefits administration portal for eligibility maintenance, as well as enrollment and claims reporting. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation, one containing the User ID and the other containing the temporary password.

Contact Type:

- **Primary Contact** – Authorized contact for all aspects of plan administration and recipient of essential plan correspondence, including contact changes, plan documents, renewals, CDT changes and billing/delinquency notices.
- **Secondary Contact** – Authorized contact for plan administration and recipient of plan correspondence in the event the Primary Contact cannot be contacted. Authorized to submit regular updates to contact list.
- **Group/All** – Authorized group contact for all aspects of plan administration and recipient of plan correspondence.
- **Group/Eligibility** – Authorized group contact for eligibility/enrollment administration. Authorized to submit and receive eligibility/enrollment additions, modifications, terminations and/or reports.
- **Group/Billing** – Authorized group contact for billing/payment administration. Authorized to submit and receive billing/payment correspondence and/or reports.

Access Status:

- **All PHI/PII** – Authorized contact for all aspects of plan administration, including but not limited to billing, eligibility, claims and reporting inquiries.
- **Eligibility Only** – Authorized contact for eligibility and enrollment reporting and inquiries.
- **COBRA Eligibility Only** – Authorized contact for COBRA eligibility and enrollment reporting and inquiries.
- **Contact Change Authority** – Authorized contact for group contact additions, changes and/or removals.
- **Ebill** – Authorized contact for electronic billing (Ebill) correspondence.
- **ASO Reporting** – Authorized contact to receive all ASO reporting, including but not limited to eligibility/enrollment and claims.

Online Resources Access:

- **Read Eligibility** – Contact should have read-only access to online eligibility.
- **Modify Eligibility** – Contact should have ability to make changes through online eligibility.
- **Claims** – Contact should have ability to view/download online claims reports.

Additional Contact	Title	Organization (if different than Group/Plan)
Email		Telephone
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA		
Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting		
Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Additional Contact	Title	Organization (if different than Group/Plan)
Email		Telephone
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA		
Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting		
Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Additional Contact	Title	Organization (if different than Group/Plan)
Email		Telephone
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Additional Contact	Title	Organization (if different than Group/Plan)
Email		Telephone
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

Additional Contact	Title	Organization (if different than Group/Plan)
Email		Telephone
Contact Type (select applicable): <input type="checkbox"/> Group/All <input type="checkbox"/> Group/Eligibility <input type="checkbox"/> Group/Billing <input type="checkbox"/> Consultant <input type="checkbox"/> TPA <input type="checkbox"/> TPA – COBRA Access Status (select applicable): <input type="checkbox"/> All PHI/PII <input type="checkbox"/> Eligibility Only <input type="checkbox"/> COBRA Eligibility Only <input type="checkbox"/> Contact Change Authority <input type="checkbox"/> Ebill <input type="checkbox"/> ASO Reporting Online Resources Access (select applicable): <input type="checkbox"/> Read-only Eligibility <input type="checkbox"/> Modify Eligibility <input type="checkbox"/> Claims <input type="checkbox"/> Not Applicable		

As an authorized representative for the above referenced Group/Plan, I approve the individuals/entities listed above to access the indicated Protected Health Information and/or Personally Identifiable Information at Delta Dental of Oklahoma. As an authorized representative, I will notify Delta Dental of Oklahoma immediately in the event of termination of access of any of the individuals/entities listed above. I acknowledge requests for updates to this form must be made in writing to ClientRelations@DeltaDentalOK.org.

Primary/Secondary/Executive Employer Contact Name (please print)	Title	Date
Primary/Secondary/Executive Employer Authorized Signature		Date

PPO – Point of Service Retiree Conversion Program

2023

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.

PPO – Point of Service Retiree Conversion Program

2023

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): <ul style="list-style-type: none"> 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): <ul style="list-style-type: none"> 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): <ul style="list-style-type: none"> Crowns – provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material Prosthetic – procedures for construction of fixed partial dentures (bridges), removable partial dentures, complete dentures; and/or adjustment or repair of an existing prosthetic 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.

PPO – Point of Service Retiree Conversion Program

2023

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 OF OKLAHOMA ONLINE RESOURCES

At **Delta Dental of Oklahoma (DDOK)**, we pride ourselves on providing our clients with the tools they need to efficiently administer dental benefits to their company and employees.

Online Resources, our portal for group administrators, allows designated persons within your organization, or your broker, to securely access information for your group.



Features included:



Eligibility Maintenance

Provides group administrators with direct access to review and maintain eligibility for their employees.



Online Payments

Fully-insured clients can pay monthly online using a credit card. Additional payment options include automatic bank draft and pay-by-phone.



Fully-insured Reporting

Delta Dental's fully-insured clients can access Online Resources to view:

- Billing invoice
- Aggregate claims
- Covered lives
- Eligibility lookup
- Overage dependent
- Subscriber list



ASO Reporting

Clients who elect to contract with DDOK on an Administrative Services Only (ASO) basis have access to our Online Reporting feature to self-generate the following reports:

- Claims by class, group, relationship and subgroup
- Covered lives
- Network utilization
- Overage dependent
- Subscriber list
- Claims lag
- Eligibility lookup

To learn more about Online Resources, please visit DeltaDentalOK.org/OnlineResources

DELTA DENTAL OF OKLAHOMA ADDITIONAL ACCOUNT SERVICES



Oral Wellness Information

Onsite Presentations *(for groups with 50+ enrollees)*

There is a strong connection between your oral health and your body's overall health. DDOK will make an onsite visit to present information and tips on oral wellness to maintain a healthier life. The presentation is open to all employees and focuses on key points about oral wellness.

Onsite Screenings *(for groups with 100+ enrollees)*

We set up private screening kiosks at health fairs and enrollment events and provide pain-free oral health assessments conducted by a registered dental hygienist.



Retiree Conversion Program

Through our Retiree Conversions Program, DDOK works with retiring employees to provide a simple process to continue their dental benefits at no cost to your group.



Annual Reporting *(for groups with 100+ enrollees)*

Network Utilization Reports

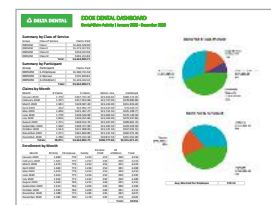
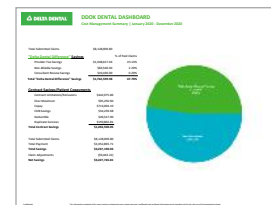
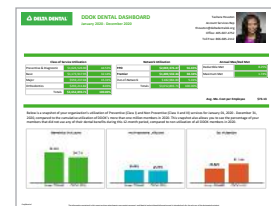
DDOK provides a summary report of network utilization giving you information on employee network access and effectiveness of subscriber savings within our networks.

Cost Management Reports

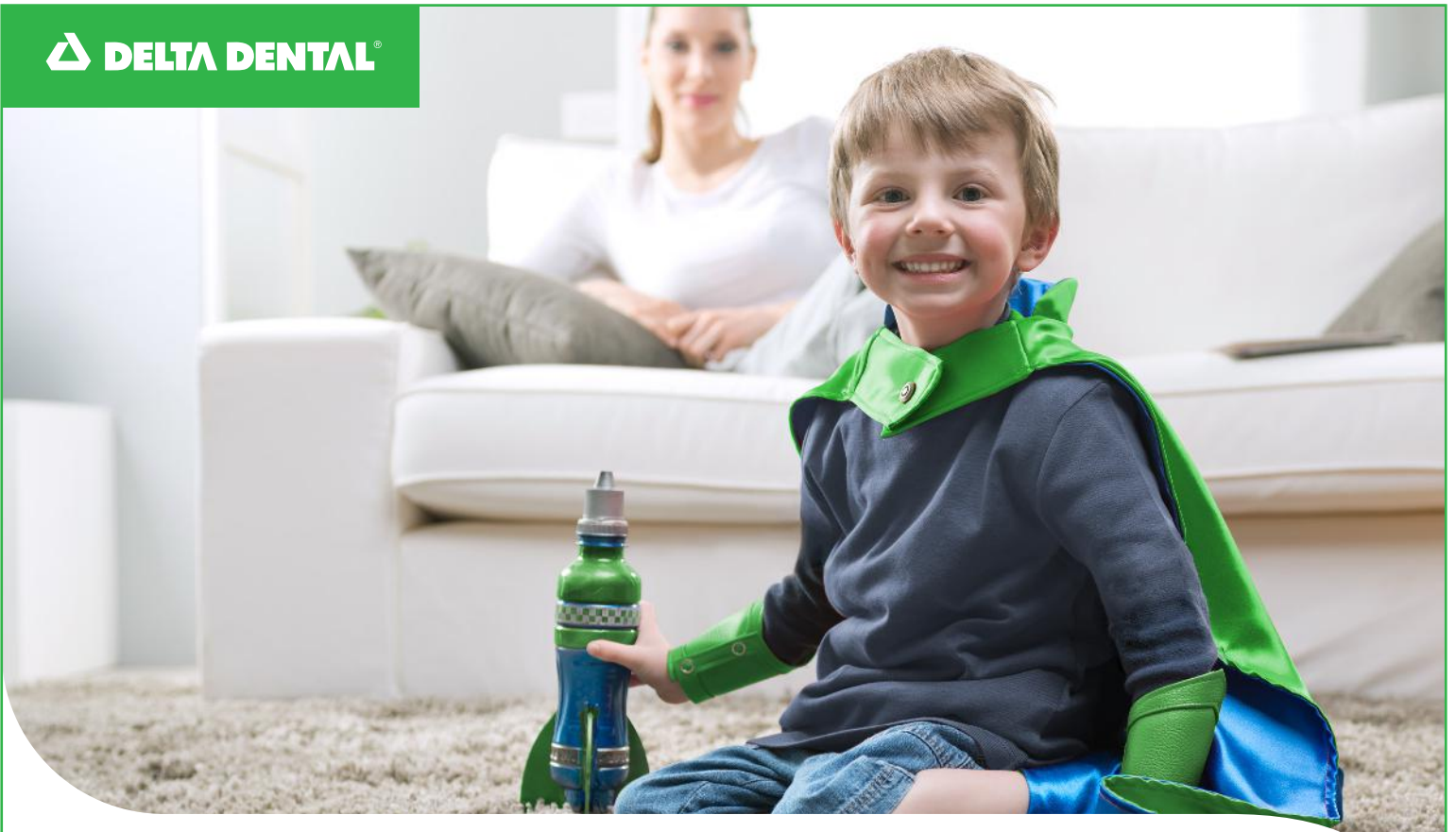
Clients receive a summary report of savings based on plan payment data. This report identifies the actual dollar amount you save annually by accessing Delta Dental participating providers.

Dental Claims Activity

Annual claims reporting shows a comprehensive breakdown of claims submitted. Provides a summary of claims paid by class of service, participant, and month. Also provides plan enrollment by month, and an average monthly cost per employee.



For more information, contact your Account Manager.



Boost Your Benefits

Check out

HOW®



**Available
Now!**

Delta Dental of Oklahoma is dedicated to advancing the oral wellness of our members. We recognize each member is unique, and some may need additional services in order to achieve optimal oral health.

Health *through* Oral Wellness® (HOW®) enhanced benefits are designed to boost members existing Delta Dental plan with additional preventive benefits, if they are at higher risk for developing caries and/or periodontal disease.*

For more information, visit
DeltaDentalOK.org/HOW

*based on the results of the HOW® approved assessment performed in a dental office



[DELTADENTALOK.ORG](https://www.deltadentalok.org)