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DELTA DENTAL OF OKLAHOMA

2025

SELF-FUNDED GROUPS

Administrative Services Only (ASO)

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Implementation Checklist for Administrative Services Agreement

2025

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 Bank 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 (minimum of 75 subscribers required to use this method)

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

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APPLICATION FOR ADMINISTRATIVE SERVICES AGREEMENT

Delta Dental of Oklahoma – Self-Funded Plans

For Plan Year **2025**

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, 2025
(month)

Step 2 – EMPLOYER INFORMATION

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

Doing Business As (DBA - if applicable)

Billing/Mailing Address	City	State	Zip
Physical Oklahoma Address (if different from billing 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)*
Form 5500 information required? No Yes If Yes, reporting timeframe required: _____

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.

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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): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

Secondary Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

Additional Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

Additional Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

Additional Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

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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

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

**Minimum of 75 subscribers required to use this method.*

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:	**Plan Types:**	
☐ Single Option	☐ Delta Dental PPO – Plus Premier	☐ Delta Dental PPO*
☐ Dual Option	☐ Delta Dental PPO – Plus Premier "Elite"	☐ Delta Dental PPO – Preventive Plus*
☐ Triple Option	☐ Delta Dental PPO – Point of Service	☐ Delta Dental PPO – Choice Advantage*
	☐ Delta Dental PPO – Point of Service Advantage	

**Please verify provider participation in the Delta Dental PPO network prior to enrollment at DeltaDentalOK.org/DentistSearch*

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

Processing Policy: DDOK Standard Current Carrier Match *(benefit breakdown required)* Other *(benefit breakdown required)*

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

Covered Services and Plan Co-Payment:	**PPO Network**	**Premier Network**	**Out-of-Network**
☐ Class I – Preventive and Diagnostic Services:	_____ %	_____ %	_____ %
☐ Class II – Basic Services:	_____ %	_____ %	_____ %
☐ Class III – Major Services:	_____ %	_____ %	_____ %
☐ Class IV – Orthodontic Services:	_____ %	_____ %	_____ %

Dependent Children Only Family

Deductible(s) and Maximum(s): Plan Year Deductible(s) and Maximum(s) renew _____01, each year.
(month)

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: _____

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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

_____ Select One: Checking Savings
Branch Telephone

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 administers (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

_____
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 Only (ASO) 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.

Electronic Delivery/Administration: By executing this Application for ASO Agreement, I hereby acknowledge that: All ASO employer plan documents, enrollee packets, group supplies, billing statements, and notices (renewal, delinquency, and/or termination) shall be provided electronically, and hereby consent to such delivery/administration. I understand that such consent to electronic delivery/administration may be declined initially, or 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. Further, I acknowledge that failure to consent initially to electronic delivery/administration of the ASO dental plan or future rescission of consent 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.

Employer's Authorized Signature Title Date

Producer/Agent Signature Date

DELTA DENTAL

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.

DELTA DENTAL

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.

Enrollment/Eligibility Update

PLAN TYPE:
(AS ESTABLISHED BETWEEN EMPLOYER AND DELTA DENTAL)

- ☐ DELTA DENTAL PPO
- ☐ DELTA DENTAL PPO – PREVENTIVE PLUS
- ☐ DELTA DENTAL PPO – PLUS PREMIER
- ☐ DELTA DENTAL PPO – PLUS PREMIER "ELITE"
- ☐ DELTA DENTAL PREMIER
- ☐ DELTA DENTAL PREMIER – CHOICE
- ☐ DELTA DENTAL PPO – CHOICE
- ☐ DELTA DENTAL PPO – CHOICE ADVANTAGE
- ☐ DELTA DENTAL PPO – POINT OF SERVICE

Employer: _____ GROUP#/SUBGROUP# _____ _____ LOCATION CODE _____

Subscriber Information: *(please complete in ink for enrollment/eligibility updates)*

SUBSCRIBER NAME (LAST)		(FIRST)		
SUBSCRIBER SOCIAL SECURITY NUMBER	BIRTH DATE	FULL-TIME HIRE DATE	COVERAGE EFFECTIVE DATE	STATUS Active COBRA Retiree Surviving Dep. Other: _____
ADDRESS				
CITY		STATE	ZIP	CHECK IF THIS IS A NEW ADDRESS

EMAIL: _____

Enrollment/Eligibility Update Information – EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION:

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:
NEW ENROLLMENT REINSTATEMENT OPEN ENROLLMENT
COBRA ELECTION TERMINATION OF BENEFITS
TERMINATION OF EMPLOYMENT AS OF _____

CHANGE IN CURRENT ENROLLMENT STATUS FOR SUBSCRIBER DEPENDENTS
REASON FOR CHANGE:
DIVORCE MARRIAGE NAME CHANGE LEGAL GUARDIANSHIP
ADOPTION OTHER _____

GROUP TRANSFER FROM GROUP#/SUBGROUP# _____ _____ TO GROUP#/SUBGROUP# _____ _____

Dependent Enrollment/Eligibility Update Information: (please complete for spouse and/or dependent children for enrollment/eligibility update)

SPOUSE NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE

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 missing information is guilty of a felony.

By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma, and acknowledge I have read the privacy policy detailed via the links below.

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.

Subscriber Signature: _____ Date: _____

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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 contracted. 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): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

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Additional Contact Title Organization (if different than Group/Plan)

Email Telephone

Contact Type (select applicable): Group/All | Group/Eligibility | Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility | Modify Eligibility Claims Not Applicable

Additional Contact Title Organization (if different than Group/Plan)

Email Telephone

Contact Type (select applicable): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

Additional Contact Title Organization (if different than Group/Plan)

Email Telephone

Contact Type (select applicable): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims Not Applicable

Additional Contact Title Organization (if different than Group/Plan)

Email Telephone

Contact Type (select applicable): Group/All Group/Eligibility Group/Billing Consultant TPA TPA – COBRA

Access Status (select applicable): All PHI/PII Eligibility Only COBRA Eligibility Only Contact Change Authority Ebill ASO Reporting

Online Resources Access (select applicable): Read-only Eligibility Modify Eligibility Claims 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

Primary/Secondary/Executive Employer Authorized Signature Date

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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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PPO – Point of Service
Retiree Conversion Program

2025

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.*

DELTA DENTAL

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Eligibility/Underwriting Requirements

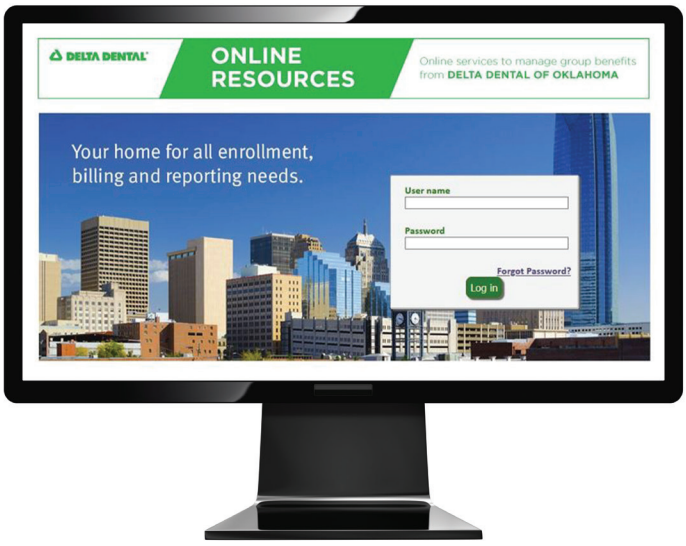
- To be eligible for coverage under the Retiree Conversion Program, the retiring employee must: (a) be enrolled as an eligible participant in his or her employer's active group dental plan with Delta Dental of Oklahoma (DDOK) at the time of retirement; and, (b) convert to the individual policy at the 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®

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 include:

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.

ASO Reporting

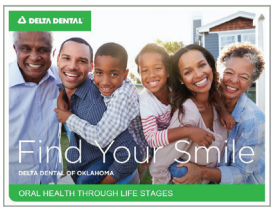
Clients who elect to contract with DDOK on an Administrative Services Only (ASO) basis have access to our Online Reporting feature to self-generate the following reports:

- 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®

DELTA DENTAL OF OKLAHOMA
ADDITIONAL ACCOUNT SERVICES

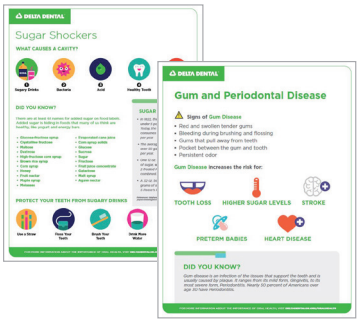


Oral Wellness

Onsite Presentations and/or Live Q&A
for groups with 50+ enrollees

DDOK will make an onsite visit to present oral wellness information and tips to maintain a healthier life. The presentation is open to all employees and focuses on key points about oral wellness.

A live question and answer (Q&A) session with a DDOK Account Manager may be added to the presentation or requested as a standalone event.



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.

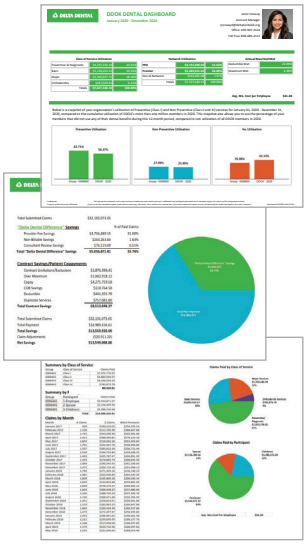
Oral-B Pro 3000 Bundle Giveaway
for groups with 250+ enrollees

Encourage employees to use their DDOK preventive care benefits. Eligible employees receiving preventive care are entered into a drawing to win an oral health care package including an Oral-B Pro 3000 electric toothbrush, full-size toothpaste and mouthwash.

Retiree Conversion Program

Through our Retiree Conversion 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.

DELTA DENTAL®

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.*

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

For more information, visit
DeltaDentalOK.org/HOW

DELTADENTALOK.ORG