DELTA DENTAL®

DELTA DENTAL OF OKLAHOMA

2024

# GROUP 26+

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# Checklist for New Groups

2024

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

Application for Group Contract

**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**: Third Party Administrators
***(Authorized group signature required)***

**Step 7**: Billing and Payment Options
***(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.*

__ Initial Enrollment (select one):

- Enrollment Forms completed and signed by each employee
- Completed One-time Load spreadsheet
- Not required for EDI and/or Online Resources enrollment options

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

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

# APPLICATION FOR GROUP CONTRACT

## Delta Dental of Oklahoma – Group *26+*

For Plan Year **2024**

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

**Step 1 – PLAN EFFECTIVE DATE:** (Month) _____01, 2024

**Step 2 – EMPLOYER INFORMATION**

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

**DBA** (if applicable)

| Billing/Mailing Address | City | State | Zip |
|---|---|---|---|
| Physical Oklahoma Address (if different from 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?** ☐ Yes ☐ No If Yes, reporting timeframe required: _____

**Please provide a minimum of two (2) authorized group contacts with a valid email address for each. A valid email address is required for each contact.** Enter the information for each contact that is to receive access through Online Resources, Delta Dental of Oklahoma's (DDOK) secure benefits administration portal for eligibility maintenance and invoice reporting and payment. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation – one (1) containing the User ID, 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 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.
- **Executive** – Authorized contact for all aspects of plan administration; should have access to billing and eligibility online.
- **Billing –** Authorized contact for billing inquiries; should have access to view and pay invoices
- **Eligibility –** Authorized contact for eligibility and enrollment inquiries

**Eligibility Access:**

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

| **Primary Group Contact** | | | | Title | | |
|---|---|---|---|---|---|---|
| Email | | | | Telephone | | |
| Contact Type (select one): | Billing | Eligibility | Executive | Eligibility Access (select one): | View only | Modify |

| **Secondary Contact** | | | | Title | | |
|---|---|---|---|---|---|---|
| Email | | | | Telephone | | |
| Contact Type (select one): | Billing | Eligibility | Executive | Eligibility Access (select one): | View only | Modify |

## Step 2, continued from previous page – EMPLOYER INFORMATION

**Additional Contact** Title

Email Telephone

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

**Additional Contact** Title

Email Telephone

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

**Additional Contact** Title

Email Telephone

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

**Additional Contact** Title

Email Telephone

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

**Additional contacts can be added if necessary. Please include contact name, title, email, telephone and designate what contact type they should be (billing and/or eligibility) on a separate page and submit with this application.** An authorized representative for the Employer approves the individuals/entities listed above 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 above or attached. A 26+ Off-Renewal Plan Change Form is available via Online Resources on the Documents - Forms and Links page. An authorized representative for the Employer may submit completed forms to ClientRelations@DeltaDentalOK.org.

## Step 3 – ELIGIBILITY AND ENROLLMENT

**A minimum of 10 enrolled or 25% of Eligible Employees, whichever is greater, required for participation in 26+ (only applies to fully insured groups).**

**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*

This date determined by the Contractor or Plan Sponsor: *

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

Employees become ineligible for coverage on (select one):

The date of termination The end of month termination occurred

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

The date threshold is exceeded The end of month threshold is exceeded

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

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

**Account Structure** (select one):

One (1) Subgroup per Plan Option  Other (Details attached)

**Processing Policy** (select one):

DDOK Standard  Current Carrier Match*  Other*

**Benefit breakdown required*

| **Covered Services and Plan Co-Insurance:** | **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: | _____ % | _____ % | _____ % |

N/A  Dependent Children Only  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:** _____

**Monthly Rates – Fully Insured only** (please indicate the appropriate rate structure and rates):

Two-tier rate structure

Employee Only_____

Family_____

Three-tier rate structure

Employee Only_____

Employee + One Dependent_____

Family_____

Four-tier rate structure

Employee Only_____

Employee + Spouse_____

Employee + Children_____

Family_____

## Step 6 – THIRD PARTY ADMINISTRATORS

Third party administrators (TPA) listed in this section are authorized to conduct the specified business service(s) below on behalf of the employer group. The Employer authorizes DDOK to communicate and transact with the TPA, as needed, to fulfill applicable transactions and/or reporting.

EDI/Eligibility[◊]_____

COBRA Administrator[◊] _____

Flexible Spending Arrangement (FSA) Administrator_____

Other[◊] _____

I authorize DDOK to disclose Protected Health Information (PHI) and Personally Identifiable Information (PII), as defined in the Health Information Portability and Accountability Act of 1996, to the TPA(s) 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(s) and DDOK. At any time, DDOK reserves the right to request a copy of the signed agreement between the TPA(s) and the Group listed on this application.

Authorized Group Contact Name (please print) Title

Authorized Group Contact Signature Date

## Step 7 – BILLING AND PAYMENT OPTIONS

All designated Billing Contact(s) will be setup with monthly E-Bill notification emails, unless otherwise indicated. Billing Contact(s) may log into Online Resources to view invoice(s) and remit payment, as needed. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation, one containing the User ID and the other the temporary password.

Billing Notification (select one): | Online Resources – Detail E-Bill Electronic Summary Bill Paper Summary Bill

Payment Options (select one): | Automatic Draft[†] | Online Resources FastPay™ Paper Check

[†]To set up automatic draft for the fifth (5th) day of each month*, please complete the information below. **A voided check must be attached to this authorization form**.

Financial Institution Branch

Branch Address City State Zip

Branch Telephone Select One: Checking Savings

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

Signature**:_____ Date: _____

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

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

## Step 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.

## Step 9 – DOCUMENTS AND FULFILLMENT

**New Group Kit**

All Group 26+ 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, Plan Agreement, Summary Plan Description, electronic identification cards and, if applicable, Retiree Conversion materials.

**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

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

| Employer's Authorized Signature | Title | Date |
|---|---|---|
| Producer/Agent Signature | | Date |

# 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<br>Active COBRA<br>Retiree Surviving Dep.<br>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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# FEATURES & SERVICES

DELTA DENTAL

## SPOTLIGHT

Delta Dental of Oklahoma provides answers through an online portal known as **Spotlight**. Spotlight provides secure access to real-time information about your benefit plan — when you want it. Our online services feature:

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

### ELECTRONIC ID CARD

While you don't have to bring your ID card with you when you visit your dentist, sometimes having it brings peace of mind that your claims will be paid appropriately. With Spotlight, you have 24/7 access to view, print, save or email your ID card directly from your computer.


### VIEW MY BENEFITS

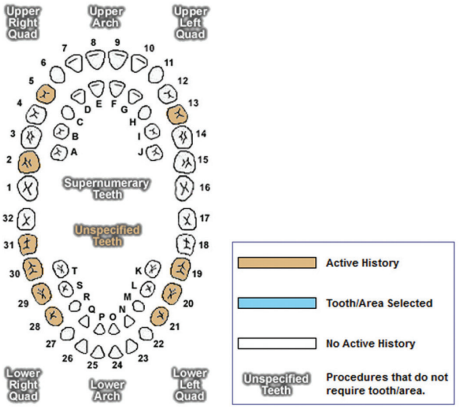
The View My Benefits tool makes it easy to understand your dental benefits. You can see a list of what your dental plan covers and if limitations apply. You can also view your benefits as a PDF to easily print, save, and email.

### ACCESS YOUR EXPLANATION OF BENEFITS (EOB)

Your EOB is the key to understanding how Delta Dental of Oklahoma pays your claims. SPOTLIGHT gives you the freedom to access your EOB before you receive it in the mail. You can also view your history for up to seven (7) years.

### MY MOUTH

The My Mouth chart in Spotlight is a graphic illustration of your teeth, with color codes showing dental work and an explanation of the procedures performed on each tooth. Its aim is to help you better understand the dental care you receive.




### FLEXIBLE SPENDING ACCOUNT SUMMARY

Your flexible spending account (FSA) summary includes documents needed to file for healthcare expense reimbursement. An itemized statement for each date of service is also available on the 'View My Claims' page.

To register for Spotlight, visit **DeltaDentalOK.org/Spotlight.**

DELTA DENTAL OF OKLAHOMA

# FEATURES & SERVICES

DELTA DENTAL

## MULTIPLE PROVIDER NETWORKS

Delta Dental offers two (2) of the nation's largest dental provider networks. Delta Dental Premier consists of more than two-thirds of the nation's dentists. Delta Dental PPO consists of nearly 50% of the nation's dentists and typically provides lower out-of-pocket costs.

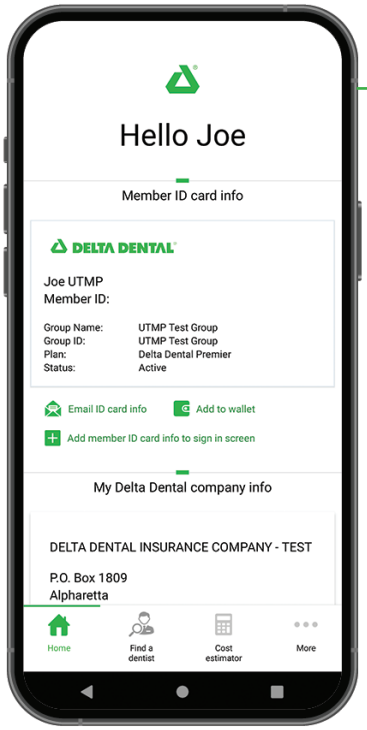
Find a Delta Dental participating provider to enjoy savings and enhanced services at **DeltaDentalOK.org/DentistSearch** or select 'Dentist Search' from your Spotlight account at **DeltaDentalOK.org/Spotlight**.

## NO BALANCE BILLING

If you visit a Delta Dental PPO participating dentist, you are not responsible for any amounts in excess of Delta Dental's PPO maximum allowable amount. Members enrolled in a Delta Dental PPO-Plus Premier plan enjoy no balance-billing with any participating network provider.

## CUSTOMER SERVICE

Our Oklahoma-based Customer Service Department is just a phone call away. Customer Service Representatives are available to answer calls live Monday – Thursday from 7:00 a.m. – 6:00 p.m. and Friday from 7:00 a.m. – 5:00 p.m. at **405-607-2100** (OKC Metro) or **800-522-0188** (Toll Free). Oral health tips, our Find a Dentist tool and many other services are available to you 24/7 at **DeltaDentalOK.org.**




## MOBILE APP

### SECURELY ACCESS BENEFITS

With Delta Dental's free mobile app you can stay up-to-date on coverage information, plan type, benefit levels, contact information, deductibles and maximums. You can check the status of your most recent dental claims, view details and even email claim information for both you and your dependents under age 18. Download the Delta Dental mobile app on the App Store (Apple) or Google Play (Android).

### ADDITIONAL TOOLS

- Find a Dentist
- View and email your mobile ID card

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