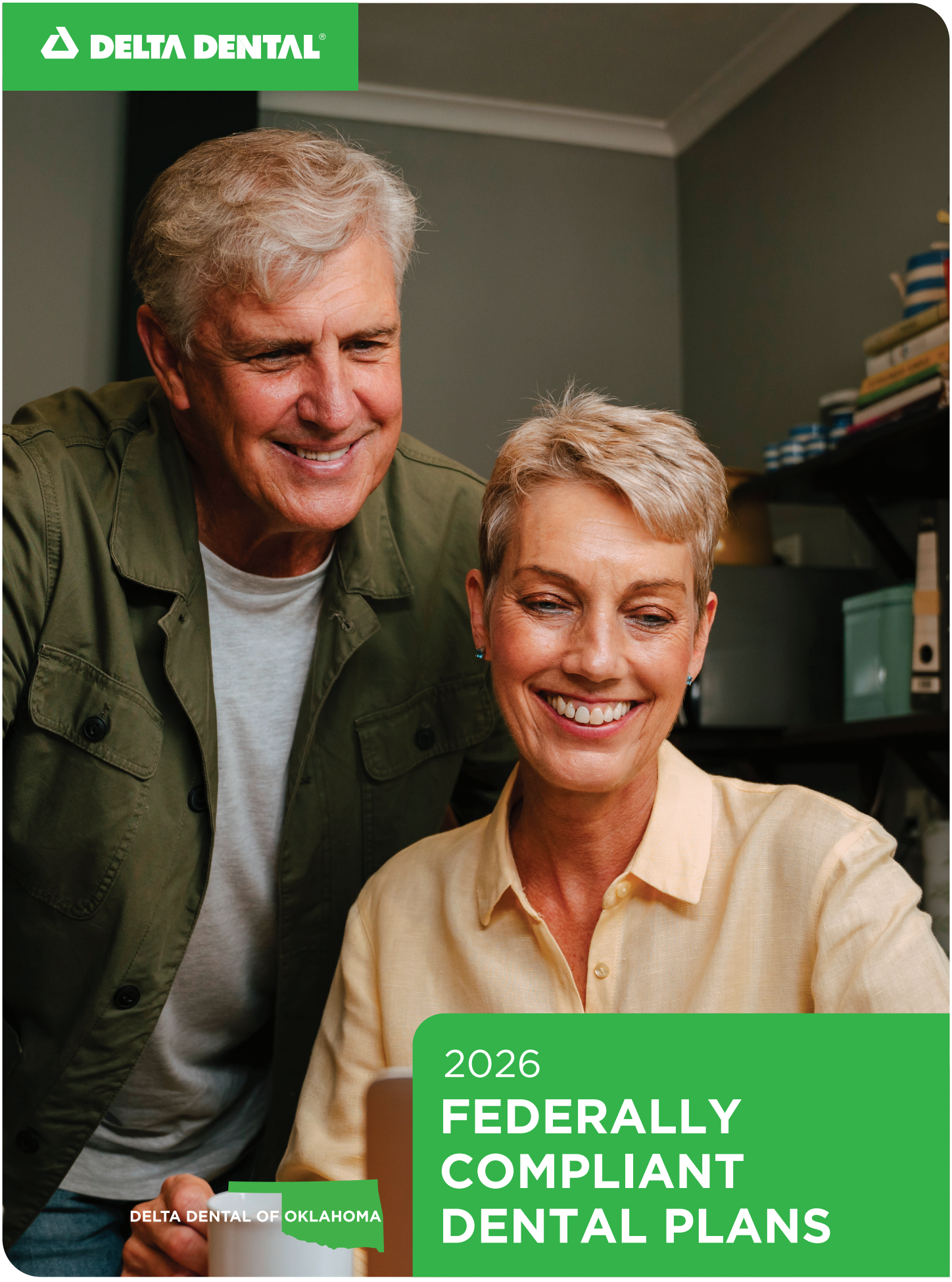
DELTA DENTAL®



DELTA DENTAL OF OKLAHOMA

2026

FEDERALLY COMPLIANT DENTAL PLANS

DELTA DENTAL

Checklist for New Groups

2026

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

☐ **Application for Group Contract**

- ☐ **Step 1**: Plan Effective Date
- ☐ **Step 2**: Employer Information
- ☐ **Step 3**: Eligibility and Enrollment
- ☐ **Step 4**: Employer Contribution
- ☐ **Step 5**: Contact Information/OR Access
- ☐ **Step 6:** Plan Options and Plan Selection
- ☐ **Step 7**: Third Party Administrators ***(Authorized bank signature required)***
- ☐ **Step 8**: Billing and Payment Options ***(Authorized bank signature required)***
- ☐ **Step 9:** Producer/Agent Information
- ☐ **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
- ☐ One-time Load Spreadsheet – Use the specifications on the 'Instructions' tab of the formatted Excel spreadsheet to capture all member elections.

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

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

DELTA DENTAL

Federally Compliant Dental Plans

Federally Compliant Plans for Groups

2026

Delta Dental PPO-Plus Premier Federally Compliant Dental plans[+] – For the 2026 plan year, Delta Dental has two Federally Compliant Plans designed to meet ACA Pediatric Dental Essential Health Benefit standards. Our plans include the Delta Dental PPO and Premier networks for maximum network access.

Plan Information	Low Option	High Option
Annual Maximum Benefit: applies to covered persons age 19 or older	$1,500	$1,500
Annual Maximum Out-of-Pocket: for **one** covered person to age 19	$450	$450
Annual Maximum Out-of-Pocket: for **two or more** covered persons to age 19	$900	$900
Annual Deductible	$75 per person	$50 per person

Co-Insurance – The percentage Delta Dental will pay for covered services

Plan Information	Co-Insurance – Low Option	Co-Insurance – High Option
Preventive & Diagnostic Services	**100%** $75 Annual Deductible applies	**100%** No Deductible
Basic Services*: Six (6) month specific benefit waiting period applies to covered persons age 19 or older	**60%** $75 Annual Deductible applies	**80%** $50 Annual Deductible applies
Major Services*: Twelve (12) month specific benefit waiting period applies to covered persons age 19 or older	**50%** $75 Annual Deductible applies	**50%** $50 Annual Deductible applies
Medically Necessary Orthodontic Services** applies to covered persons to age 19 only	**50%** No Deductible	**50%** No Deductible

[+]**A minimum of two (2) enrolled individuals per plan required for participation in FCP plans.**

- Processing policies, limitations and exclusions will apply for medically necessary procedures. Dependent children are eligible for coverage to age 26.
- Deductibles and Co-Insurance will apply to Maximum Out-of-Pocket.
- Maximum Out-of-Pocket does **not** apply to out-of-network services.

* **Medically Necessary Extractions –** The surgical or non-surgical removal/extraction of third molars must be medically necessary.

** **Medically Necessary** – Orthodontic treatment and/or services are only covered with orthognathic surgery cases or certain designated syndromes or genetic disorders such as cleft palate. Benefits are only allowed for medically necessary orthodontic services to help correct severe handicapped malocclusions caused by cranio-facial orthopedic deformities involving teeth.

Coverage Type	Monthly Rates Low Option	Monthly Rates High Option
Individual Only	$42.00	$87.00
Individual + Spouse (Couple)	$84.00	$174.00
Individual + 1 Dependent	$84.00	$174.00
Individual + 2 Dependents	$126.00	$261.00
Individual + 3 or more Dependents	$168.00	$348.00
Individual + Spouse + 1 Dependent (Family/Couple +1)	$126.00	$261.00
Individual + Spouse + 2 Dependents (Family/Couple +2)	$168.00	$348.00
Individual + Spouse + 3 or more Dependents (Family/Couple +3)	$210.00	$435.00

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

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

DELTA DENTAL

Federally Compliant Dental Plans

2026

Delta Dental Program of Benefits for PPO – Plus Premier Federally Compliant Plans

Delta Dental of Oklahoma's benefits consist of Preventative & Diagnostic, Basic Services, Major Services and Medically Necessary Orthodontic services. The benefits listed below are not a complete list and do not contain any limitations. Limitations to benefits can be found in the Summary Plan Description:

Largest Network of Dentists

- Access to 95 percent of Oklahoma dentists who participate in the Delta Dental PPO and/or Premier networks
- Our Delta Dental PPO network delivers the greatest savings when you visit a PPO provider
- You will still enjoy lower out-of-pocket costs when you receive treatment from a dentist who only participates in our Premier network, but the savings are not as significant
- No balance-billing when treatment is received from a Delta Dental participating provider

Preventive & Diagnostic Services (Class I Benefits):

- Oral evaluation
- Routine prophylaxis, including cleaning and polishing
- Bite-wing and periapical x-rays
- Full-mouth x-rays
- Topical application of fluoride for eligible children
- Topical application of sealants, for eligible children only, limited to permanent first and second molars free of caries and restorations on the occlusal surface

Basic Services (Class II Benefits):

- Amalgam and composite fillings
- Stainless steel crowns, for eligible children only, when the natural teeth cannot be restored with another filling material
- Endodontics – includes pulpal therapy and root canal treatment
- Oral Surgery – non-surgical extractions; medically necessary, non-prophylactic (diseased) third molar non-surgical extractions; incision and drainage of abscess; and other coverall oral surgery procedures
- Periodontics – procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, root planning and scaling
- Anesthesia – Nitrous oxide/analgesia benefits are limited to invasive procedures (procedures that penetrate the hard or soft tissue). Nitrous oxide/analgesia is not payable with evaluations and cleanings

Major Services (Class III Benefits):

- Major Services – provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material
- Prosthodontics – procedures for constructions of fixed bridges, partial dentures and complete dentures
- Oral Surgery Services – Surgical extractions; medically necessary, non-prophylactic (diseased) third molar extractions; and other oral surgical procedures
- Occlusal guards are a benefit by report, for eligible children only, when used to prevent the destructive force of bruxism for periodontal purposes. This is a benefit if the eligible child has periodontal coverage and has had periodontal therapy or is undergoing therapy

Medically Necessary Orthodontics (Class IV Benefits):

- Orthodontic Benefits are available only with orthognathic surgery cases or certain designated syndromes or genetic disorders such as cleft palate. Benefits are only allowed for medically necessary orthodontic services to help correct severe handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth.

APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – *Federally Compliant Plans (FCP)*

For Plan Year **2026**

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, 2026

Step 2 – EMPLOYER INFORMATION

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

Doing Business As *(DBA, if applicable)*

Billing/Mailing Address

City | State | Zip

Physical Oklahoma Address *(if different from billing/mailing address)*

City | State | Zip

Telephone Number | Nature of Business

Federal Tax ID Number | SIC Code

ERISA Exempt: ☐ No ☐ Yes *(exemption typically only applies to government employers/entities or religious institutions)*

Step 3 – ELIGIBILITY AND ENROLLMENT

A minimum of two (2) enrolled Eligible Employees is required. At least one (1) Eligible Employee must be enrolled in a plan option in order for that option to be available to the group.

Total Number Eligible Employees, as reported to the Oklahoma Employment Security Commission (OESC): _____

Step 4 – EMPLOYER CONTRIBUTION

Employer contribution to the employee cost of the plan (select one): ☐ None ☐ A portion ☐ All

Step 5 – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

Please provide a minimum of two (2) authorized group contacts with a valid email address for each, as our Federally Compliant product is administered electronically. Enter the information for each contact that is to receive access through Online Resources, Delta Dental of Oklahoma's (DDOK) secure benefits administration portal for eligibility maintenance 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 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 plan documents, renewals, CDT changes, billing/delinquency notices, etc.
- **Secondary Contact** – Authorized contact for plan administration and recipient of plan correspondence in the event the Primary Contact cannot be contacted.
- **Executive** – Authorized contact for all aspects of plan administration; should have access to billing and eligibility online.
- **Billing** – Authorized contact for billing inquiries; should have access to view and pay invoices online.
- **Eligibility** – Authorized contact for eligibility and enrollment inquiries; should have access to enrollment online as indicated (view only or modify).

ELIGIBILITY ACCESS:

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

Primary Contact Title

Email Telephone

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

Secondary Contact Title

Email Telephone

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

Additional Contact Title

Email Telephone

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

Additional Contact Title

Email Telephone

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

Additional contacts can be added, if necessary. Please include the name, title, email, telephone and contact type designation for each on a separate page and submit with the 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. An authorized representative for the Employer may submit changes to ClientRelations@DeltaDentalOK.org.

DELTA DENTAL

Step 6 – FULLY INSURED PLAN OPTIONS AND PLAN SELECTION (select all that apply)

Plan Year: Calendar

MONTHLY RATES FOR *COMBINED* PLANS	☐ Low Option	☐ High Option
Ages 0 – 20 (Per Covered Person)	$42.00	$87.00
Ages 21 and older (Per Covered Person)	$42.00	$87.00

BENEFITS SUMMARY

		Low Options	High Options
Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%	100%
	Class II – Basic Services	60%	80%
	Class III – Major Services	50%	50%
	Class IV – Orthodontic Services*	50%	50%
Deductible per Plan Year – *Combined Low*	Classes I, II and III Services Only	$75 per Person	n/a
Deductible per Plan Year – *Combined High*	Classes II and II Services Only	n/a	$50 per Person
Plan Maximum Year Benefit Payment – *for covered persons age 19 and older only*	Classes I, II and III Services Combined	$1,500	$1,500
Plan Benefit waiting Period(s) – *for covered persons age 19 and older only*	Class II Services	6 Months	6 Months
	Class III Services	12 Months	12 Months
Maximum Out-of-pocket Cost Per Benefit Plan Year – *for covered persons to age 19*	One Covered Person	$450	$450
	Two or more Covered Persons	$900	$900

*Medically Necessary Only for Covered Person(s) to age 19

Step 7 – THIRD PARTY ADMINISTRATORS

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

EDI/Eligibility◊_____ email _____ phone _____

COBRA Administrator◊ _____ email _____ phone _____

Flexible Spending Arrangement (FSA) Administrator _____ email _____ phone _____

Other◊ _____ email _____ phone _____

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 *(marked with ◊)*, 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

Step 8 – PAYMENT OPTIONS

All designated Billing Contacts will receive a monthly summary invoice via email, as well as automatic draft reminders, if applicable. Billing Contacts may remit payment via Automatic Draft or online, by logging into Online Resources to submit payment by credit card, checking or savings account each month.

Payment type (select one): ☐ Online Resources – move to step 9

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

Financial Institution | Branch | Branch Telephone

Branch Address | City | State | Zip | Account Type (select one): ☐ Checking ☐ Savings

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

Signature**: _____ Date: _____

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

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

Step 9 – PRODUCER/AGENT INFORMATION

Agency	**Five 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 – PRODUCER/AGENT INFORMATION (CONTINUED)

The Producer/Agency named in this form is authorized to request and approve designated business decisions/changes on behalf of the Group. The Group understands and agrees Delta Dental of Oklahoma (DDOK) shall communicate and transact with the named Producer/Agency, as needed, to complete applicable transactions.

☐ None

☐ Limited Authority – authorized to make the following decisions and/or changes on behalf of the employer group:

- Group Name Change
- Group Demographic Change
- Federal Tax Identification Number (TIN) Change
- Minimum Hours Worked
- New Hire Probationary Period
- Member/Dependent Term Rule
- Domestic Partnership Coverage
- Group Contact Change and/or Online Resources Access Update

☐ Broad Authority – authorized to make Limited Authority decisions/changes, in addition to the following on behalf of the employer group:

- Benefit Year Change
- Contract/Anniversary Year Change
- Employer Contribution Change
- Division/Location Additions/Removals
- Change of Third-Party Administrator(s) (TPA)

☐ Full Authority – authorized to make Broad Authority decisions/changes, in addition to the following on behalf of the employer group:

- Rate Tier Change
- Plan Type Addition/Removal
- Product Conversion
- Alternate Identification (Alt ID) Conversion
- Plan Design Change(s)
- Group Termination Requests
- Group Reinstatement Requests

Step 10 – ACKNOWLEDGEMENT AND SIGNATURES

Delta Dental has not reviewed the employer's request for plan coverage nor designed the group plan to meet any federal requirements for Discriminatory Employee Benefit Plans. Said plan may not be in compliance with criteria established for Discriminatory Employee Benefit Plans and employer holds Delta Dental Plan of Oklahoma harmless if said plan fails to meet any such requirements.

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.

Electronic Delivery/Administration: By executing this Application For Group Contract, I hereby acknowledge that: All Select 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 Select group 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

NEW GROUP KIT

All Federally Compliant plan(s) 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 the welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.

DELTA DENTAL

PPO – Plus Premier Federally Compliant Plans Enrollment Form

Delta Dental of Oklahoma | DeltaDentalOK.org

For Plan Year 2026

Employee Name _____ **Date of Birth** _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Social Security Number _____ **Email** _____

Employer _____ **Group Number** _____ **Subgroup** _____ **Location Code** _____

Each covered Person's Social Security Number (SSN) MUST be provided. Please include yourself if applying for coverage under this plan.

Covered Person Name	**SSN**	**Date of Birth**
Covered Person Name	**SSN**	**Date of Birth**
Covered Person Name	**SSN**	**Date of Birth**
Covered Person Name	**SSN**	**Date of Birth**

PROGRAM SELECTION *(choose High OR Low plan)*

☐ **Federally Compliant Plan – High**

Program Types *(choose one)*	**Your Cost Per Person**
☐ Ages 0 - 20	$87.00 per month
☐ Ages 21 and older	$87.00 per month

☐ **Federally Compliant Plan – Low**

Program Types *(choose one)*	**Your Cost Per Person**
☐ Ages 0 - 20	$42.00 per month
☐ Ages 21 and older	$42.00 per month

DELTA DENTAL SUBMISSION INFORMATION

Mail to: **Delta Dental of Oklahoma**
Attn: Client Relations
PO Box 54709
Oklahoma City, OK 73154

Email to: ClientRelations@DeltaDentalOK.org

ENROLLMENT/ELIGIBILITY UPDATE INFORMATION

Eligibility Date

Effective Date of Update/Change/Termination

Dependents eligible for coverage after group's waiting period has been met.

Change in status for: ☐ Subscriber ☐ Spouse ☐ Dependent(s)

Reason for change: ☐ Name Change ☐ New Address ☐ Marriage ☐ Divorce ☐ Adoption/Guardianship* ☐ Other: _____

**Legal documents must be submitted for update/change*

Termination of Coverage Date

Group/Subgroup Transfer

From Group/Subgroup Number _____ To Group/Subgroup Number _____

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

By 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.

Applicant Signature: _____ **Date:** _____

DELTA DENTAL®

Time to Focus on Your Smile

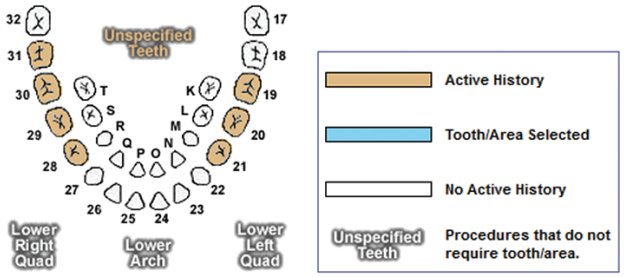
SPOTLIGHT

is **Delta Dental of Oklahoma's** online health services site where subscribers can securely access real-time information regarding their benefits plan.

Maximize your dental benefits:

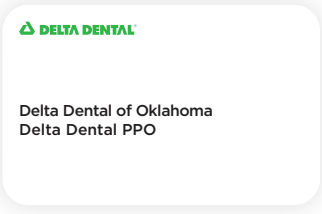
- Find a dentist
- View benefits
- Track claim status
- Access Explanation of Benefits
- Secure messaging with our Customer Service team

My Mouth Chart



An individual tooth-by-tooth illustration of recent dental treatment.

Electronic ID Card



When you bring your own ID Card, you will have the peace of mind that your claims will be paid appropriately.

Visit **DeltaDentalOK.org/Spotlight** to register and to opt out of receiving paper statements today!

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

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

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

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

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

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

فلديك الحق في الحصول على المساعدة والمعلومتا)الضرورية بلغتك من دون اية ، de Delta Dental Federally Compliant Plans إن كان لديك أو لدى شخص تساعده أسئلة بخصوص)
تكلفة .للتحدث مع مترجم اتصل بـ 800-522-0188.

သင္သို႔မဟုတ္္ ငကူညီေ နသူတ္ ္ိိိ ္ိိိးက de Delta Dental Federally Compliant Plans c ပတ္္ က ၍ေ မိးခြန ိးရ သလာပါက ကုန္ကစရသတ္ ေ ပိးရန္မလသုဘဲ မသမသဘာသာစကာိး ဖc အကူအညီရယူ သ ူည္။ စကာိး ပန c ေ ဟလသုပါက 800-522-0188 သသု႔ ေ ြငဲဆသုပါ။

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

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

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

ຖ້າທ່ານ, ຫ ຼື ຄ ົ ນທ ່ ທ່ານກ ໍາລ ັງຊ່ວຍເຫ ຼື ອ, ມ ຄ ໍາຖາມກ່ຽວກ ັບ de Delta Dental Federally Compliant Plans, ທ່ານມ ສ ິດທ ່ ຈະໄດ້ຮ ັບການຊ່ວຍເຫ ຼື ອແລະຂ ໍ ້

ມູນຂ່າວສານທ ່ເປ ັນພາສາຂອງທ່ານບ ໍ ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລ ົມກ ັ

ບນາຍພາສາ, ໃຫ້ໂທຫາ 800-522-0188.

หากคุณ หรือคนที่คุณก าลังช่วยเหลือมีค าถามเกี่ยวกับ de Delta Dental Federally Compliant Plans
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 800-522-0188

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

ᏂᎯ ᏍᏟᏚ Ꮁ ᏟᏓᏛᎾᏗ ᎠᏰ ᎩᏩ ᎯᏍᏕ ᎱᏍᎬ ᏳᏚ Ꮁ ᎤᏓᏛᎾᏗᎠᎱ ᏍᏗ, ᏱᏍᏓ ᎤᏬᏟᏍᏗ ᎯᎠ ᎤᎾᏓᏟᎬᎢ de Delta Dental Federally Compliant Plans. ᎠᏓᏍᎪᎸ ᏛᏅ ᎠᏓᏍᏕᏔᏗ ᏒᏟᏁᏗ ᏃᎴ ᏒᏟᏃ ᎯᏎᏗ ᏟᏚ ᎱᏍᏕ ᏟᏕᏔᎨ ᎯᏍᏗᏰ ᏟᏙᎱ Ꮥ ᏬᏂᎯᏍᏗ ᎬᏗ ᏃᎴ ᏧᎬᏩᏗ ᏂᏲᏒᎾ ᏲᏒᎢ. ᎠᏁᏔᏗᏍᎩ ᏍᏗᏬᏂᎯᏍᏗ ᏰᏟᏚ Ꮁ, ᏗᏬᏃᏑ Ꮧ ᏗᏎᏍᏗ ᎯᎠ 800-522-0188.

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

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