DELTA DENTAL

Delta Dental of South Dakota
PO Box 1157 Pierre, SD 57501
800-627-3961
Fax 605-224-0909
www.deltadentalsd.com

Enrollment/Change Form

Effective date: 7/1/2021

Hire date: _____

Group name: NESD Head Start Group number: _____

Employee name: _____ SSN: _____

Mailing address: _____ DOB: _____

City/State/Zip: _____ Gender: ☐ M ☐ F

Cell phone:* _____ Email:* _____

Marital status (common law marriage is not recognized in South Dakota): Single ☐ Married ☐

List only the names of dependents you are enrolling. I understand that should I decide to apply for single coverage, even though I am eligible for family coverage, I cannot change my policy until open enrollment or a qualifying event (within the past 30 days). I also understand that Delta Dental of South Dakota reserves the right to reject a change form.

First Name Last Name Gender Date of Birth

☐ Add
☐ Drop Spouse _____

Cell phone* _____ Email* _____

☐ Add
☐ Drop Child _____

Cell phone* _____ Email* _____

☐ Add
☐ Drop Child _____

Cell phone* _____ Email* _____

☐ Add
☐ Drop Child _____

Cell phone* _____ Email* _____

☐ Add
☐ Drop Child _____

Cell phone* _____ Email* _____

Use an additional sheet if you have more dependents. List dependents you want removed from your plan in the space provided above.

Change in coverage

Marriage date: _____ Divorce date: _____

Other (explain): _____ Date of change: _____

Signature: _____ Date: _____

I accept the insurance provided by my employer's group dental plan and authorize deductions from my earnings for the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required. I understand that by accepting insurance, I am required to remain enrolled as a covered employee until the next open enrollment period, a qualifying event, or until the termination of my employment.

*By providing this information, I consent to Delta Dental using this contact information for quality improvement activities (e.g. surveys) for individuals over the age of 18.

Required Nondiscrimination and Accessibility Statement*

DELTA DENTAL

Discrimination is Against the Law

Delta Dental of South Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental of South Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of South Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters;
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters;
  - Information written in other languages.

If you need these services, call 1-877-841-1478.

If you believe Delta Dental of South Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Delta Dental of South Dakota, Compliance Manager, 720 N. Euclid Ave., Pierre, SD 57501, phone: 1-800-627-3961, compliance@deltadentalsd.com , fax: 1-605-224-0909, TTY: 1-888-781-4262. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-841-1478 (TTY: 1-888-781-4262).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 1-877-841-1478 (TTY: 1-888-781-4262).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-841-1478（TTY：1-888-781-4262）。

ဟ်သူဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-877-841-1478 (TTY: 1-800-874-9426)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-841-1478 (TTY: 1-888-781-4262).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877-841-1478 (टिटिवाइ: 1-888-781-4262) ।

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-841-1478 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-781-4262).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-841-1478 (መስማት ለተሳናቸው: 1-888-781-4262).

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-877-841-1478 (TTY: 1-888-781-4262).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-841-1478 (TTY: 1-888-781-4262).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-841-1478 (TTY: 1-888-781-4262) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-841-1478 (телетайп: 1-888-781-4262).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-841-1478 (TTY: 1-888-781-4262).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-841-1478 (телетайп: 1-888-781-4262).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-841-1478 (ATS : 1-888-781-4262).

* Under Section 1557 of the Affordable Care Act (ACA), Delta Dental of South Dakota is required to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency (LEP) to the availability of language assistance services.

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DELTA DENTAL®

Delta Dental of South Dakota
No Minimum Voluntary Plan #9070
2021 Rates

% Paid by Delta Dental

100% **Diagnostic and Preventive Services** *These services do not apply to the Annual Maximum Benefit.*

- Routine examinations - two per calendar year.
- Routine dental cleaning (prophylaxis) - two per calendar year.
- Bitewing x-rays - two per calendar year up to age 19, and once per calendar year age 19 and over.
- Full mouth x-rays - one in any five year interval.
- Fluoride applications - two per calendar year up to age 19.
- Space maintainers (fixed, band type) on primary posterior teeth up to age 14.
- Dental sealants - for unrestored first and second permanent molars of children up to age 16.

50% **Basic Services**

- Pre-formed or stainless steel restorations, restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings. If a tooth-colored filling is used to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling.
- Extractions and other oral surgery.
- Emergency treatment for relief of pain.

50%* **Endodontics and Periodontics**

- Root canals.
- Treatment of diseases of the tissues supporting the teeth.
- Periodontal maintenance cleanings. *These cleanings do not apply to the Annual Maximum Benefit.*

50%* **Major Services**

- Crowns, bridges, dentures and implants.

0% **Orthodontics**

- Treatment necessary for the proper alignment of teeth.

Deductible: A one-time $50 per person deductible.

Annual Maximum Benefit: $1,200 per person per calendar year. All services (except Diagnostic and Preventive) are subject to the annual maximum benefit and will not be paid if the annual maximum benefit has been reached.

Dependent children are covered to age 26. There is no age restriction for unmarried dependent children who are full-time students.

Coverage Year: January - December

Monthly rates: Single $44.00 Family $107.20

Network: PPO Plus Premier

* One year wait for coverage.

See other side for information on our Health *through* Oral Wellness® program.

Delta Dental of SD
PO Box 1157
Pierre, SD 57501
1-800-627-3961

Plan requirements

This plan requires a minimum of two enrolled employees. The employer determines the length of employment and number of hours required for an employee to be eligible.

Health through Oral Wellness®

Health through Oral Wellness® is a unique, patient-centered program that adds benefits to a Delta Dental plan based on individual oral health needs. A Delta Dental network dentist trained in Health through Oral Wellness will conduct a clinical risk assessment during a regular preventive visit. The assessment measures the risk and severity of periodontal disease, and the risk of tooth decay.

If the assessment determines a member is at risk for tooth decay, additional benefits include fluoride treatments, sealants, and oral hygiene instruction. If a member is at risk for periodontal (gum) disease, has periodontal disease or has had periodontal surgery, the member will be eligible for two additional cleanings* and four fluoride treatments.

If a member has any of the following health conditions, they are eligible for additional benefits.

- Diabetes (2 additional cleanings*)
- High-risk cardiac care (2 additional cleanings*)
- Kidney failure or dialysis (2 additional cleanings*)
- Cancer-related treatment - chemotherapy or radiation (2 additional cleanings* and 2 applications of fluoride varnish)
- Suppressed immune system (2 additional cleanings* and 2 applications of fluoride varnish)
- Rheumatoid arthritis (2 additional cleanings*)
- Stroke (2 additional cleanings*)
- Pregnancy (1 additional cleaning* during the time of pregnancy)

* Cleanings can either be a general cleaning (prophylaxis) or a periodontal maintenance cleaning. Periodontal maintenance cleanings are typically covered under the "Endodontics and Periodontics" category, not the "Diagnostic and Preventive Services" category.

NESD HEAD START
DELTA DENTAL – WAIVER FORM

EMPLOYEE NAME_____

By signing this form you are acknowledging that you were offered and declined to enroll in the Delta Dental plan offered to you through your employer NESD Head Start. Your next opportunity to enroll in your employer sponsored dental plan will be during the next open enrollment period with an effective date of July 1, 2022.

If you are waiving coverage for yourself or your dependents you may be able to enroll yourself or your dependents in this plan if you notify Delta Dental within 60 days of a qualifying event.

I understand that that by waiving coverage at this time, I will not be allowed to participate unless I experience a special enrollment event or at the next open enrollment event.

Employee Signature_____

Date_____