OHIO DENTAL PLAN COVERAGE

Who is eligible? The Ohio Dental Program is open to bleeding disorder patients with VWD or Hemophilia in Ohio who have NO AVAILABLE dental coverage through any other source. Dependents may also be eligible, based on need and availability.

Where does the plan coverage come from? The Greater Ohio Bleeding Disorders Foundation acts as the fiscal agent for all Ohio chapters and HTCs for the Ohio Dental Program. GOBDF coordinates coverage with Delta Dental.

What does it cost? There is an annual $25 per person enrollment fee for a person with a bleeding disorder and $50 each for additional family members with a $200 per family maximum. Each enrollee will also have a $100 deductible due to the dentist for services over and above exams/cleanings. Each family has an annual maximum of $300 out of pocket. The monthly premium costs will be paid out of grants that were written and supported by all Ohio chapters and HTCs from Cascade Hemophilia Consortium and other HTCs funds. There may be assistance available for bleeding disorder patients to meet out of pocket costs. Contact Program Manager for more details.

What is the coverage? Up to FOUR free cleanings per year, per enrollee. Also, includes $1,250 in services per enrollee.

Services	Amount of Coverage
Class I Services	4 Exams/cleanings per year, x-rays – paid at 100%
Deductible	Applies to basic and major services only – $100 per individual. $300 Family maximum.
Class II Services	Fillings, extractions, crowns, relines & repairs – paid at 100% after deductible
Class III Services	Bridges, implants, dentures – paid at 100% after deductible
Annual Maximum	$1,250 Individual annual limit applies to all services except diagnostic & preventative

Who accepts the Delta Dental Plan? Most dentists accept Delta Dental. A list of dentists who participate in Delta Dental's Preferred and Premier networks can be found at www.deltadental.com. Click on "Find a Dentist" on the right side of the screen, or call your current dentist to ask if they accept Delta Dental PPN.

When can I sign up for coverage? The applications are available year-round and placement into the program is done throughout the year based on availability. Send in your application asap. New enrollees will be added at the beginning of each month. You will get a call when your application is received. Contact your HTC or Chapter for more information or call the program manager, Randi Clites at 330-730-1259.

How long will I be covered? To maintain coverage on the Dental Program, you must meet comprehensive care guidelines. Patients must attend comprehensive clinic based on recommendations of their provider. You will be required to receive at least one dental cleaning a year to qualify to reapply during annual enrollment periods. As long as you stay compliant, you will maintain coverage as long as it is needed.

DELTA DENTAL®

Eligibility Enrollment/Update

No form is required if waiving benefits

Check: ○ **Indiana** ○ **Michigan** ○ X **Ohio** ○ **North Carolina**

Group Name: GOBDF

Dental Group #/Subgroup #: _____ - _____

Vision Group #/Subgroup #: _____ - _____

Plan Enrollment/Update Information *(Please indicate type of update and fill in appropriate information)*:

Type of Update: ○ X New Enrollment ○ Termination of Benefits ○ Change/Correction to Information ○ Reinstatement

Coverage Effective Date: _____ **Change is for:** ☐ Subscriber ☐ Spouse ☐ Dependent

Group/Subgroup Transfer

From (Group#/Subgroup#): _____ - _____ **To** (Group#/Subgroup#): _____ - _____

Subscriber Information *(Please fill in for first-time enrollments, changes, or corrections)*:

Subscriber Name

_____ _____ _____

(Last) *(First)* *(M.I.)*

Social Security Number Date of Birth

_____ _____

Street Address

_____

City State Zip Code

_____ _____ _____

Date of Hire: _____

○ Dental ○ Vision (only available if the group contract includes it)

Sex: ○ Male ○ Female

Status*: ○ Active ○ COBRA ○ Retiree ○ Surviving

☐ Check here if this is a new address

Spouse/Dependent Information *(Please fill in for first-time enrollments, changes, or corrections)*:

Spouse Name

_____ _____ _____

(Last) *(First)* *(M.I.)*

Social Security Number Date of Birth

_____ _____

○ Dental ○ Vision (only available if the group contract includes it)

Sex: ○ Male ○ Female

Status*: ○ Legal ○ Surviving

Dependent #1 Name

_____ _____ _____

(Last) *(First)* *(M.I.)*

Social Security Number Date of Birth

_____ _____

○ Dental ○ Vision (only available if the group contract includes it)

Sex: ○ Male ○ Female

Status*: ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

Dependent #2 Name

_____ _____ _____

(Last) *(First)* *(M.I.)*

Social Security Number Date of Birth

_____ _____

○ Dental ○ Vision (only available if the group contract includes it)

Sex: ○ Male ○ Female

Status*: ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

Dependent #3 Name

_____ _____ _____

(Last) *(First)* *(M.I.)*

Social Security Number Date of Birth

_____ _____

○ Dental ○ Vision (only available if the group contract includes it)

Sex: ○ Male ○ Female

Status*: ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

Dependent #4 Name

_____ _____ _____

(Last) *(First)* *(M.I.)*

Social Security Number Date of Birth

_____ _____

○ Dental ○ Vision (only available if the group contract includes it)

Sex: ○ Male ○ Female

Status*: ○ IRS Dep. ○ Surviving ○ Disabled ○ Sponsored

*See reverse side for instructions.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

Subscriber's Signature: _____ **Date:** _____

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

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

Enrollment: Check for first time enrollment for yourself, spouse or your dependents.

Reinstatement: Check for reinstatement coverage for yourself, spouse or your dependents.

Change/Corrections: When reporting a change or correction, the information that is incorrect or has changed should be listed. Please include both the first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for Subscriber, Spouse, or Dependent.

Group Transfers: Use the "FROM: Group#/Subgroup# and TO: Group#/Subgroup#" when transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

Subscriber Information – This section must be completed for us to process your enrollment, changes or corrections to your record. All information should apply to you, the primary subscriber. Please print clearly or type including first and last name.

Coverage Effective Date: The date that Delta Dental coverage or changes takes effect.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

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

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**

Surviving: The surviving spouse or child of a deceased subscriber.

Spouse/Dependent Information – This section must be completed for us to process your enrollment, changes or corrections to the record(s) for a spouse or dependent. Please print clearly or type including first and last name.

Dependent Status Definitions:

Legal: Your current spouse.

Surviving: The surviving spouse or child of a deceased subscriber.

IRS Dependent: An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried or married dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Disabled: Your permanently disabled child.

Sponsored: (Use only if specified in your Group's contract with Delta Dental). Sponsored Dependents whom you are legally responsible for could include parents, grandparents and foreign exchange students.

Email: eligibility@deltadentalmi.com

Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916

NO FORM IS REQUIRED IF WAIVING DENTAL OR VISION BENEFITS

Ohio Dental Plan – Release of Information Form
Authorization to Disclose Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Applicant Name:_____ Date of Birth:_____

Parent/Guardian/Personal Representative (if applicable)

Name:_____ Relationship to Client:_____

AUTHORIZATION

I authorize:
Greater Ohio Bleeding Disorders Foundation
17407 Lorain Ave Ste 206, Cleveland OH 44111
216-834-0051

TO RELEASE the above-named applicant's protected health information TO AND OBTAIN Information FROM:

_____
Name of Applicant's current Hemophilia Treatment Center and/or Hematologist

_____ _____
Address Phone Number

EXTENT OF AUTHORIZATION

☒ I authorize the release of the above-named applicant's information related to the Ohio Dental Plan application including eligibility for the program, status of the application, dental benefit coverage, dental care needs, and diagnosis and treatment of the above-named applicant's bleeding disorder.

☒ I understand that this release of information form does NOT include records relating to mental health care, communicable diseases (including HIV and AIDS) or alcohol/drug abuse treatment.

This information may be used by the person I authorize to receive this information to assist in determination of eligibility for the Ohio Dental Plan, billing or claims payment and management of dental program benefits and coordination of dental care.
I understand that this consent will remain in effect until I give written notice to discontinue. I have the right to change my mind and revoke this authorization at any time. This must be in writing to Greater Ohio Bleeding Disorders Foundation. I also understand that any uses or disclosures already made with my permission cannot be taken back. I understand that this consent will automatically expire if I am terminated from the Ohio Dental Program.
I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for the Ohio Dental Plan unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

Signature of Applicant or Parent (if minor): _____ Date_____

Ohio Dental Plan - Release of Information Form
Authorization to Disclose Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Applicant Name:_____ Date of Birth:_____

Parent/Guardian/Personal Representative (if applicable)

Name:_____ Relationship to Client:_____

AUTHORIZATION

I authorize:
Greater Ohio Bleeding Disorders Foundation
17407 Lorain Ave Ste 206, Cleveland OH 44111
216-834-0051

TO RELEASE the above-named applicant's protected health information TO AND OBTAIN Information FROM:

Delta Dental
PO Box 9085
Farmington Hills, MI 48333-9085
800-524-0149

EXTENT OF AUTHORIZATION

☒ I authorize the release of the information contained on the Ohio Dental Plan application form including eligibility for the program, status of the application and dental benefit coverage.

☒ I understand that this release of information form does NOT include records relating to mental health care, communicable diseases (including HIV and AIDS) or alcohol/drug abuse treatment.

This information may be used by Greater Ohio Bleeding Disorders Foundation to verify applicant's dental benefits and to process payments of dental plan premiums. I understand that Greater Ohio Bleeding Disorders Foundation will NOT use this information in the marketing of any other services GOBDF provides.

I understand that this consent will remain in effect until I give written notice to discontinue. I have the right to change my mind and revoke this authorization at any time. This must be in writing to Greater Ohio Bleeding Disorders Foundation be taken back. I understand that this consent will automatically expire if I am terminated from the Ohio Dental Program.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization but that my refusal to sign may affect my eligibility for dental benefits through the Ohio Dental Plan.

By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

Signature of Applicant or Parent (if minor): _____Date_____

Signature of Guardian/Personal Representative (if applicable): _____

OHIO BLEEDING DISORDER DENTAL (OBDD) PROGRAM APPLICATION

APPLICATION INSTRUCTIONS

1. Complete, sign, and date the OBDD Program application. Answer all questions completely.
2. Complete, sign, and date the Delta Dental Enrollment Application.
3. Send enrollment fee with completed application. Make check payable to: Greater Ohio Bleeding Disorders Foundation (GOBDF.)
4. Review the "checklist" (section 7) at the end of this application to ensure you have provided all the required information for Greater Ohio Bleeding Disorders Foundation to review and process your application.

SECTION 1: APPLICANT INFORMATION

Use name of bleeding disorder patient and contact information from Head of Household (HOH) in this section.

If more than one bleeding disorder patient lives in the household, use eldest information.

Patient Name: _____ Date of Birth: _____

Dr./HTC: _____ Social Security Number: _____

If Minor, Parent/Guardian/HOH Name: _____

Date of Birth of HOH: _____ SS# of HOH: _____

Marital Status: ☐Married ☐Single ☐Widow Bleeding Disorder: ☐Hemophilia ☐VWD

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Primary Phone Number: _____ Email Address: _____

SECTION 2: ADDITIONAL ENROLLEE INFORMATION

Dependent #1 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #2 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #3 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #4 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

SECTION 3: CONFIRM ENROLLMENT GUIDELINES

1. Are you a resident of the state of Ohio or receive BD care in Ohio? □Yes □No
2. Do you have hemophilia, VWD, or another factor deficient bleeding disorder? □ Hem □VWD □Other
3. Are you eligible for dental insurance through an employer? □Yes □No
4. Do you have coverage under Medicaid or Medicare? ☐Yes ☐No

If you answered "other" for BD, or "yes" to 3 or 4, please explain reason for request of approval to dental program:

SECTION 4: EMPLOYMENT INFORMATION

Applicant's employment status: ☐Employed Full-Time ☐Employed Part-Time ☐Self-Employed ☐Unemployed ☐Retired

Spouse's employment status: ☐Employed Full-Time ☐Employed Part-Time ☐Self-Employed ☐Unemployed ☐Retired

Please provide your annual household income: ☐ 0 - $14,999 ☐ $15,000 – $29,999 ☐$30,000 – $64,999 ☐ over $65,000

SECTION 5: ANNUAL ENROLLMENT FEE EXPLANATION

The total cost of each policy through the OBDD program is currently about $1,400 per year, per family. The enrollment fee for any **bleeding disorder patient will be $25**, however other members living in the household must pay a **$50 per person**, per year enrollment fee. **There is a maximum enrollment fee for the family of $200**. The OBDD Program will pay the balance of your premiums as long as you stay compliant with the program.

Each person must pay an annual $100 deductible for dental services other than cleaning and x-rays. This deductible is due directly to your treating dentist and will not be paid by the OBDD program, unless a need arises. ***It is extremely important to take advantage of the twice yearly preventative care available***. Preventative care is an essential part of keeping dental costs low for your family and our program.

SECTION 6: VERIFYING YOUR UNDERSTANDING OF THIS APPLICATION

1. I understand that the OBDD Program through GOBDF can only accept a limited number of applicants, and that priority will be given to Hemophilia and Von Willebrand patients. Other bleeding disorders patients will be approved on a case-by-case basis based on resources and situations; coverage may be limited to a certain time frame.
2. I understand that I am subject to removal and exclusion from this program if provided information is false, fraudulent, or contains intentional misrepresentation of facts.
3. I understand that it is my responsibility to inform GOBDF of any changes that may affect my eligibility, including any access to dental insurance that I may be offered in the future by returning the form or email the program manager to be removed from the program as soon as I am eligible for additional dental coverage.
4. I understand that if I move or move my bleeding disorder care out of the state of Ohio, I must notify GOBDF, so that I can be removed from the program/plan using the form provided or email to the program manager.
5. I understand that annual re-enrollment is necessary to remain in this program. I understand that if I do not meet these guidelines: complete the annual re-enrollment process, complete the annual survey, stay compliant in my treatment plan with the hematologist, visit my dentist at least one time in the program year AND pay my annual enrollment fee by deadline, I will be removed from this program.

6. I understand that if I voluntarily opt out or if I am involuntarily removed from the OBDD Program, I may not reapply for at least one year after my coverage ends.
7. I understand that identifying information will be shared with Delta Dental and Cascade Hemophilia Consortium for the purposes of verifying my dental benefits and for processing dental premium payments. I understand that my identifying information will NOT be used for marketing of any other services GOBDF or Cascade provides.
8. I understand that, by signing below, I certify that all information and documents provided as part of this application are complete, accurate and true to the best of my knowledge and belief.

_____ _____

Applicant's Signature Date

SECTION 7: CHECKLIST FOR SUBMITTING YOUR APPLICATION

❒ **Completed Ohio Dental Plan Application**

- Please be sure the application is fully completed.
- Please provide proof of Ohio residency
- Proof of Hemophilia Treatment Center or Hematologist you receive care through.
- Please be sure your enrollment fee payment made out to GOBDF is enclosed.

Applications will be processed monthly. You should receive confirmation of receipt of application within a week. If you do not, contact the program manager. This doesn't guarantee coverage. It is only confirmation your application will be reviewed at the end of the month.

The application will be reviewed the last week of the month for services to begin the first day of the next month. EXAMPLE: You mail out application on January 5th. GOBDF will process the application week of January 21st and services will begin Feb 1.

You are not approved until the last week of the month when the program manager reviews the application. The Program Manager will call or email you to let you know that you are being enrolled into the program. You will then receive coverage information by the first week of the month.

Contact Randi Clites, Dental Program Manager, email randi@gobdf.org/ cell 330-730-1259.

Please mail this application with all required documentation to:

Greater Ohio Bleeding Disorders Foundation
17407 Lorain Ave #206
Cleveland OH 44111