CASCADE HEMOPHILIA CONSORTIUM

DELTA DENTAL®

THE NORTHERN OHIO HEMOPHILIA FOUNDATION INC.

OHIO DENTAL PLAN COVERAGE

Who is eligible? The Ohio Dental Program is open to all bleeding disorder patients in Ohio who have NO AVAILABLE dental coverage through any other source, however is currently on a waiting list until January 2018. Send in your application, without enrollment fee, to hold your spot.

Where does the plan coverage come from? The Northern Ohio Hemophilia Foundation acts as the fiscal agent for all Ohio chapters and HTCs for the Ohio Dental Program. NOHF 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 United Way Summit County.

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

Services	Amount of Coverage
Class I Services	2 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. 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. Severe patients must attend comprehensive clinic once per year and all other diagnoses once every other year. 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.

Funding Provided By: CASCADE HEMOPHILIA CONSORTIUM

Administered By: NOHF

Benefits Provided Through: DELTA DENTAL

OHIO BLEEDING DISORDER DENTAL 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: The Northern Ohio Hemophilia Foundation (NOHF). You will receive a call when you are approved for services to begin.
4. Review the "checklist" (section 7) at the end of this application to ensure you have provided all of the required information for The Northern Ohio Hemophilia 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: _____ Gender: ☐Male ☐Female

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

Dependent #5 Name: _____ Date of Birth: _____

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

Dependent #6 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? ☐Yes ☐No
2. Are you eligible for dental insurance through your employer? ☐Yes ☐No
3. Are you eligible for dental insurance through your spouse's employer? ☐Yes ☐No
4. If your employer or your spouse's employer offers dental insurance, why are you not covered under that dental plan?

   _____

5. If you are under the age of 26, are you eligible for dental insurance through a parent's employer? ☐Yes ☐No
6. If you are eligible through a parent's employer, why are you not covered under that dental plan?

   _____

7. Do you have coverage under Medicaid, Medicare or (B)CMH – ☐Yes ☐No If yes, circle type.

SECTION 4: EMPLOYMENT INFORMATION, IF CHANGED IN 2016-17

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 $1,700 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 a $100 deductible for dental services other than cleaning and x-rays. This deductible is due directly to your treating dentist. Assistance may be available for the deductible as funds are available.

SECTION 6: VERIFYING YOUR UNDERSTANDING OF THIS APPLICATION

1. I understand that the OBDD Program through NOHF can only accept a limited number of applicants and that priority will be given to bleeding disorder patients and additional family members applicants based on their resources to access dental care.
2. I understand that I am subject to removal and exclusion from this program if this information is false, fraudulent or contains intentional misrepresentation of facts.
3. I understand that it is my responsibility to inform NOHF of any changes that may affect my eligibility, including any access to dental insurance that I may be offered in the future.
4. I understand that if I move or move my bleeding disorder care out of the state of Ohio, I must notify NOHF so that I can be removed from the program/plan.
5. I understand that annual re-enrollment is necessary in order to remain in this program. I understand that if I do not meet these guidelines: complete the annual re-enrollment process, complete the annual surveys, 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 my 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 NOHF 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 residency.
- Please provide release of information forms.
- Please be sure your enrollment fee payment made out to NOHF is enclosed.

Do you have questions about this application? Contact Randi Clites at NOHF 216-834-0051 or cell 330-730-1259.

Please mail this application with all required documentation to:

The Northern Ohio Hemophilia Foundation
5000 Rockside Road Ste 230, Independence, OH 44131
Fax: 216-834-0055 or scan to randi@nohf.org

DELTA DENTAL

Eligibility Enrollment/Update

Check: Indiana Michigan North Carolina (Ohio)

Client Name: NOHF

Client#/Subclient# 0893 - 0001

Subscriber Information *(please complete for all enrollments/updates:)* Example: ABCDEF123456

Subscriber Name (Last) HOH - ADULT (First) (M.I.) Sex ☐ Male ☐ Female

Subscriber Social Security Number Birth Date Status* ☒ Active ☐ COBRA ☐ Retiree ☐ Surviving Coverage Effective Date

Street Address ☐ Check here if this is a new address Email

City State ZIP Code

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

Type of Update: ☒ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination of Benefits ☐ Waive Benefits

Group Transfer From: Client/Subclient# N/A - N/A To: Client/Subclient# N/A - N/A

Rate Code Change* From: N/A To: Effective Date of Change Beginning of next month

Change is for: ☐ Subscriber ☐ Dependent

Enrollment/Corrections to Information *(please fill in for spouse/dependents for first-time enrollment or corrections):*

SPOUSE Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number Birth Date Status* ☐ Legal ☐ Surviving

DEPENDENT #1 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number Birth Date Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

DEPENDENT #2 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number Birth Date Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

DEPENDENT #3 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number Birth Date Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

DEPENDENT #4 Name (Last) (First) (M.I.) Sex ☐ Male ☐ Female

Social Security Number Birth Date Status* ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

*See reverse side for instructions and explanation of codes.

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.

1 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.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

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.

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 or your dependents.

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

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Delta Dental program.

Rate Codes:

Rate 1	Employee Only
Rate 2	Employee and spouse
Rate 3	Employee, spouse and children
Rate 5	Employee, one child, no spouse
Rate 6	Employee and more than one child, no spouse

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

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 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: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, **but only if specified in your group's contract with Delta Dental.**

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

Ohio Dental Plan
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:

The Northern Ohio Hemophilia Foundation
5000 Rockside Rd, Ste 230
Independence, OH 44131
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 The Northern Ohio Hemophilia 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_____

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

Ohio Dental Plan
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:

The Northern Ohio Hemophilia Foundation
5000 Rockside Rd, Ste 230
Independence, OH 44131
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 Northern Ohio Hemophilia Foundation to verify applicant's dental benefits and to process payments of dental plan premiums. I understand that The Northern Ohio Hemophilia Foundation will NOT use this information in the marketing of any other services NOHF 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 The Northern Ohio Hemophilia 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 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): _____