### Exhibit 6

### PPO Dental Plan Design

### [Supplier Name]

### Plan Year 2021

# **Instructions:**

1. Bidder may submit up to two (2) dental plans. Refer to Bidder Instructions. If the Bidder submits a PPO dental plan, use the following template for each PPO plan.
2. Exhibit 6 must be signed by the Supplier’s President, Chief Executive Officer or authorized representative.
3. Any exceptions must be reflected in Bidder Instructions Requested Exceptions to Terms.
4. All plan design options must correspond to Exhibit 5 for Dental premium quotes.
5. List complete benefits when submitting “PY2021 No Plan Changes” and the “PY2021 with Plan Changes.” **Plan design shall be from the** **member’s perspective**.
   1. If awarded the contract, the Supplier’s plan design will be included in Option Period material. For an example of the layout and style of verbiage, refer to pages 30-34 of the PY2020 Employee Benefit Option Guide located at <https://omes.ok.gov/sites/g/files/gmc316/f/2020BOG.pdf>.
6. New and existing Suppliers must complete “No Plan Changes” column.
   1. For existing Suppliers, this column reflects the Supplier’s current plan characteristics without changes.
7. A current OEIBA Program Dental Supplier has the option to also complete column “PY2021 with Plan Changes”.
   1. Column “PY2021 No Plan Changes”: This assumes that the Supplier’s current plan characteristics are applied exactly to this column without changes.
   2. Column “PY2021 with Plan Changes”: This should include any proposed plan changes from a Supplier plan. Supplier should also include all plan characteristics that will remain the same. Proposed plan changes must be in **bold**.
8. *Example:*

|  |  |  |
| --- | --- | --- |
|  | **PY2021 No Plan Changes**  **(Required)** | **PY2021 with Plan Changes**  **(Optional)** |
| **Annual Calendar Year Deductible** | Member pays-  Network: $25 individual/$75 family, Basic and Major services combined  Non-network: $25 individual/$75 family,  Preventive, basic and major services combined plus amounts above allowable fees | Member pays-  **Network: $30 individual/$85 family,** Basic and Major services combined  **Non-network: $30 individual/$85 family,**  Preventive, basic and major services combined plus amounts above allowable fees |

|  |  |  |
| --- | --- | --- |
|  | **[PPO Plan Name]** | |
| **Covered Services** | **PY2021 No Plan Changes**  **(Required)** | **PY2021 with Plan Changes**  **(Optional)** |
| **Annual Calendar Year Deductible** |  |  |
| **Diagnostic and Preventive Care**  Oral Exams  Routine Cleanings  Routine X-rays  Fluoride Treatment  Sealants  Space Maintainers (non-orthodontic) |  |  |
| **Basic Care**  Fillings  Non-Routine X-rays  Emergency Services to Relieve Pain  Oral Surgery, Simple Extractions  Endodontics (e.g., root canals)  Periodontics (e.g., gum treatment) |  |  |
| **Major Care**  Crowns / Inlays / Onlays  Root Canal Therapy /  Oral Surgery, All Except Simple Extractions  Surgical Extraction of Impacted Teeth  Relines, Rebases, and  Adjustments  Repairs - Bridges, Crowns, Inlays, and Dentures  Anesthetics  Prosthodontics (e.g., partials/full dentures)  Implants  Bridges |  |  |
| **Orthodontic Care**  Identify if a waiting period applies. |  |  |
| **Plan Year Maximum** |  |  |
| **Filing Claims** |  |  |

**PROPOSED DENTAL PLAN DESIGN(S)**

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Signature Printed Name Date

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Title Supplier Name

(To be signed by the Supplier’s President, Chief Executive

Officer or authorized representative.)