

DELTA DENTAL OF OKLAHOMA
GROUP 26+



2018

 **DELTA DENTAL®**

When enrolling in a new group, there are several key areas essential in providing a smooth implementation. In order to better serve our clients, we have developed a checklist to aid in the process of enrolling and setting up new groups.

- Application for Group Contract completed in its entirety and signed by the person authorized to contract for the group.
- Individual enrollment form completed and signed by each employee enrolling in the dental plan; enrollment may also be submitted by electronic file. For more information on acceptable electronic file formats, please contact Sales@DeltaDentalOK.org.

Please mail new group submissions to:
Delta Dental of Oklahoma
Attention: Sales
P.O. Box 54709
Oklahoma City, Oklahoma 73154-1709

or send an email to:

Sales@DeltaDentalOK.org



For Delta Dental of Oklahoma Use Only:
Group No. _____

APPLICATION FOR GROUP CONTRACT
Delta Dental of Oklahoma – Group 26+
For Plan Year 2018

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 – EMPLOYER INFORMATION

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

DBA (if applicable)

Billing/Mailing Address

City State Zip

Physical Address (if different from billing address)

City State Zip

Telephone Number Fax Number

Website Address

Type of Business

Federal Tax ID Number SIC Code

ERISA Exempt: No Yes (exemption typically only applies to government employers/entities or religious institutions)
Form 5500 information required? Yes No If Yes, reporting timeframe required: _____

Group Executive Title

Email Telephone Fax

Primary Group Contact Title

Email Telephone Fax

Billing Contact Title

Email Telephone Fax

Eligibility Contact Title

Email Telephone Fax

Step 2 – PLAN EFFECTIVE DATE: (Month): _____ (Day): _____, 2018

Step 3 – ELIGIBILITY AND ENROLLMENT: A minimum of 10 enrolled or 25% of Eligible Employees, whichever is greater, required for participation in 26+.

Total Number Employees: _____ Total Number Ineligible Employees*: _____

Total Number Eligible Employees: _____

*Indicate Reason(s) for Ineligibility _____

Employees are eligible for coverage on (select one):

- The date of hire The first of the month following the date of hire
- The _____ day of continuous, full-time employment*
- The first of the month following _____ days of continuous, full-time employment*

Is the following included with this application? (select all that apply): Enrollment Forms Electronic Enrollment Data

*Cannot exceed 90 days between first day of full-time employment and coverage start date.

Step 4 – FUNDING OPTIONS (select one): Fully Insured Self-Insured/Administrative Services Only (ASO)

Step 5 – PLAN OPTIONS AND PLAN SELECTION (select all that apply)

Benefits Summary: Please indicate the applicable benefits information below by placing a checkmark in the appropriate box(es) and/or completing those areas requiring information, based on proposed benefits plan.

Plan Options:

- Single Option
- Dual Option
- Triple Option

Plan Types:

- Delta Dental PPO – Plus Premier “Elite” Delta Dental PPO – Point of Service
- Delta Dental PPO – Plus Premier Delta Dental PPO

Covered Services and Plan Co-Insurance:

	PPO Network	Premier Network	Out-of-Network
<input type="checkbox"/> Class I – Preventive and Diagnostic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class II – Basic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class III – Major Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class IV – Orthodontic Services:	_____ %	_____ %	_____ %

N/A Dependent Children Only Family

Deductible and Maximum (select one): Calendar Year Contract Year

Plan Year Deductible Per Person: _____ **Maximum Plan Year Deductible Per Family:** _____

Maximum Plan Year Benefit Payment, excluding Orthodontics: _____

Maximum Lifetime Orthodontic Benefit Payment, if applicable: _____

Additional Benefit Information, if applicable: _____

Monthly Rates – Fully Insured only (please indicate the appropriate rate structure and rates):

- | | | |
|--|--|---|
| <input type="checkbox"/> Two tier rate structure | <input type="checkbox"/> Three tier rate structure | <input type="checkbox"/> Four tier rate structure |
| Employee Only _____ | Employee Only _____ | Employee Only _____ |
| Family _____ | Employee + One Dependent _____ | Employee + Spouse _____ |
| | Family _____ | Employee + Children _____ |
| | | Family _____ |

Step 6 – EMPLOYER CONTRIBUTION

Employer contributes _____ % OR \$ _____ to employee cost of plan.

Step 7 – OPTIONS FOR ACCESS TO ONLINE RESOURCES – FOR CLIENTS AND BROKERS

Enter the information for each contact that is to receive online access through Online Resources. If a contact should have access to all subgroups then enter "ALL" in the Subgroup(s) Access box. Select each type of access. You may choose one method of invoice receipt, E-Bill or Bill by Fax.

An email address is required for each contact requesting access to Online Resources.

Subgroup Access: Name the contact(s) who will receive access to the specified subgroup(s).

Online Eligibility: Name the contact(s) who will receive access to *view and/or modify* eligibility in Online Resources.

View Only: Read-only access to online eligibility.

Modify: Ability to make changes through online eligibility.

Billing: Name the contact(s) who will receive access to billing.

E-Bill: Access to receive the invoice through email.

Bill by Fax: Access to receive the invoice by Fax.

Contact Name	Online Resources User Name if previously assigned	Subgroup(s) Access	Online Eligibility Select One		Billing Select One		Email Address required. Please add Fax Number if selecting Bill by Fax.
			View Only	Modify	E-Bill	Bill by Fax	

I _____, an authorized representative for _____, approve access to our account for the person(s) named above. I understand that it is the responsibility of our company to submit written notification to Delta Dental of Oklahoma if a user's access to Online Resources needs to be terminated. *** Through the selection of the above options, I agree my company will receive our monthly bill from Delta Dental via the above selected option only.**

Signature: _____ Date: _____

*A Group Change Form is available on Online Resources, and completed forms may be submitted to ClientRelations@DeltaDentalOK.org by a current authorized contact for your company.

Step 8 – BILLING AND PAYMENT OPTIONS

Billing Notification (select one): Online Resources – E-Bill (email notification) Fax Paper Bill

Payment Options (select one): Automatic Draft[†] FastPay™ online Pay-by-Phone Paper Check

[†]To set up automatic draft, please complete the information below. **A voided check must be attached to this authorization form.**

Billing Contact Telephone Fax Email

Financial Institution Branch

Branch Address City State Zip

Branch Telephone

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/CONSULTANT INFORMATION

Producer/Agent/Consultant Name

Five Digit Broker Number

Agency

City

State

Zip

Email Address

Telephone

Fax

Support Staff Name

Support Staff Telephone Number

Support Staff Fax Number

Support Staff Email Address (if applicable)

Producer/Consultant Fee Payment Options, if applicable:

EFT to Producer

EFT to Agency

Step 10 – HOLD HARMLESS

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.

Employer's Authorized Signature

Title

Date

Producer/Agent/Consultant Signature

Date

Please ship my new group kit[†] to:

Producer

Group Contact

[†]New group kit contains welcome letter, Plan Agreement, Summary Plan Description and identification cards.



Enrollment/Eligibility Update

PLAN TYPE:
(AS ESTABLISHED
BETWEEN EMPLOYER
AND DELTA DENTAL)

- DELTA DENTAL PPO
- DELTA DENTAL PPO - PLUS PREMIER
- DELTA DENTAL PPO - PLUS PREMIER "ELITE"
- DELTA DENTAL PPO - NO MAX
- DELTA DENTAL PREMIER
- DELTA DENTAL PREMIER - CHOICE
- DELTA DENTAL PPO - CHOICE
- DELTA DENTAL PPO - CHOICE ADVANTAGE
- DELTA DENTAL PPO - POINT OF SERVICE

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS, EXPLANATION OF CODES AND PRIVACY POLICY STATEMENT.

Employer: _____

GROUP#/SUBGROUP# LOCATION CODE
 -

Subscriber Information: (please complete in ink for enrollment/eligibility updates)

SUBSCRIBER NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX	MARITAL STATUS
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S
SUBSCRIBER SOCIAL SECURITY NUMBER	BIRTH DATE	FULL-TIME HIRE DATE	COVERAGE EFFECTIVE DATE		STATUS		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Dep. <input type="checkbox"/> Other: _____		
ADDRESS							
CITY				STATE	ZIP	CHECK HERE IF THIS IS A NEW ADDRESS <input type="checkbox"/>	

E-MAIL: _____

Enrollment/Eligibility Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: - -

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:		REASON FOR CHANGE:	
<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> REINSTATEMENT	<input type="checkbox"/> CHANGE IN CURRENT ENROLLMENT STATUS FOR:	<input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENTS
<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> COBRA ELECTION	<input type="checkbox"/> DIVORCE <input type="checkbox"/> MARRIAGE <input type="checkbox"/> NAME CHANGE <input type="checkbox"/> LEGAL GUARDIANSHIP <input type="checkbox"/> ADOPTION <input type="checkbox"/> OTHER _____	
<input type="checkbox"/> TERMINATION OF BENEFITS		<input type="checkbox"/> DECLINE	
<input type="checkbox"/> TERMINATION OF EMPLOYMENT AS OF _____ - _____ - _____			

GROUP TRANSFER-GROUP#/SUBGROUP# TO: GROUP#/SUBGROUP#
 - -

Dependent Enrollment/Eligibility Update Information: (please complete for spouse and/or dependent children for enrollment/eligibility update)

SPOUSE NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE					
<input type="text"/>	<input type="text"/>					
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*				
<input type="text"/>	<input type="text"/>					
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*				
<input type="text"/>	<input type="text"/>					
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*				
<input type="text"/>	<input type="text"/>					
DEPENDENT CHILD NAME (LAST)		(FIRST)		(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*				
<input type="text"/>	<input type="text"/>					

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an 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 on the back of this form.

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 updating/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 in order to process your enrollment or update your records. All information in this section should apply to you, the primary subscriber. Please print clearly in ink.

Full-Time Hire Date: The date you were hired with your employer.

Coverage Effective Date: The date Delta Dental coverage takes effect for you (and/or your dependents, if enrolled).

Status Definitions (Please select only one status)

Active You are an eligible subscriber.

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

COBRA You are no longer an active subscriber but you have continued coverage under COBRA. Please check with your human resources or personnel department for information regarding COBRA.

Surviving Dep. The surviving spouse or child of a deceased subscriber to whom the employer continues to provide benefits other than under provisions of COBRA.

Enrollment/Eligibility 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.

New Enrollment: Check for first time enrollment for yourself or your eligible dependents.

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

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

Group Transfers: Must be completed when you are transferring from one subgroup to another. (All dependents will transfer)

Dependent Enrollment/Eligibility Update Information - This section should be completed when: (1) enrolling dependents or (2) if you are submitting updates/changes to Delta Dental enrollment. (Please include both first and last names of any individuals for whom you are enrolling or submitting an update or change).

* Disabled: Your permanently disabled dependent child. (Requires submission of medical statement)

Delta Dental of Oklahoma Privacy Policy

All companies part of the Delta Dental of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality. For this reason and in compliance with the Gramm-Leach-Bliley Act of 1999, Delta Dental has developed a Privacy Policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental has which may contain your confidential information. Financial companies are able to choose how they share your personal information, however Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

Information We Collect - We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, check, credit or debit card payments, insurance claims, and our website. We also collect your personal information from other companies. The types of personal information we collect and share depend on the product or service you have with us. This information can include your name, address, social security number, date of birth, transaction and claim history, medical information, and checking account information.

Utilization Of Information - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business in order to provide our Customers with services and products. These functions include processing your requests, claims and transactions, maintaining your account(s), providing information about new products, responding to court orders and legal investigations, reporting to credit bureaus, and to comply with Federal and State Laws. The information Delta Dental uses to provide a service cannot be restricted by our Customers. However, Delta Dental is able to limit this information on your behalf under HIPAA.

Federal law gives consumers the right to limit information sharing in relation to affiliates' everyday business purposes, information about your creditworthiness, affiliates using your information to market to you, and non-affiliates using your information to market to you. In addition, state laws and other individual companies may give you additional rights to limit sharing.

Delta Dental does not have any affiliates, nor do we share information with non-affiliates for marketing purposes. When you are no longer our Customer, we will continue to share your information as described in this notice.

Our Security - To protect your personal information from unauthorized access and use, we maintain physical, electronic, and procedural safeguards that comply with Federal Law, including computer safeguards and secured files and buildings. We consider nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process.

While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers. Therefore, our Customer's confidential information is protected.

If the group plan is terminated or you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at 800-522-0188 (Toll Free) or 405-607-2100 (OKC Metro).

Under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.

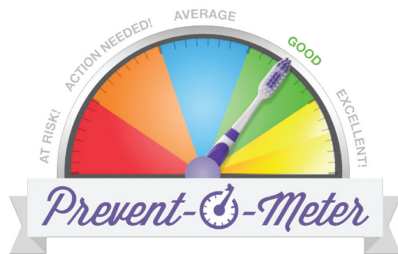
SPOTLIGHT

Delta Dental of Oklahoma provides answers through an online portal known as **SPOTLIGHT**. SPOTLIGHT is online, real-time, 24/7 secure access to benefit information you want—when you want it. Our online services provide:

- Claims Status
- Find a Dentist
- Oral Health Education and more!

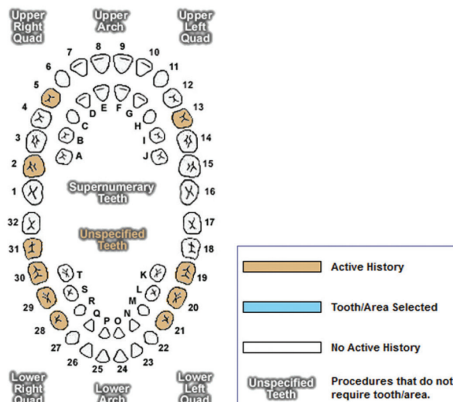
PREVENT-O-METER

A graphical illustration that keeps you up to date on your preventive visits.



MY MOUTH

The My Mouth chart in SPOTLIGHT is a graphic illustration of your teeth, with color codes that show dental work, and an explanation of the procedures performed on each tooth. It is aimed at helping you better understand the dental care you receive.



VIEW MY BENEFITS

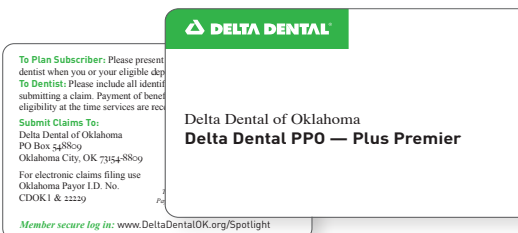
The View My Benefits tool makes it easy to understand your dental benefits. You can see a list of what your dental plan covers and if limitations apply. You can also view your benefits as a PDF to easily print, save, and email.

ACCESS YOUR EXPLANATION OF BENEFITS (EOB)

Your EOB is the key to understanding how Delta Dental of Oklahoma pays your claims. SPOTLIGHT gives you the freedom to access your EOB before you receive it in the mail. You can also view your history for up to seven years.

PRINT YOUR ID CARD

While you don't have to bring your ID card with you when you visit your dentist, sometimes having it brings peace of mind that your claims will be paid appropriately. With SPOTLIGHT, you have 24/7 access to view, print, save or email your ID card directly from your computer. To register for SPOTLIGHT, visit: DeltaDentalOK.org/Spotlight.



DELTA DENTAL OF OKLAHOMA FEATURES & SERVICES



MULTIPLE PROVIDER NETWORKS



Delta Dental offers two of the nation's largest dental provider networks. Delta

Dental Premier consists of more than two-thirds of the nation's dentists. Delta Dental PPO consists of nearly 50% of the nation's dentists and typically provides lower out-of-pocket costs.

NO BALANCE BILLING



If you visit a Delta Dental PPO participating dentist, you are not responsible

for any amounts in excess of Delta Dental's PPO maximum allowable amount. Members enrolled in a Delta Dental PPO-Plus Premier plan enjoy no balance-billing with any participating network provider.

CUSTOMER SERVICE



Our Oklahoma-based Customer Service Department is just a phone

call away. Customer Service Representatives are available to answer calls live Monday - Thursday from 7 a.m. - 6 p.m. and Friday from 7 a.m. - 5 p.m. at

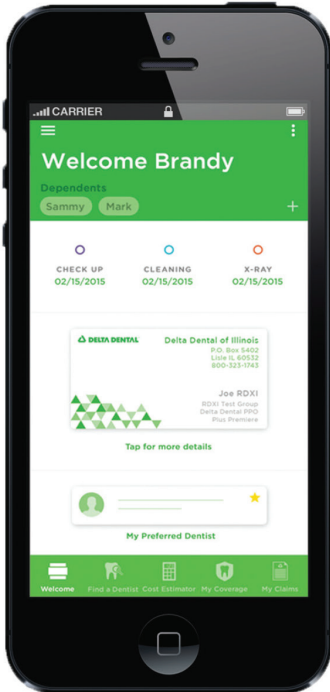
405-607-2100 (OKC Metro) or

800-522-0188 (Toll Free). Oral

health tips, our Find a Dentist tool and many other services are

available to you 24/7 at

DeltaDentalOK.org.



MOBILE APP

SECURELY ACCESS BENEFITS



With Delta Dental's free mobile app you can stay up-to-date on coverage information, plan type, benefit levels, contact information, deductibles and maximums. You can check the status of your most recent dental claims, view details and even email claim information for both you and your dependents under age 18. In order to securely access this information, be sure to register on the **DeltaDental.com** website and login using your mobile device.

ADDITIONAL TOOLS

- Find a Dentist
- View and email your mobile ID card
- Musical toothbrush timer to help you stay up-to-date with your oral wellness routine

See better – live better



Delta Dental vision provided by EyeMed

Your eyes say a lot about you – from your emotions to vision and your overall health. And, when you're proactive about protecting your eyes, the impact is clear.

Regular eye exams not only correct vision problems, they also can reveal early warning signs of more serious health conditions such as hypertension, cardiovascular disease and diabetes. So, schedule exams annually and you'll be set on a path to better health.

Keep on saving

You can use your EyeMed discount as often as you like, all year long, on nearly all your vision care purchases at EyeMed's participating providers.

Visit deltadental.com to learn more

Need to locate a provider? Want to learn about vision wellness? Visit deltadental.com.



Locate a provider

You love choices - and so do we. That's why our network has thousands of independent doctors and retail providers.



Schedule an appointment

Call ahead or stop by one of the many providers that offer walk-ins. Most also have evening and weekend hours to fit any schedule.



Show your ID card

When you arrive, let the provider know you have an EyeMed discount through Delta Dental.



Member/Patient Services:
1.866.723.0391
ACCESS DISCOUNT PLAN

DELTA DENTAL
Discount Plan Number
9231093

Signature: _____

This is not insurance.
Dependents are eligible.

deltadental.com

DELTA DENTAL OF OKLAHOMA EYEMED VISION CARE



Delta Dental has teamed up with EyeMed Vision Care to offer members significant savings on eye care and eyewear for no additional cost. Visit eyemedvisioncare.com/deltad for provider information, detailed benefits and a printable ID card.

VISION CARE SERVICES

Exam and Dilation as Necessary

DISCOUNTS & CO-PAYS

\$5 off Comprehensive Exam
\$5 off Contact Lens Exam

COMPLETE PAIR OF GLASSES PURCHASE:

The following Frame, Lenses, and Lens Options discounts & fees apply only if a complete pair is purchased in same transaction. Items purchased separately will be discounted 20% off of the retail price.

STANDARD PLASTIC LENSES INCLUDING STANDARD SCRATCH:

Single Vision \$50
Bifocal \$70
Trifocal \$105

MEMBER PAYS:

FRAMES:

Any frame available at provider location 35% off retail price

LENS OPTIONS:

UV Treatment \$15
Tint (Solid and Gradient) \$15
Standard Tint \$15
Standard plastic scratch coating \$15
Standard Polycarbonate \$40
Standard Anti-reflective Coating \$45
Standard Progressive (add-on to bifocal) \$65
Other add-ons and services 20% off retail price

MEMBER PAYS:

CONTACT LENSES*:

Conventional (Discount applied to materials only) 15% off retail price

LASER VISION CORRECTION:

Lasik or PRK 15% off retail price or 5% off promotional price

FREQUENCY:

Examination Unlimited
Frame Unlimited
Lenses Unlimited
Contact Lenses Unlimited

PLAN LIMITATIONS/EXCLUSIONS

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
 - Medical and/or surgical treatment of the eye, eyes, or supporting structures.
 - Corrective eyewear required by an employer as a condition of employment and safety eyewear.
 - Services provided as a result of any Worker's Compensation law.
 - Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount).
 - Discount is not available on those frames where the manufacturer prohibits a discount.
- Visit eyemedvisioncare.com/deltad to learn more or locate a provider near you.

* After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at eyemedvisioncare.com. Member will receive a 20% discount on items purchased at participating providers not included under plan coverage. 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services or contact lenses. Retail prices may vary by location. Not valid for groups domiciled in the state of Washington.

LASIK and PRK correction procedures are provided by the U.S. Laser Network, owned by LCA-Vision. Members must first call **877-552-7376 for nearest laser facility and to receive authorization for the discount.



DELTA DENTAL.ORG