OVERVIEW OF DENTAL AND VISION PLANS 2023–2024

For STRS Ohio Defined Benefit Plan and Combined Plan Participants

STRS Ohio offers dental and vision coverage under separate plans. Coverage is available to eligible benefit recipients who participate in the Defined Benefit Plan or Combined Plan. Members who retire before Aug. 1, 2023, need 15 or more years of total service to be eligible for coverage. At least 20 years of total service is required for members who retire on or after Aug. 1, 2023. Once the benefit recipient enrolls, his or her eligible dependents may also enroll. Enrollment in an STRS Ohio medical plan is not required to enroll in the dental and vision plans. You may enroll in either or both plans.

The dental plan is administered by Delta Dental and the vision plan is administered by Vision Service Plan (VSP). Both plans provide participating provider and nonparticipating provider coverage.

The enrollment contract period ends Dec. 31, 2024, regardless of your effective date of coverage. Once you're enrolled in the dental and/or vision plan, you must remain enrolled through Dec. 31, 2024, and pay monthly premiums even if you no longer need or use the services under the plan (e.g., you get dentures, laser vision correction or other insurance). **Early contract cancellation is not permitted.**

Premiums for dental and vision coverage are deducted from your monthly STRS Ohio benefit payment through December 2024. If your monthly premium exceeds your benefit payment, the balance must be paid in full through a direct debit account.

Information about the dental and vision plans will be sent to you before your effective date of retirement. If you have questions about eligibility, call STRS Ohio toll-free at 888-227-7877. Specific coverage questions should be directed to the appropriate plan.

STRS OHIO HealthCare PROGRAM

Dental Plan Premiums

DELTA DENTAL®

$30.66/month Per benefit recipient

$40.29/month Per other adult (includes spouse or disabled adult child)

$22.98/month Children under age 26 (flat rate regardless of the number of children covered)

Example: Dental coverage for a benefit recipient, other adult and two children would be $93.93/month.

Benefit recipient	$30.66
Other adult	$40.29
Two children	+$22.98
	$93.93

PLAN FEATURES

Delta Dental PPO Point-of-Service Plan

	PPO Dentist (highest coverage level)		Premier Dentist		Nonparticipating Dentist	
	Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays*	You Pay
CLASS I — PREVENTIVE AND DIAGNOSTIC SERVICES						
Diagnostic and Preventive Services — Used to diagnose and/or prevent dental abnormalities or disease. Includes two exams and three cleanings per calendar year; fluoride treatments once per calendar year to age 19.	100%	0%	80%	20%	80%	20%
Radiographs — X-rays. Bitewing X-rays limited to twice per calendar year; full mouth X-rays once per 36 months.	100%	0%	80%	20%	80%	20%
Sealants — Used to prevent decay of pits and fissures of permanent back teeth. Once per molar every 36 months to age 14.	100%	0%	80%	20%	80%	20%
Brush Biopsy — Covered on an as-needed basis (no limit).	100%	0%	80%	20%	80%	20%
CLASS II — BASIC SERVICES						
Emergency Palliative Treatment — Used to temporarily relieve pain.	60%	40%	50%	50%	50%	50%
Endodontic Services — Used to treat teeth with diseased or damaged nerves (e.g., root canals).	60%	40%	50%	50%	50%	50%
Periodontic Services — Used to treat diseases of the gums and supporting structures of the teeth.	60%	40%	50%	50%	50%	50%
Oral Surgery Services — Extractions and dental surgery, including preoperative and postoperative care.	60%	40%	50%	50%	50%	50%
Minor Restorative Services — Used to repair teeth damaged by disease or injury (e.g., fillings).	60%	40%	50%	50%	50%	50%
Relines and Repairs — Relines and repairs to bridges and dentures (once per 36 months).	60%	40%	50%	50%	50%	50%
TMD Treatment — Treatment of the disorder of the temporomandibular joint, including related films.	60%	40%	50%	50%	50%	50%
CLASS III — MAJOR SERVICES						
Major Restorative Services — Used when teeth cannot be restored with another filling material (e.g., crowns, inlays or onlays limited to once per tooth per five years).	35%	65%	25%	75%	25%	75%
Prosthodontic Services — Used to replace missing natural teeth (e.g., bridges, dentures and implants). Once per five years.	35%	65%	25%	75%	25%	75%
Maximum Payment — $1,500 total per person per calendar year for Class I, Class II and Class III services.						
Deductible — $50 deductible per person per calendar year, limited to a maximum deductible of $100 per family per calendar year for Class II and Class III services.						

*When you receive services from a nonparticipating dentist, the percentages in this column indicate the portion of Delta Dental's nonparticipating dentist fee that will be paid for those services. This nonparticipating dentist fee may be less than what your dentist charges, which means you will be responsible for the difference.

Vision Plan Premiums

$6.65/month	**Benefit recipient only**
$13.36/month	**Benefit recipient and one other adult (includes spouse or disabled adult child)**
$14.38/month	**Benefit recipient and children under age 26**
$21.08/month	**Benefit recipient and all other combinations of enrollees (includes any combination of spouse, disabled adult child and children under age 26)**

PLAN FEATURES

VSP Choice Plan

Plan Feature	Frequency	Copayment	Services From VSP Doctor or Affiliate Provider[1]	Services From Out-of-Network Doctor
Eye Exam	12 months[2]	$10	Covered in full after $10 copayment	Reimbursed up to $50
Lenses[3]	24 months[2]	$10	Covered in full after $10 copayment	Reimbursed up to $50 for single vision Reimbursed up to $75 for bifocal Reimbursed up to $100 for trifocal Reimbursed up to $125 for lenticular
Frames[3]	24 months[2]	$10	Covered in full, up to $130 retail allowance, after $10 copayment[4]	Reimbursed up to $70
Medically Necessary Contact Lenses[5, 7]	24 months[2]	$20	Covered in full after $20 copayment	Reimbursed up to $210
Elective Contact Lenses[5, 6]	24 months[2]	$0	Covered up to $125	Reimbursed up to $125
Laser Vision Correction[8]		$0	Discounted services	None

1 Coverage with a participating retail chain may differ. Once your coverage is effective, visit www.vsp.com for details on participating retail chains and their coverage.

2 Based on the date of your last service.

3 A 20% discount is provided for additional complete pairs of prescription glasses and/or nonprescription sunglasses purchased within 12 months of the last covered eye exam.

4 Your VSP coverage provides guaranteed savings whether you choose a frame that is covered by the retail allowance or one that exceeds it. If you choose a frame valued at more than the plan's retail allowance, you will receive a 20% discount on the amount over the allowance, and you will be responsible for the balance.

5 Enrollees can use the plan to cover either contact lenses or frames and lenses.

6 Your plan includes a 15% discount on the VSP doctor's professional services when buying contact lenses. Materials are provided at the customary fees.

7 Medically necessary contact lenses must be prescribed by a VSP doctor for certain conditions. Your VSP doctor must get prior approval from VSP for medically necessary contact lenses.

8 Discounts on laser vision correction (PRK or LASIK surgery) are available through contracted laser centers. Program availability may vary based on location.

Who to Contact

For enrollment and eligibility questions

STRS Ohio Member Services Center 888-227-7877
STRS Ohio website ..... www.strsoh.org
STRS Ohio email ..... Go to www.strsoh.org and select "Contact" from the top menu

For dental coverage-related questions

Delta Dental Customer Service Department 866-349-1286
Delta Dental website ..... www.deltadentaloh.com/strsohio

For vision coverage-related questions

VSP Member Services 800-877-7195
VSP Member Services line for the hearing impaired 800-428-4833
VSP website ..... www.vsp.com