

STRS OHIO

HealthCare
PROGRAM

DENTAL^{AND} VISION
— PLANS —
2023–2024



For STRS Ohio Defined Benefit Plan
—AND— Combined Plan Participants

Welcome

Thank you for your interest in STRS Ohio’s dental and vision plans. Dental coverage is provided by Delta Dental; vision coverage is provided by Vision Service Plan (VSP).

These two plans are available to eligible benefit recipients who participate in the Defined Benefit Plan or Combined Plan. Members who retire before Aug. 1, 2023, need at least 15 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. For eligibility and enrollment guidelines, visit the Health Care section of the STRS Ohio website.

Eligible individuals may choose to enroll in either the dental or vision plan, or both plans. There is a separate premium for each plan. If you elect coverage, you are responsible for paying the entire premium amount through deductions from your monthly STRS Ohio benefit payment.

Dental and vision plan enrollment is separate from STRS Ohio medical coverage. You do not need to be enrolled in an STRS Ohio medical plan to join a dental and/or vision plan. To enroll an eligible dependent in a plan, the benefit recipient must be enrolled.

In this booklet, you’ll find specific information about coverage features and monthly premiums for each plan. If you have questions after reviewing the information, please 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

The STRS Ohio Health Care Program is authorized by Chapter 3307 of the Revised Code, which may be amended at any time by the Ohio General Assembly. Furthermore, coverage under the program may be modified or eliminated at any time by the State Teachers Retirement Board. Health care coverage is not guaranteed. STRS Ohio may change or discontinue all or part of the program for all or a class of eligible benefit recipients and covered dependents at any time. Premiums, copayments/coinsurance, deductibles and all other charges or fees paid by an enrollee may change at any time.

This booklet is an overview of the STRS Ohio dental and vision plans. It is not a legal document. Your plan will send you a comprehensive description of your coverage after enrollment is confirmed.

What's Inside

Section 1: Coverage Considerations	1
---	---

Section 2: The Dental Plan

Monthly Premiums	2
Plan Features	2
Exclusions.....	4
Limitations.....	4
How to Use Your Dental Plan.....	5
Finding a Participating Dentist	6
Explanation of Payments	6
PPO Dentist	6
Premier Dentist	6
Nonparticipating Dentist.....	6
Frequently Asked Questions About the Dental Plan	7

Section 3: The Vision Plan

Monthly Premiums	8
Plan Features	8
Coverage When VSP Doctors Are Used.....	10
Eye Exam.....	10
Lenses	10
Frames	10
Medically Necessary Contact Lenses.....	10
Elective Contact Lenses.....	10
Laser Vision Correction.....	10
Coverage When Out-of-Network Doctors Are Used	11
VSP Value and Discounts.....	11
Exclusions.....	11
How to Use Your Vision Plan	12
Finding a VSP Doctor.....	12
Frequently Asked Questions About the Vision Plan	13
Service.....	13
Coverage.....	13

Section 4: Required Notices	15
--	----

Section 1557 Notice of Nondiscrimination	15
General Notice of COBRA Continuation Coverage Rights.....	16



Section 1: Coverage Considerations

As you evaluate your option to enroll in the dental and/or vision plan, please consider the following:

Eligibility and Enrollment Guidelines

Guidelines are the same for the dental and vision plans. Review the guidelines in the Health Care section of the STRS Ohio website to determine if you are eligible to enroll in a plan.

Dental and vision plan enrollment is separate from STRS Ohio medical coverage. Enrollment in an STRS Ohio medical plan is not required to obtain dental and/or vision coverage. To enroll an eligible dependent in a plan, the benefit recipient must be enrolled.

You can sign up for coverage when you submit your *Service Retirement Application* to STRS Ohio. If you apply for coverage during open enrollment or because you experience a qualifying event, you can enroll through your STRS Ohio Online Personal Account. Please note that upon enrollment, you authorize the release of all information to STRS Ohio and its designees for use in the administration of the plan.

Length of Enrollment Contract Period

The enrollment contract period ends on Dec. 31, 2024, regardless of your effective date of coverage. Once you are 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 services under the plan (e.g., you get dentures, laser vision correction or other insurance). **Early contract cancellation is not permitted.**

Coverage Features

Carefully review the coverage features of the plan. See Pages 2–5 for the dental plan and Pages 8–11 for the vision plan.

Monthly Premiums

You will pay the full premium amount for coverage. Separate monthly premiums apply to the dental and vision plans. See Page 2 for dental premiums and Page 8 for vision premiums.

By enrolling in the dental and/or vision plan, you authorize STRS Ohio to deduct monthly premiums for coverage from your monthly STRS Ohio benefit payment. If your monthly premium exceeds your benefit payment, the remainder of your premium must be paid in full through a direct debit account with your financial institution and STRS Ohio. (A direct debit account allows premium payments to be withdrawn automatically from your checking or savings account.)

Participating Providers

It is important to find out if participating providers are conveniently located in your area. For details about finding providers, see Page 6 for dental providers and Page 12 for vision providers.



Section 2: The Dental Plan

STRS Ohio offers affordable dental coverage through Delta Dental. The coverage available to you and your eligible family members is explained in this section.

Monthly Premiums

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

You must continue to pay monthly premiums through December 2024 even if you no longer need or use the services under the plan. Early contract cancellation is not permitted.

\$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 <u>+\$22.98</u>
	\$93.93

Plan Features

The Delta Dental PPO Point-of-Service Plan includes two network options — Delta Dental PPO and Delta Dental Premier. Although you can obtain services from any licensed dentist, you will maximize your coverage and lower your out-of-pocket costs by using a PPO dentist. If you choose a Premier

provider, you will receive a lower level of coverage; however, you may still save money. See Page 6 for an explanation of payments. The chart on Page 3 summarizes the plan's main features.

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. The nonparticipating dentist fee may be less than what your dentist charges, which means you will be responsible for the difference.

Exclusions

Standard exclusions for the plan include but are not limited to:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation or similar entity.
Note: This provision does not apply to any programs provided under Title XIX Social Security Act (Medicaid).
2. Services, as determined by Delta Dental, for correction of congenital or developmental malformations, cosmetic surgery or dentistry for aesthetic reasons.
3. Services or appliances started before an individual became eligible under this plan.
4. Prescription drugs, premedications and relative analgesia. General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless medically necessary. Charges for hospitalization, laboratory tests and examinations.
5. Preventive control programs including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Replacement, repair, relines or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not charge for this service.
9. Lost, missing or stolen appliances of any type and replacement or repair of orthodontic appliances.
10. Services, for which no valid dental need can be demonstrated, that are specialized techniques or experimental in nature as determined by the standards of generally accepted dental practice.
11. Appliances, surgical procedures and restorations for increasing vertical dimension; for restoring occlusion (orthodontia); for replacing tooth structure loss resulting from attrition, abrasion or erosion; or for implantology techniques.
12. Treatment provided by someone other than a dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
13. Those plan features excluded by the policies and procedures of Delta Dental including the processing policies.
14. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
15. Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
16. Services that are covered under a hospital, medical/surgical or prescription drug program.
17. Services that are not within the classes of coverage that have been selected and are not in the contract.

Limitations

Standard limitations for the plan include but are not limited to:

1. Prophylaxes (cleanings) are payable three times per calendar year. Oral exams are payable twice per calendar year. Periodontal cleanings are payable twice per calendar year after periodontal surgery.
2. Bitewing X-rays are payable twice per calendar year.
3. Full mouth X-rays (which include bitewing X-rays) are payable once in a 36-month period. A panoramic X-ray (including bitewings) is considered a full mouth X-ray.
4. Amalgam and resin restorations (fillings) are payable once within a 24-month period, regardless of the number or combination of restorations placed on a surface.
5. Cast restorations (including jackets, crowns, inlays and onlays) and associated procedures (such as cores and post-substructures) on the same tooth are payable once in any five-year period.
6. Porcelain, porcelain substrate and cast restorations are not payable for children less than 12 years of age.
7. Optional treatment: If you select a more expensive service than is customarily provided or for which Delta Dental does not determine a valid dental need is shown, Delta Dental can make an allowance based on the fee for the customarily provided service.

8. Prosthodontic (Class III) limitations:
 - One complete upper and one complete lower denture can be covered once in any five-year period for any individual.
 - A partial denture, fixed bridge or removable bridge for any individual can be covered once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - Fixed bridges and removable cast partials are not payable for children less than 16 years of age.
 - A reline or the complete replacement of denture base material is limited to once in any three-year period per appliance.
9. Preventive fluoride treatments are payable for children until their 19th birthday, once per calendar year.
10. When services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each dentist.
11. Care terminated due to the death of an enrollee or eligible dependent will be paid to the limit of Delta Dental's liability for the services completed or in progress.
12. The maximum amount payable per calendar year will be limited to \$1,500 per person.
13. Delta Dental will not be obligated to pay for, in whole or in part, any service to which the deductible applies until the specified plan deductible amount is met.
14. Processing policies may limit treatment.

How to Use Your Dental Plan

While Delta Dental offers members the freedom to receive services from any licensed dentist, you may lower your out-of-pocket costs by going to a dentist who participates in the PPO network. If your dentist does not participate in the PPO network, you may still save money by going to a dentist who participates in the Premier network. See Page 6 for an explanation of payments.

Using your Delta Dental plan is easy. Simply:

1. Find a dentist who participates in the Delta Dental PPO or Premier network. See Page 6 for more information.
2. Make your appointment with a participating dentist and give the following information:
 - Your name
 - Your Delta Dental group name (State Teachers Retirement System of Ohio)
 - Your Delta Dental group number (9888-0001)
 - Program type (Delta Dental PPO Point-of-Service)
 - Your Delta Dental identification number (STRS Ohio identification number or the benefit recipient's Social Security number)

If you're making an appointment for a dependent, provide the dependent's name and date of birth.

Note: You will receive a Delta Dental identification card; however, you do not need to present this card to receive care. Your dentist can verify your eligibility for coverage by calling Delta Dental's Customer Service Department toll-free at 866-349-1286.

3. Keep your scheduled appointment.

Note: Delta Dental recommends a pretreatment estimate before any services are rendered where the total charges will exceed \$200. Ask your dentist to submit a treatment plan to Delta Dental before providing services. Delta Dental reviews the treatment plan and advises you and your dentist via a pretreatment estimate which services are covered by your plan and the amount Delta Dental may pay. Delta Dental's estimated payment for services depends on eligibility and the annual maximum payment available under your plan.

You are not required to seek a pretreatment estimate. You will receive the same coverage under your plan whether or not an estimate is requested. The pretreatment estimate is merely a convenience so you will know the portion of the cost that is covered under your plan before the dental service is provided. Since you may be responsible for any costs not covered under your plan, this may be useful information when deciding whether to incur those costs.

You and your dentist should review your pretreatment estimate before your dentist proceeds with treatment. Once treatment is complete, the dates of service will be entered on the estimate and submitted to Delta Dental for payment.

If you have any questions about your plan, call Delta Dental's Customer Service Department.

Finding a Participating Dentist

To locate a participating dentist near you:

- Call your dentist's office and ask if your dentist participates in the Delta Dental PPO or Premier network. Remember, you may lower your out-of-pocket costs by going to a PPO dentist.
- Call Delta Dental's Customer Service Department toll-free at 866-349-1286 to access Delta's Automated Service Inquiry (DASI) system. DASI is available

24 hours a day, seven days a week and can provide you with a random listing of PPO or Premier dentists in your area. If you would rather talk to a representative in Delta Dental's Customer Service Department, simply say "REPRESENTATIVE." Delta Dental representatives are available to assist you Monday through Friday, 8:30 a.m.–8 p.m. EST.

- Visit Delta Dental's website at www.deltadentaloh.com/strsohio.

Explanation of Payments

PPO DENTIST

You will receive the highest level of coverage if you go to a Delta Dental PPO dentist. PPO dentists are paid directly based on their submitted fees or the amount in their local PPO dentist schedule, whichever is less. If the PPO dentist schedule amount for a covered service is lower than the dentist's submitted fee, the dentist cannot charge you the difference.

For example: If a PPO dentist charges \$100 for a service covered at 100%, and if the PPO dentist schedule amount for that service is \$80, Delta Dental will pay the dentist \$80 and you will owe nothing. The dentist cannot charge you the \$20 difference between the submitted fee and the PPO dentist schedule amount.

Submitted fee:	\$100
PPO dentist schedule amount:	\$80
Delta Dental pays 100% of \$80:	\$80
You pay:	\$0

The PPO dentist accepts the PPO dentist schedule amount. Delta Dental will send payment directly to the dentist. The \$20 difference cannot be charged to you.

PREMIER DENTIST

Although your coverage levels will be lower for all services when you go to a non-PPO dentist, you may still save money if that dentist participates in the Delta Dental Premier network. Premier dentists are paid directly based on their submitted fee or their maximum approved fee, whichever is less. If the maximum approved fee for a covered service is lower than the dentist's submitted fee, the dentist cannot charge you the difference.

For example: If a Premier dentist charges \$100 for a service that is covered at 80%, and if the maximum approved fee for that service is \$95, Delta Dental will pay the dentist \$76 (80% of \$95). You will owe the dentist the remaining \$19. The dentist cannot charge you the \$5 difference between the submitted fee and the maximum approved fee.

Submitted fee:	\$100
Maximum approved fee:	\$95
Delta Dental pays 80% of \$95:	\$76
You pay:	\$19

Delta Dental pays 80% of the maximum approved fee directly to the dentist and you pay 20%. The \$5 difference between the maximum approved fee and the submitted fee cannot be charged to you. Because your coverage level is lower when you go to a Premier dentist, you pay \$19.

NONPARTICIPATING DENTIST

If you go to a nonparticipating dentist (a dentist who does not participate in PPO or Premier), you will probably pay more. The payment for covered services will be the lesser of the dentist's submitted fee or the local nonparticipating dentist fee. If the local nonparticipating dentist fee is lower than the dentist's submitted fee, you will be responsible for paying the difference.

Delta Dental will usually send payment directly to you, and you will be responsible for paying the dentist whatever he or she charges. In addition, you may have to pay the dentist at the time of your appointment.

For example: If a nonparticipating dentist charges \$100 for a service that is covered at 80%, and if the local nonparticipating dentist fee for that service is \$90, Delta Dental will pay you \$72 (80% of \$90). You will owe the dentist the remaining \$28 because you are responsible for paying the full \$100.

Dentist's submitted fee:	\$100
Local nonparticipating dentist fee:	\$90
Delta Dental pays 80% of \$90:	\$72
You pay:	\$28

Delta Dental pays 80% of the nonparticipating dentist fee and you pay 20%. You are also responsible for the difference between the local nonparticipating dentist fee and the dentist's submitted fee.

Additionally, services obtained outside the United States will be subject to coverage levels of nonparticipating dentists. These claims will be converted to U.S. dollars and then processed.

Frequently Asked Questions About the Dental Plan

1. What is Delta Dental PPO Point-of-Service?

Delta Dental PPO Point-of-Service is Delta Dental's national preferred provider organization program that provides access to two of the nation's largest networks of participating dentists — the PPO network and the Delta Dental Premier network. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of these networks.

2. What are the advantages of choosing a PPO dentist?

You will receive the highest level of coverage for services when you use a PPO dentist. In addition, the PPO dentist will be paid directly for covered services based on the submitted fee or the amount in the local PPO dentist schedule, whichever is less. If the PPO dentist schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your coinsurance and deductible, if any, when you go to a PPO dentist for covered services. PPO dentists will also submit your claims, which means fewer hassles for you.

3. What are the advantages of choosing a Delta Dental Premier dentist?

Although you will receive a lower level of coverage for some services when you go to a Premier dentist, the dentist will be paid directly for covered services based on the submitted fee or the local maximum approved fee, whichever is less. If the maximum approved fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference.

As with PPO dentists, this means you will be responsible only for your coinsurance and deductible, if any, when you go to a Premier dentist for covered services. And, like PPO dentists, Premier dentists will submit your claims for you.

4. How can I find a participating dentist?

To receive the names of participating dentists near you, call Delta Dental's Customer Service Department toll-free at 866-349-1286. To speak directly to a representative regarding provider options, say "REPRESENTATIVE." You can also visit Delta Dental's website.

5. What happens if I go to a nonparticipating dentist?

If you go to a dentist who does not participate in the PPO or Premier network, you will still be covered, but you are responsible for paying the difference between the dentist's charges and the amounts Delta Dental allows. Delta Dental will pay you directly for covered services based on the dentist's submitted fee or the local nonparticipating dentist fee, whichever is less. You will be responsible for paying the dentist. You may also have to submit your own claims.

6. Do I need to tell my dentist which dental plan I'm enrolled in?

Yes. Tell your dentist you have Delta Dental PPO Point-of-Service coverage through Delta Dental Plan of Ohio. Below is the information to provide your dentist:

Group Name: State Teachers Retirement System of Ohio

Group Number: 9888-0001

Program Type: Delta Dental PPO Point-of-Service

Identification Number: STRS Ohio identification number or benefit recipient's Social Security number

Effective Date: Your effective date of coverage on or after Jan. 1, 2023

7. Do I need a Dental Delta identification card to receive care?

You will receive an identification card that includes Delta Dental's Customer Service Department phone number and website address. It is best to present this card to your dentist; however, your dentist can verify your eligibility for coverage without the card by calling Delta Dental's Customer Service Department.

8. Who do I contact if I have other questions?

Please call Delta Dental's Customer Service Department toll-free at 866-349-1286. Delta's Automated Service Inquiry (DASI) system is available 24 hours a day, seven days a week and can answer many of your questions. In addition, customer service representatives are available to assist you Monday through Friday, 8:30 a.m.–8 p.m. EST. You can also visit Delta Dental's website.

9. Why must I remain enrolled in the dental plan through Dec. 31, 2024?

This requirement allows STRS Ohio to offer a lower cost plan and helps ensure STRS Ohio can continue to offer this optional coverage in the future.



Section 3: The Vision Plan

STRS Ohio offers affordable vision coverage through Vision Service Plan (VSP). The coverage available to you and your eligible family members is explained in this section.

Monthly Premiums

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

You must continue to pay monthly premiums through December 2024 even if you no longer need or use the services under the plan. Early contract cancellation is not permitted.

\$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

The VSP Choice Plan provides different levels of coverage depending on whether you choose a VSP doctor or an out-of-network doctor. To maximize your vision coverage, use a VSP doctor (one who meets VSP's strict quality standards). Please remember that your out-of-network

doctor reimbursement rate does not guarantee full payment, and VSP cannot guarantee enrollee satisfaction when services are received from out-of-network doctors. The chart on Page 9 summarizes the plan's main features.

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. See Page 10 for additional information.



Coverage When VSP Doctors Are Used

While VSP offers members the freedom to receive services from any provider, when a VSP doctor is visited, members benefit from cost controls established with VSP doctors. Dollar-for-dollar you receive the best value from your VSP coverage when you visit a VSP doctor. If you decide not to see a VSP doctor, copayments still apply. You'll also receive lesser coverage and typically pay more out-of-pocket.

EYE EXAM

Covered in Full, Minus \$10 Copayment

LENSES

Covered in Full, Minus \$10 Copayment; Costs of Noncovered Options

VSP pays in full any necessary lenses, including single vision, bifocal, trifocal or other more complex lenses. Polycarbonate and progressive lenses are also covered by the plan.

Enrollees may elect lenses or lens characteristics that are not necessary for their visual welfare, but are desired for cosmetic reasons. Examples are tinted or photochromic lenses, scratch coating or blended bifocals. For all noncovered options selected, the enrollee is required to pay an additional cost. These cosmetic options are charged to the enrollee according to a cost-controlled price determined by VSP.

FRAMES

Wide Selection of Frames Covered in Full, Up to \$130 Retail Allowance (or \$70 at Costco and Walmart), Minus \$10 Copayment; Added Cost if Enrollee Chooses a Frame Exceeding the Allowance

VSP provides a \$130 retail allowance (or \$70 at Costco and Walmart) toward a new frame after a \$10 copayment. If you choose a frame that costs more than the plan's allowance, you will receive a 20% discount on the amount over your frame allowance, and you will be responsible for the balance.

MEDICALLY NECESSARY CONTACT LENSES

Covered in Full, Minus \$20 Copayment

Medically necessary contact lenses are prescribed by a VSP doctor for treatment following cataract surgery, to correct extreme vision problems not correctable with prescription glasses, and for certain conditions of anisometropia and/or keratoconus. Medically necessary contact lenses require prior authorization by VSP.

ELECTIVE CONTACT LENSES

Covered in Full, Up to \$125 Allowance

Elective contact lenses are chosen in lieu of lenses and frames. The eye exam is covered in full after a \$10 copayment. An allowance of \$125 will be provided toward the contact lenses, fitting fees and any follow-up evaluations.

Additionally, VSP offers a 15% discount on contact lens professional services (evaluation, fitting fees and any follow-up evaluations). This discount applies only to professional services and does not apply to contact lenses. Any costs exceeding the \$125 allowance are the enrollee's responsibility. Under this plan, if the enrollee elects contact lenses, the enrollee will be eligible for a frame and lenses 24 months after obtaining the contact lenses.

LASER VISION CORRECTION

Discounted Services

If you are considering laser vision correction, VSP can help you make an informed decision. VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you access to laser vision correction surgery for hundreds of dollars less than you might pay privately. On average, enrollees can receive 15% off the regular price or 5% off the promotional price from contracted facilities. After surgery, enrollees can use the frame allowance, if eligible, for sunglasses from any VSP doctor. Visit VSP's website at www.vsp.com to learn more about this program.

Note: If you use laser vision correction coverage, you still must remain enrolled in the vision plan and pay premiums through Dec. 31, 2024.

Coverage When Out-of-Network Doctors Are Used

Services obtained through out-of-network doctors are subject to the same copayments and limits as services provided by VSP doctors as explained in the chart on Page 9. Bills for services from out-of-network doctors may be submitted to

VSP for reimbursement up to the amounts shown in the plan features chart. Additionally, services obtained outside the United States are considered out-of-network. These claims will be converted to U.S. dollars and then processed.

VSP Value and Discounts

No Claim Forms

When you visit a VSP doctor, no claim forms are necessary. Providing your name and STRS Ohio identification number or the last four digits of the benefit recipient's Social Security number are the only requirements.

Prescription Glasses

A 20% discount is applied to the VSP doctor's usual and customary fees for additional noncovered glasses when a complete pair is purchased within 12 months of the exam.

Contact Lenses

A 15% discount is available on the VSP doctor's professional services when purchasing prescription contact lenses (at doctor's usual and customary fees). This benefit is available in conjunction with the VSP contact lens allowance or can be used to purchase contact lenses in addition to glasses.

Discounted Prices

- Apply to the VSP doctor's usual and customary fees.
- Are available for 12 months following the date of the covered eye exam; 20% off additional glasses and sunglasses, including lens options.

- Are offered through any VSP doctor within 12 months of the last covered eye exam.
- Apply only to professional services for prescription glasses and contact lenses.
- Do not apply to solutions or cleaning products.

Hearing Aids

VSP members receive discounts on hearing aids by TruHearing. These savings are also available to your dependents and extended family members. To learn more, visit www.vsp.truhearing.com or call TruHearing toll-free at 877-396-7194 and identify yourself as a VSP member. A TruHearing representative will answer your questions and schedule a hearing exam with a local provider. The provider will test your hearing, select the right hearing aid and ensure it fits and performs optimally.

Special Offers

VSP has special offers on glasses and sunglasses, contacts, LASIK, hearing aids and more. Visit www.vsp.com/offers for more information.

Exclusions

This vision plan is designed to cover your visual needs rather than cosmetic materials. If any of the following options are selected, you will be responsible for the additional costs:

- Blended lenses
- Contact lenses (other than the normal frequency)
- Oversized lenses
- Photochromic or tinted lenses other than Pink 1 and 2
- Coated or laminated lenses
- Frames that exceed the allowance
- Certain limitations on low vision care
- Cosmetic lenses
- Optional cosmetic processes
- UV-protected lenses

The following professional services or materials are not covered. Discounts may apply to some items.

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (nonprescription)
- Two pairs of glasses in lieu of bifocals
- Medical or surgical treatment of the eyes
- Corrective vision services, treatments and materials of an experimental nature

Lenses and frames furnished under this plan that are lost or broken will not be covered except at the normal intervals when coverage is otherwise available.

How to Use Your Vision Plan

While VSP offers members the freedom to receive services from any provider, when a VSP doctor is visited, members benefit from cost controls established with VSP doctors and pay less out of pocket for care.

Using your VSP Choice Plan is easy:

1. Find a VSP doctor at www.vsp.com or call toll-free at 800-877-7195.
2. Make an appointment with your VSP doctor and give the following information:
 - Your name
 - Your VSP group name (State Teachers Retirement System of Ohio)
 - Your STRS Ohio identification number or the last four digits of the benefit recipient's Social Security number
 - Your date of birth

If you are making an appointment for a dependent, provide the dependent's name and date of birth.

Note: You will not receive a VSP identification card. Simply provide the information noted on this page when making your appointment.

3. Keep your scheduled appointment.
4. Pay any copayments. You are responsible for additional costs for cosmetic options or noncovered services. VSP and your VSP doctor will take care of the rest. Remember, when you visit a VSP doctor, there is no paperwork.
5. During your visit, ask whether the services and materials — such as eyewear — that you want are covered by VSP. Tints, special lenses and scratch-resistant coatings are some of the cosmetic options that may be available to you at discounted prices.

If you have coverage questions, contact VSP Member Services.

Finding a VSP Doctor

To locate a VSP doctor near you:

- Call VSP Member Services toll-free at 800-877-7195: Monday through Saturday, 9 a.m.–8 p.m. EST. (Please note that VSP is closed on Thanksgiving Day and Christmas Day.) An Interactive Voice Response system is available outside of regular phone hours. Use your touch-tone phone to request a VSP doctor.

Note: Hearing impaired individuals can call VSP Member Services toll-free at 800-428-4833.
- Visit VSP's website at www.vsp.com.

Frequently Asked Questions About the Vision Plan

SERVICE

1. Do I need a VSP identification card?

No. You do not need to present an identification card to confirm your eligibility, and no identification card will be sent to you. You should notify your doctor about your participation in the VSP vision plan. Your doctor can verify your eligibility by calling VSP Member Services.

2. Can I see one VSP doctor for my exam and have my glasses made through another VSP doctor?

Yes. If you see two VSP doctors, you simply make an appointment for the exam with the VSP doctor of your choice, then make another appointment for materials with your other VSP doctor of choice. The VSP doctors will contact VSP directly to verify eligibility and plan coverage and to obtain authorization to provide services.

Note: If you want to have your prescription filled with a VSP doctor other than the one who performed the exam, please check with the VSP doctor's office to ensure it will fill another VSP doctor's prescription.

3. What if I have an emergency, such as lost, stolen or broken glasses?

If an emergency arises, call VSP Member Services toll-free at 800-877-7195 and explain the situation to the representative. VSP will determine from your records if you are eligible for coverage. If so, make an appointment with a VSP doctor, who will call VSP to verify your eligibility for coverage.

If you choose to see an out-of-network doctor, submit to VSP your itemized receipts or attach them to a completed generic insurance form or a HCFA-1500 form (available from your vision care doctor). Provided you are eligible for services, VSP will reimburse the claim according to VSP's out-of-network doctor schedule of allowances. (See Page 14, Number 11, for full details on submitting claims for services received from an out-of-network doctor.)

4. What if I am dissatisfied with a VSP doctor or the materials received through a VSP doctor?

VSP guarantees enrollee satisfaction when seeing a VSP doctor. If you receive services or materials that are unsatisfactory, please contact VSP Member Services. VSP will review the situation and forward the resolution to you.

COVERAGE

5. If I am eligible for both an exam and eyewear (e.g., frame, lenses, etc.), but I choose to have only an exam, can I use my coverage for materials later in the year?

Yes. Please be aware that by receiving your exam and materials at different times during the year, you will be eligible only for a new exam 12 months from your last exam, and new lenses and a frame 24 months from your last purchase. Therefore, by "splitting up" your coverage, you may not be eligible for both an exam and materials at the same time the following year.

6. When seeing a VSP doctor, what type of frame selections will be covered in full by VSP?

VSP covers a wide selection of frames on the market today. Because buying habits and tastes differ from one region to the next, frame inventories may vary from office to office. Your VSP plan 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 that costs 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.

7. Am I eligible for contact lenses?

Yes. You may choose to obtain contact lenses instead of glasses. For elective contact lenses dispensed by a VSP doctor, the plan provides up to a \$125 allowance toward contact lens materials, any contact lens exam and fitting fees. In addition, coverage includes the standard vision exam in full, after you pay the \$10 copayment.

You will also receive a 15% discount off the fitting and evaluation exam. This makes the allowance comparable to VSP's payment for lenses and a covered frame. You are eligible for contact lenses every 24 months. Coverage for contact lenses can be used in place of coverage for lenses and a frame for this 24-month period.

For contact lenses dispensed by an out-of-network doctor, the same allowance will be provided for contact lenses, fitting and evaluation fees. However, the 15% discount on professional fees is not available, and the maximum reimbursement from VSP for elective contact lenses provided by an out-of-network doctor is \$125.

8. Which types of elective contact lenses can I receive through VSP?

As long as your elective contact lenses contain a prescription, your allowance remains the same for all types of contact lenses (\$125). If the contact lenses, fitting and evaluation fees exceed \$125, you are responsible for the payment of any remaining balance. VSP has guidelines and limitations regarding certain disposable contact lens materials. Please contact VSP Member Services for more information.

9. Are my dependents also responsible for the payment of the plan copayment?

Yes. Your covered dependents are responsible for paying the copayment at the time covered services are obtained.

10. What is covered when I choose to see an out-of-network doctor?

If you choose to see an out-of-network doctor, VSP will reimburse you up to the amounts allowed under the out-of-network doctor reimbursement rates of the plan. (See the plan features chart on Page 9.)

Please remember that your out-of-network doctor reimbursement rates do not guarantee full payment, and VSP cannot guarantee enrollee satisfaction when services are received from out-of-network doctors.

11. When I see an out-of-network doctor, how is the bill handled?

When you see an out-of-network doctor, you pay the entire bill and submit the following information to VSP:

- Out-of-network doctor's bill, including a detailed list of the services received
- Your STRS Ohio identification number or the last four digits of the benefit recipient's Social Security number
- Patient's name, date of birth, phone number and address
- Covered benefit recipient's name, phone number and address
- Name of the organization that provides your VSP coverage (State Teachers Retirement System of Ohio)
- Relationship to the covered STRS Ohio benefit recipient (such as self, spouse, child, etc.)

Note: Visit www.vsp.com to print an out-of-network claim form. You may also submit this information on a completed generic insurance form or a HCFA-1500 form (available from your vision care doctor).

Claims must be filed with VSP within six months after seeing the out-of-network doctor.

Please keep a copy of the information for your records and send the originals to:

**Vision Service Plan
Attn.: Out-of-Network Provider Claims
P.O. Box 385018
Birmingham, AL 35238-5018**

Contact VSP Member Services for more information.

12. What are some cosmetic options that may require me to pay out-of-pocket expenses?

Some examples of cosmetic options are:

- Scratch coating
- Anti-reflective coating
- Photochromic or tinted lenses (except Pink 1 and 2)
- Oversized lenses (61mm or greater)
- Any frame that exceeds your plan allowance

These cosmetic options will not be covered in full by VSP. Due to agreements with VSP doctors and laboratories, some noncovered services may be provided at a discounted cost. See Page 11 for more information.

13. If I no longer need corrective lenses because my vision is corrected through laser vision correction, can I cancel my vision coverage?

No. You must remain enrolled in the vision plan and pay premiums through Dec. 31, 2024, even if you no longer need to use the plan. Remember, after surgery, you may be able to use the frame allowance for sunglasses from any VSP doctor.

14. Why must I remain enrolled in the vision plan through Dec. 31, 2024?

This requirement allows STRS Ohio to offer a lower cost plan and helps ensure STRS Ohio can continue to offer this optional coverage in the future.

Section 4: Required Notices

Section 1557 Notice of Nondiscrimination

The State Teachers Retirement System of Ohio (STRS Ohio) Health Care Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The STRS Ohio Health Care Program does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The STRS Ohio Health Care Program:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters or written information in other formats (large print, audio, accessible electronic formats or other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact STRS Ohio's Section 1557 Coordinator. If you believe the STRS Ohio Health Care Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: STRS Ohio's Section 1557 Coordinator, 275 E. Broad St., Columbus, OH 43215; phone: 614-227-4097; fax: 614-744-3343; email: legal@strsoh.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; Phone: 800-368-1019 (toll-free); 800-537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 614-227-4097.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 614-227-4097.

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 614-227-4097

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 614-227-4097.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 614-227-4097

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 614-227-4097.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 614-227-4097.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 614-227-4097.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 614-227-4097.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 614-227-4097.

주의: 한국어를 _사용하시는 _경우, 언어 _지원 _서비스를 _무료로 _이용하실 _수 _있습니다. 614-227-4097.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 614-227-4097.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。614-227-4097.

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 614-227-4097.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 614-227-4097.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 614-227-4097.

General Notice of COBRA Continuation Coverage Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under an STRS Ohio health plan (the Plan). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. COBRA continuation coverage can become available to qualified beneficiaries (spouses and children) who lose health coverage under the Plan due to certain events. For additional information about your rights and obligations under the Plan and under federal law, please contact your COBRA Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A covered spouse or dependent child of a member could become a qualified beneficiary if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for the coverage.

- If you are a covered spouse, you may become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: (1) your spouse dies; or (2) you become divorced or legally separated from your spouse.
- If you are a covered child (biological or adopted), you may become a qualified beneficiary if you lose coverage under the Plan because of the following qualifying events: (1) your parent dies; (2) your parents become divorced or legally separated; or (3) you are no longer eligible for coverage under the Plan as a dependent child.

Notifying STRS Ohio of COBRA qualifying event

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after STRS Ohio has been notified that a qualifying event has occurred. It is the beneficiary’s responsibility to notify STRS Ohio within 60 days of the occurrence of the qualifying event. The 60-day notification period begins the date the qualifying event occurs. After the beneficiary notifies STRS Ohio, the COBRA Administrator will be informed that a qualifying event has occurred. The COBRA Administrator will then send the beneficiary an informational packet within 30 days after receiving notification from STRS Ohio.

How is COBRA coverage provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA

continuation coverage. Covered members may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children.

How long does COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the member, divorce or legal separation, or a child losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

COBRA continuation coverage begins on the date that Plan coverage would otherwise have been lost by reason of a qualifying event and stops at the end of the maximum period. It may stop earlier if: (1) premiums are not paid on a timely basis; (2) after the COBRA election, coverage is obtained with another group health plan (e.g., through an employer) that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary; or (3) after the COBRA election, a beneficiary becomes entitled to Medicare coverage.

Other coverage options

Other coverage options may be available for you and your family. You may be able to enroll in another group health plan for which you are eligible, such as a spouse’s plan, if you request enrollment within 30 days of loss of coverage. Additionally, you may be eligible to enroll in an individual plan through Medicaid or the Health Insurance Marketplace. By enrolling through the Marketplace, you may qualify for lower monthly premiums and lower out-of-pocket costs. Being eligible for COBRA coverage does not limit your eligibility for coverage or a tax credit through the Marketplace. You can learn more about these options at www.healthcare.gov.

For more information

For more information about your COBRA rights under the Public Health Services Act, contact the Centers for Medicare & Medicaid Services (CMS) toll-free at 800-633-4227 or visit www.cms.gov.

Specific questions about your COBRA continuation coverage rights as an STRS Ohio enrollee should be addressed to your COBRA Administrator: Mutual Health Services, A Division of Medical Mutual Services, LLC, P.O. Box 5700, Cleveland, OH 44101. Phone: 800-367-3762, ext. 14548 (toll-free); fax: 330-666-2845.

Notify your COBRA Administrator of address changes

To protect your family’s rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.



888-227-7877
www.strsoh.org



866-349-1286
www.deltadentaloh.com/strsohio



800-877-7195
800-428-4833 (for the hearing impaired)
www.vsp.com



275 E. Broad St., Columbus, OH 43215-3771 • 888-227-7877 • www.strsoh.org

