DELTA DENTAL®

Vermont Retirement Systems Dental Plan

Read Your Dental Plan Description Carefully—This Outline of Coverage provides a very brief description of the important features of your dental benefits plan. This is not the insurance contract, and only the actual policy provisions will control. The Dental Plan Description itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you ***READ YOUR Dental Plan Description CAREFULLY!*** *Not all time limitations and exclusions are shown herein. Benefit percentages shown are based on the actual charges submitted up to the Maximum Allowable Charge for participating dentists, or Delta Dental's allowance for non-participating dentists.*

Outline of Coverage Delta Dental PPO plus Premier Network		Plan A	Plan B
Coverage A	**DIAGNOSTIC:** Evaluations twice in a 12-month period X-rays (Complete series or panoramic film) once in a 5-year period Bitewing x-rays once in a 12-month period X-rays of individual teeth as necessary **PREVENTIVE:** Cleanings twice in a 12-month period Fluoride once in a 12-month period to age 19 Space maintainers to age 16 Sealant application to permanent molars, once per tooth in a 3-year period, for children to age 19	100%	100%
Coverage B	**BASIC RESTORATIVE:** Amalgam fillings Composite fillings (anterior teeth only) **ORAL SURGERY:** Surgical and routine extractions **ENDODONTICS:** Root canal therapy **PERIODONTICS:** Periodontal maintenance (cleaning) *Only one cleaning is covered in a 12-month period; this can be routine (Coverage A) or Periodontal (Coverage B), but not both.* Treatment of gum disease Clinical Crown Lengthening once per lifetime per site **DENTURE REPAIR:** Repair of a removable denture to its original condition **EMERGENCY PALLIATIVE TREATMENT**	50%	80%
Coverage C	**MAJOR RESTORATIVE:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants Note: Teeth missing prior to the effective date of a Northeast Delta Dental plan are not considered a pre-existing condition. Full contract benefits are provided.	50%	50%
Calendar Year Maximum for services covered under A, B and C.		$1,000	$1,500
Calendar Year Deductible (Does Not Apply to Coverage A. Applies only to Coverages B and C) Any dental expenses incurred during October - December that are used to meet a deductible for the plan year ending December 31 will also satisfy the deductible for the next plan year.		**$**100 per person ($300 per family)	$50 per person ($150 per family)
Health through Oral Wellness® program included (please see reverse for details)			
MONTHLY RATES effective 1/1/2023 - 12/31/2025			
	One Person	$43.92	$50.79
	Two Persons	$77.84	$92.65
	Family	$121.59	$148.48

Please Note:

- The plan selection must be the same for both retiree and eligible dependents.

(**Please see Reverse**)

Delta Dental PPO plus Premier Dentist Network

You will get the best value from your Delta Dental Plan when you receive your dental care from one of our PPO (greatest savings) or Premier network participating dentists:

- ✓ No Balance Billing: Because participating dentists accept Northeast Delta Dental's allowed fees for services, you will typically pay less when you visit a participating dentist.
- ✓ No Claims Paperwork: Participating dentists will prepare and submit claims for you.
- ✓ Direct Payment: Northeast Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

To find out if your dentist participates in our PPO or Premier network, you can: call your dentist, visit our website at nedelta.com, or call Customer Service at 1-800-832-5700.

Claim Process for Participating Dentists

Your participating dentist will submit your claim to Northeast Delta Dental (claims for any of your covered dependents should be submitted under *your* Subscriber ID number). Northeast Delta Dental will produce an Explanation of Benefits (available through our Benefit Lookup site at nedelta.com) detailing what has been processed under your plan's coverage. You are responsible to pay any outstanding balance directly to the dentist.

Non-Participating Dentists

If you visit a non-participating dentist, you may be required to submit your own claim and pay for services at the time they are provided. Claim forms are available by visiting nedelta.com or by calling Northeast Delta Dental. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a non-participating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for non-participating dentists in the geographic area in which services are provided. It is your responsibility to make full payment to the dentist

Predetermination of Benefits

Northeast Delta Dental recommends that you ask your dentist to submit *a pre-treatment estimate* for any dental work involving costly or extensive treatment plans. Predeterminations help avoid any potential confusion and enable us to help you estimate any out-of-pocket expenses you may incur.

Coordination of Benefits

When an individual covered under this plan has additional group coverage, the Coordination of Benefits (COB) provision described in your Dental Plan Description booklet will determine the sequence and extent of payment. If you have any questions about COB, please contact our Customer Service department at 1-800-832-5700.

Identification Cards

Two identification cards will be produced and distributed shortly after your initial enrollment. Both cards are issued in your name but can be used by any family member covered under your plan. Any future cards will be issued electronically via our Benefit Lookup site accessible through nedelta.com. You can also use our smartphone app and enjoy access to dentist search, claims and coverage, and your ID card. Simply scan the QR code to the right.

Health through Oral Wellness℠ (HOW)

A healthy mouth is part of a healthy life, and Northeast Delta Dental's innovative Health through Oral Wellness program [HOW] works with your dental benefits to help you achieve and maintain better oral wellness. HOW is all about YOU because it's based on your specific oral health risk and needs. Best of all, it's secure, confidential, and easy to do. Here's how to get started:

1. REGISTER

Go to **www.healththroughoralwellness.com** and click on "Register Now"

2. KNOW YOUR SCORE

After you register, please take the free oral health risk assessment by clicking on "Free Assessment" in the Know Your Score section of the website

3. SHARE YOUR SCORE WITH YOUR DENTIST

The next step is to share your results with your dentist at your next dental visit your dentist can discuss your results with you and perform a clinical version of the assessment. Based on your risk, you may be eligible for additional preventive benefits!*

**Additional preventive benefits are subject to the provisions of your Northeast Delta Dental policy.*

Dental Plan Description Booklet

You will receive a Dental Plan Description Booklet shortly after your enrollment. The booklet describes the benefits of your program and tell you how to use your dental plan. Please read it carefully to understand the benefits and provisions of your Delta Dental program.

Who is Eligible

You, your spouse or Civil Union Partner, Domestic Partner, your children up to age 26, regardless of student status, and any incapacitated dependent children, regardless of age. If enrolling one eligible dependent, all of your eligible dependents must be enrolled, unless they are covered under another dental program.

Renewability

Your plan will automatically renew for a new twelve (12) month Plan Year if the premium continues to be paid. Premiums are subject to change annually in accordance with advance notice. You or Northeast Delta Dental may choose not to renew this plan upon advance notice. The plan will not be renewed if this dental program is no longer available.

THIS INFORMATION SHOULD BE USED ONLY AS A GUIDELINE. FOR DETAILED INFORMATION ON THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS, PLEASE REFER TO THE APPROPRIATE DENTAL PLAN DESCRIPTION.

Email inquiry: customerservice@nedelta.com

Northeast Delta Dental
One Delta Drive
P.O. Box 2002
Concord, NH 03302-2002
www.nedelta.com

DELTA DENTAL®

VERMONT RETIREMENT SYSTEMS ENROLLMENT FORM

Delta Dental Plan of Maine
Delta Dental Plan of New Hampshire
Delta Dental Plan of Vermont

PLEASE SEE INSTRUCTIONS ON REVERSE

PLEASE TYPE OR PRINT LEGIBLY – IN BLUE OR BLACK INK ONLY
AS YOUR ID CARD IS GENERATED FROM THIS FORM

Please send form to:

Vermont Retirement Systems
109 State Street, 4th Floor
Montpelier, VT 05609-6901

1. SUBSCRIBER INFORMATION - To be completed by Retiree

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. #	GENDER	DATE OF BIRTH
		— —	☐ M ☐ F	

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ Other _____

EMAIL

2. GROUP INFORMATION - To be completed by Retiree

Group Name and Number – Check the Group Name and Plan that apply.

☐ Vermont State Employees' Retirement System, Group Number 7629: ☐ Plan A (1000) ☐ Plan B (1001)
☐ Vermont State Teachers' Retirement System, Group Number 7657: ☐ Plan A (1000) ☐ Plan B (1001)
☐ Vermont State Municipal Employees Retirement System, Group Number 7755: ☐ Plan A (1000) ☐ Plan B (1001)

STREET ADDRESS, CITY, STATE, ZIP

Vermont Retirement Systems
109 State Street, 4th Floor
Montpelier, Vermont 05609-6901

DENTAL EFFECTIVE DATE

3. REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: _____

ADD:

☐ **New Enrollment**
☐ COBRA Due to: _____
☐ Marriage
☐ Birth ☐ Age Two
☐ Adoption*
☐ Spouse's employment change

DELETE:

☐ Spouse's employment change
☐ Divorce
☐ Deceased
☐ No longer dependent for IRS purposes
☐ Cancel coverage

MISCELLANEOUS CHANGE:

☐ Name change – Previous name: _____
☐ Address change
☐ Other _____

COVERAGE LEVEL REQUESTED:

☐ Employee (only) ☐ Employee/Children
☐ Employee/Spouse ☐ Employee/Family
☐ Employee/Child ☐ Other _____

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	GENDER M/F	RELATION TO SUBSCRIBER	ADD / DELETE	CHECK IF DEPENDENT IS INCAPACITATED*

***NOTE: Legal documentation is required.**

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? ☐ Yes ☐ No
Will this dental coverage replace another Northeast Delta Dental Plan? ☐ Yes ☐ No

If yes to either question, complete the following:

DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE
DENTAL INSURANCE COMPANY	**POLICY HOLDER ID # / SOCIAL SECURITY #**	**EFFECTIVE DATE**

I certify that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my plan sponsor requires retiree contributions for this coverage, I authorize the deductions of these amounts from my pension payments. I further authorize my plan sponsor to deduct any dental premium which is owed by me as of the date my application is approved.

SIGNATURE _____ DATE _____

Vermont Retirement Systems
Instructions for Completing the Northeast Delta Dental Enrollment / Change Form

Section 1. Subscriber Information
-This information pertains to the retiree. Please complete all items.

Section 2. Group Information
-Please check the group you wish to join
-Check Plan A or Plan B as your choice of coverage
-Complete Dental Effective Date

Section 3. Reason for Submission
-Please complete items that pertain to your situation

Section 4. Dependent Information
-Please complete this section to add eligible or delete ineligible dependents. -
-See below for definition of Eligible Persons/Dependents.

Section.5. Other Group Coverage (Coordination of Benefits)
-Please complete this section.

Signature and Date
-Please sign and date your Enrollment / Change Form prior to mailing.

Mail the Enrollment / Change form to:
Vermont Retirement Systems
109 State Street, 4th Floor
Montpelier, Vermont 05609-6901

Eligible Persons/Dependents - Retirees, spouses, partners of a civil union, domestic partners of subscribers who are such at the time of the subscriber's initial enrollment in the plan, surviving dependent beneficiaries,and eligible dependents may be enrolled. Children may be covered until their 26th birthday. If enrolling dependents, all eligible dependents must be enrolled unless they are covered elsewhere. In all cases, Delta Dental will provide Coverage for newborn children for the first thirty-one (31) days following birth at no additional premium. Coverage will continue if the child is formally enrolled by returning an enrollment form to the Retirement Division within the first sixty (60) days following birth, or the child may be enrolled the first of the month following the child's first birthday.

Retirees may add a newly acquired dependent on the first of the month following a qualifying event, such as a marriage, birth, or adoption of a new child. The enrollment/change form to add the new dependent, which must be returned to the Retirement Division along with proof of the qualifying event, i.e., marriage certificate, birth certificate, or adoption papers.