

OPEN ENROLLMENT MAY 1 – 17, 2023

MEDICARE ELIGIBLE RETIREES

Open Enrollment will begin on **May 1, 2023** and will end on **May 17, 2023** for the plan year beginning July 1, 2023. This is your once-a-year opportunity to enroll, cancel or change your dental benefits.

WHAT YOU NEED TO KNOW

The benefit plan premiums (or rates) for the dental plan will not change for the upcoming plan year beginning July 1, 2023.

The premium table for the dental plans for the plan year beginning July 1, 2023, is attached. If you would like to enroll, change or cancel coverage during this open enrollment period, please contact Human Resources for the appropriate form. All forms must be completed and returned to Human Resources **prior** to the close of Open Enrollment on May 17, 2023. **Changes made during Open Enrollment will become effective on July 1, 2023.**

Completed enrollment forms can be returned via email (humanresources@dover.de.us), fax (302-736-7093) or USPS postmarked on or before May 17, 2023.

Mailing Address

City of Dover
ATTN: HR Dept
PO Box 475
Dover DE 19903

If you have any questions or concerns, please contact a member of the Human Resources Department via phone at (302) 736-7073 or email at humanresources@dover.de.us.

Keep Smiling Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.4 Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care⁵, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at 855-248-2020 and Amplifon at 888-779-1429.

Save with a PPO dentist





¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

⁵ Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

Plan Benefit Highlights for: City of Dover

Group No: 15426

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	\$50 per person / \$150 per family each plan year Separate \$50 Orthodontics lifetime deductible per person			
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes			
Maximums	Low Plan: \$1,000 per person each plan year High Plan: \$1,500 per person each plan year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

	Low Plan		High Plan	
Benefits and Covered Services*	Delta Dental PPO dentists [†]	Non-Delta Dental PPO dentists [†]	Delta Dental PPO dentists [†]	Non-Delta Dental PPO dentists [†]
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %	100 %
Basic Services Fillings and simple extractions	80 %	80 %	80 %	80 %
Endodontics (root canals)	0 %	0 %	80 %	80 %
Surgical Periodontics	0 %	0 %	50 %	50 %
Non-Surgical Periodontics (gum treatment)	80 %	80 %	50 %	50 %
Oral Surgery	0 %	0 %	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	0 %	0 %	50 %	50 %
Prosthodontics Bridges, dentures and implants	0 %	0 %	50 %	50 %
Orthodontic Benefits Adults and dependent children	0 %	0 %	50 %	50 %
Orthodontic Maximums	N/A	N/A	\$1,000 Lifetime	\$1,000 Lifetime

^{*} Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

[†] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of Delaware	Customer Service	Claims Address
One Delta Drive	800-932-0783	P.O. Box 2105
Mechanicsburg, PA 17055		Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

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Delta Dental Plan Premiums

Effective: July 1, 2023

Plan Type	Coverage Level	Monthly Cost*	
Delta Dental High Plan	Employee Only	\$	40.35
	Employee & One Dependent	\$	75.70
	Family	\$	119.65
Delta Dental Low Plan	Employee Only	\$	27.24
	Employee & One Dependent	\$	52.33
	Family	\$	98.07

^{*} Deducted 2nd paycheck of each month



Signature of Enrollee _____

ENROLLMENT/CHANGE FORM

FOR GROUP USE ONLY

Delta Dental Insurance Company

Division Effective Low Plan Date Date Delta Dental Insurance Company Name of Employer P.O. Box 1809 High Plan _____ Alpharetta, GA 30023-1809 Pay Code Benefit deltadentalins.com VERY IMPORTANT — Please Print Legibly Package **Enrollee/Change Information Enrollee Classification** ☐ Marital Status Change ☐ Full-Time ☐ Hourly Certified ■ New Enrollment ☐ Terminate Enrollee Coverage SSN/Enrollee ID Number Correction or previous ID under which benefits are received ☐ Part-Time ☐ Salaried ☐ Classified ☐ Add/Delete Dependent ■ Address Change Other Retired ☐ Member/Other __ **Primary Enrollee Information** COBRA (if applicable) Social Security Number Enrollee ID Number (if applicable) Date of Birth Marital Status Termination ☐ Non-binary ☐ Male ☐ Female ☐ Single ☐ Married Middle Initial Reduction in Hours First Name Last Name Divorce/Legal Separation* Mailing Address (Street) City State ZIP Code Widowed/Surviving Dependent* Email Address (internal use only) Phone Type Phone Number Dependent Child No Longer Eligible* Cell Work Home Policy Holder Name (first/last) Name of Other Dental Carrier Date of Birth Indicate qualifying date: _ *If a dependent is enrolling under his/her social security Policy Holder Street Address State ZIP Code number, the SSN currently enrolled under must be Effective Date of Other Policy **Dependent Information** Dependent First Name Student / Disabled** Relationship Add / Term Social Security Number Date of Birth Name of School (overage student)** Male / Female (Last only if different from enrollee) Spouse Dependent Dependent Dependent Dependent Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status. I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract. I decline coverage at this time.