Delta Dental of Tennessee Welcomes Employees Of Subway Sandwiches and Salads, LLC

Your Delta Dental Benefit Highlights

Group #6381 coverage effective January 01, 2015

Network	*Delta Dental PPO*	*Delta Dental Premier*	*Out of Network*
Services	**Delta Dental Pays***		
Diagnostic & Preventive			
Oral examinations, cleanings, x-rays, fluoride treatments, space maintainers	100%	100%	100%
Basic Services			
Restorative (fillings), general anesthesia, simple extractions	80%	80%	80%
Major Services			
Periodontic Therapy *treatment of gums and bones supporting teeth*	50%	50%	50%
Endodontic Therapy *root canal therapy*	50%	50%	50%
Complex Oral Surgery	50%	50%	50%
Complex Restorations & Related Services *crowns, bridges, dentures, implants*	50%	50%	50%
Orthodontic Services			
Straightening of teeth for dependents to age 19	50%	50%	50%
Maximums			
Calendar Year – Per Person *Excludes Orthodontics*	$1000		
Lifetime Orthodontics	$1000		
Annual Deductible			
Per Person Family	$50 $150		
Deductible excludes Diagnostic & Preventive & Orthodontic Services			

Bi-Weekly Rates (based on 26 pay periods)

Employee Only: $12.00 *Employee + Spouse: $24.96*

Employee + Child(ren): $27.22 *Employee + Family: $44.92*

You're now a member of Tennessee's largest dental benefits family!

As a member of Delta Dental of Tennessee, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier. With 3 out of 4 dentists participating, these two networks provide great access to care as well as the privilege of reduced rates through our agreed upon fees with dentists. When seeing a dentist in either the Premier or PPO networks you cannot be balance billed – giving you added savings. You are also free to visit non-network dentists, but you may be balance billed.

Finding a Delta Dental provider

Finding a dentist in one of our networks is easy. Simply visit our Web site, www.DeltaDentalTN.com, or call our Customer Service hotline at 800-223-3104.

When do benefits start?

Your benefits begin on the effective date indicated on the highlight form. You may visit a dentist at any time following that date. If you do not enroll when first eligible, you must wait until the first open enrollment period to enroll in the plan. Please refer to your Certificate of Coverage for re-enrollment requirements.

View your benefit details online

You can get information on your Delta Dental benefits at your convenience using our Consumer Toolkit. Review claims, amounts used toward annual maximum, print ID cards, and more. Visit www.DeltaDentalTN.com and select the login for Subscribers.

Questions?

If you have questions about your Delta Dental benefits, visit our Web site, www.DeltaDentalTN.com, call our Customer Service hotline at 800-223-3104, or consult your Benefits Administrator.

Age and frequency limitations apply. For a detailed description of your benefit plan, please refer to your Certificate of Coverage. This form is not a contract of insurance. Terms and conditions are set forth in the Master Group Policy issued directly to your group administrator.

**You are not responsible for charges exceeding the maximum plan allowance (MPA) if you go to a participating Delta Dental dentist. You are responsible for charges exceeding the MPA if you go to a non-participating dentist. The MPA charges are based on fees charged in your geographic area.*

DELTA DENTAL

ENROLLMENT FORM

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228-1699
Telephone 615-255-3175

SOCIAL SECURITY NUMBER

			_			_				

GROUP NUMBER _____ **SUBLOCATION NUMBER** _____ **GROUP NAME** _____

FIRST NAME	M	LAST NAME

STREET ADDRESS

CITY	STATE	ZIP

BIRTH DATE		EFFECTIVE DATE		SEX	M	F
					☐	☐

If enrolling spouse and/or dependents, please list them below

FIRST NAME & M.I. (LAST NAME IF DIFFERENT)	SEX		BIRTH DATE
	M	F	
SPOUSE:			
CHILD:			
CHILD:			
CHILD:			
CHILD:			

I agree to make the required contribution. I certify that the information contained in this form is true and correct to the best of my ability.

Signature: _____ Date: _____

DECLINE COVERAGE

I have been given the opportunity to apply for group dental insurance coverage through my employer and choose at this time to not take coverage. I understand that by signing this area I am declining this coverage because:

☐ I have other dental coverage ☐ I do not want at this time ☐ Other: _____

Declination Signature: Date: