

Retiree Dental Open Enrollment

November 1 – December 6, 2019
for coverage beginning on
January 1, 2020

Information packet including:

- Open Enrollment Fact Sheet
- Delta Dental Information Sheet
- Delta Dental Enrollment Form
- Delta Dental Direct Debit Application

Retiree Dental Open Enrollment Fact Sheet

An open-enrollment period for the retiree dental plan available through Delta Dental of Tennessee will be held from November 1 through December 6. TVA retirees (or spouses of deceased retirees) are eligible to enroll if they receive monthly retirement benefits from the TVA Retirement System, the Civil Service Retirement System, or the Federal Employees Retirement System.

Enrollment forms must be postmarked by December 6, 2019.

IMPORTANT! There will be a **six-month waiting period** for retirees who did not enroll in the plan when first eligible and enroll during this open-enrollment period. The waiting period will apply to all “major services” except: oral surgery, periodontics and endodontics. The six-month waiting period means that no benefits are payable under the plan until coverage in the plan has been in effect for six months. **THIS WAITING PERIOD APPLIES ONLY TO RETIREES WHO DID NOT ENROLL WHEN FIRST ELIGIBLE AND WHO ENROLL NOW DURING THIS OPEN-ENROLLMENT PERIOD. IT DOES NOT APPLY TO RETIREES WHO ENROLL WITHIN 30 DAYS OF BECOMING ELIGIBLE FOR THIS PLAN.**

Retirees who were enrolled in this plan previously and have since cancelled their coverage cannot re-enroll in the plan.

The monthly premiums for 2020 will be \$33.42 for individual coverage and \$78.87 for family coverage.

Premium payment options are:

Monthly deduction from TVA Retirement System benefit (beginning with the fourth month of coverage)	Enrollees choosing this option must include a check or money order for the first three months of coverage with the enrollment forms.
Monthly bank draft from designated bank account (fee of \$1 per transaction)	Enrollees choosing this option must include a Direct Debit Application with the enrollment forms.
Monthly credit card payment through VISA, MasterCard, Discover, or American Express (fee of \$1 per transaction)	Enrollees choosing this option must provide credit card information on the enrollment forms.
Payment of 12-month premium in full upon enrollment	Enrollees choosing this option must include a check or money order with the enrollment forms.

Enrollment forms must be returned to Delta Dental of Tennessee, 240 Venture Circle, Nashville, TN 37228-1699, Attn: TVA Administrator. Do not return the enrollment form to TVA.

Questions about premium payment, effective date of coverage, benefits, confirmation of enrollment, claims, and all other customer service matters must be directed to Delta Dental at 1-800-223-3104.

TVA Retirees
Group #1500
Effective Date 01/01/2020

Delta Dental PPO Plus Premier Network	
Calendar Year Maximum	\$1,500
Annual Deductible Applies to Basic and Major Only	Per Person \$50 Family \$150
Diagnostic and Preventive Services <ul style="list-style-type: none"> • Oral examinations (2 exams in a calendar year) • Prophylaxis cleanings (limit of 2 in a calendar year) • X-rays (covered as required but not more frequently than 1 set of bitewing x-rays in a calendar year; full mouth x-rays once every 36 months) • Fluoride treatment (covered not more than twice in a calendar year for persons to age 19) • Space maintainers to age 15 	100%
Basic Services <ul style="list-style-type: none"> • Restorative (fillings) • Sealants to age 16 (1st and 2nd permanent molars, once per tooth per lifetime) • Repairs (full and partial dentures) • Simple Extractions 	80%
Major Services <ul style="list-style-type: none"> • Crowns • Bridges • Partial dentures • Full Dentures • Denture Reline & Rebase • Oral Surgery (surgical extractions) • Periodontics (treatment of gums and bones supporting teeth) • Endodontics (root canal therapy) • Implants 	50%

Age and frequency limitations apply. For a detailed description of your benefit plan, please review your Certificate of Coverage

Finding a Participating Delta Dental Dentist

There are over 189,000 participating dental locations in the nation. To verify participation status, visit Delta Dental's web site at www.DeltaDentalTn.com (choose Delta Dental PPO or Premier), call our Customer Service Department at 615-255-3175 inside the Nashville calling area or 1-800-223-3104 outside of Nashville, ask your group administrator, or simply ask your dentist if he/she is a participating Delta Dental dentist.

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228
1-800-223-3104
(615) 255-3175
www.DeltaDentalTn.com

Maximum Plan Allowance (MPA)

You are not responsible for charges exceeding the 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.

When do Benefits Start?

Benefits are available immediately for any services you receive after the effective date of your plan.

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.

MONTHLY RATES

Employee Only: \$33.42
Family: \$78.87

(Other payment options may be available for those who do not receive a pension check. If your payment is not made on an annual basis or monthly deduction from TVARS, there will be a service fee of \$1.00 per transaction.)

Please see your enclosed enrollment form for payment options.

IF YOU DROP COVERAGE, YOU MAY NEVER RE-ENROLL

Choosing Your Dentist

You may choose any licensed dentist. However, it is to your advantage to choose a participating Delta Dental dentist. Here's why:

- Claim forms will be completed and submitted at no charge. Non-participating dentists may require you to complete forms yourself or to pay a service charge.
- Payment will be based on Delta Dental's Maximum Plan Allowance fee. You only have to pay your co-insurance; you are not responsible for charges exceeding the Maximum Plan fee.
- Because Delta Dental reimburses its dentists directly, they agree to charge you no more than your co-insurance and/or deductible; you don't have to pay the whole bill and wait for reimbursement.
- If a non-participating dentist's fees exceed the industry average Maximum Plan Allowance, you must pay the difference plus your co-insurance. You may also have to pay the entire bill in advance.

The Advantage of Pre-determination

If you're thinking about having dental work done that will cost you more than \$300, ask your dentist to request a pre-determination before starting treatment. This will let you know approximately how much the work will cost and what your share of the costs will be. Pre-determination is not a guarantee of benefits.

Benefit Waiting Period

For retirees who did not enroll in the plan when first eligible, but enroll during an open enrollment period, there is a six month waiting period for Crown Repair, Certain Major Restorative Services, Relines and Repairs, Implant Repair, and Prosthodontic Services. This waiting period does not apply to retirees who enroll within 30 days of becoming eligible for this plan.

Optional Services

Services that a subscriber or covered dependent decide to have provided, which are more expensive than those that Delta Dental of Tennessee pays for, are called Optional Services. In these cases, Delta Dental of Tennessee's payment will be limited to what would normally be paid and the subscriber will be responsible for the remainder of the dentist's fee.

For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, Delta Dental of Tennessee will pay for only the cost of the amalgam.

What is not Covered?

- Cosmetic surgery or procedures for purely cosmetic reasons; services for congenital or developmental malformations; treatment to restore tooth structure lost from wear; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; treatment to stabilize teeth (equilibration, periodontal splinting or double abutting on bridges).
- Services for any disturbance of the temporomandibular joints (jaw joints) or myofascial pain dysfunction.
- Services rendered by a dentist beyond the scope of his license; services performed by any person other than a dentist or auxiliary personnel legally authorized to perform services under the supervision of a dentist.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- Oral hygiene instruction, dietary instructions, prescribed drugs or other medication, experimental procedures, or conscious sedation.
- General anesthesia is only a benefit when administered by a properly licensed dentist in connection with covered surgery services.
- Dental services for which the eligible person incurs no charge; dental services to the extent that charges for such services exceed what would have been made and actually collected if no coverage existed hereunder.
- Temporary partial dentures are a benefit only when anterior teeth are missing.
- Porcelain, gold or veneer crowns are not covered benefits for children under 12; nor fixed bridges or cast partials for children under 16.
- Services for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability Laws; services which are provided to the eligible person by any Federal, State or local agency, unless this exclusion is prohibited by law.

IF YOU DROP COVERAGE, YOU MAY NEVER RE-ENROLL



TVA RETIREES ENROLLMENT GROUP 1500

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228-1699
Ph: 800-223-3104
Attn: TVA Administrator

Subscriber Information

Name: _____ St: _____ Zip: _____
First Middle Last
Address: _____ Phone: _____ Birth Date: _____
City: _____ SSN: _____ Sex: Male Female
Email: _____ Retirement Date: _____

Dependents to be covered (if any)

Name <small>(First, Middle, Last)</small>	Birth Date <small>(mm/dd/yy)</small>	Relation <small>(Spouse or Child)</small>	Sex <small>(M/F)</small>

Method of Payment (Select One)

TVARS Deduction- Monthly: Single - \$33.42 Family - \$78.87

Please Note: These deductions will begin on the 4th month. Applicants must include a check or money order in the amount of \$100.26 for single or \$236.61 for family for first 3 months of premium.

Or

Monthly Bank Draft:* Applicant must complete Direct Debit Application

Please Note: \$1.00 fee per transaction

Or

Monthly Credit Card:* Visa MasterCard Discover American Express

Please Note: \$1.00 fee per transaction

Card Number

CVV

Exp. Date (mm/yy)

Or

Annual Premium: Single - \$401.04 Family - \$946.44

Send check with enrollment form: Make payable to Delta Dental of Tennessee

*Monthly bank draft and credit card deductions are made on the 24th of each month.

Certification and Agreement

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

Printed Name: _____ Signature: _____ Date: _____

NOTE: IF YOU DROP COVERAGE, YOU MAY NOT RE-ENROLL

For Delta Use Only: E.D: _____

DDTN SS 3 EF-TVA (Rev 2/18)



Mail or Fax to:
 TVA Administrator
 Delta Dental of Tennessee
 240 Venture Circle
 Nashville, TN 37228
 FAX (615) 244-8108

Delta Dental of Tennessee Authorization for Direct Debit (ACH Debits)

Name: _____ Social Security Number: _____

I (we) hereby authorize Delta Dental of Tennessee, herein called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) [] CHECKING or [] SAVINGS account indicated below and the depository named below, herein called DEPOSITORY, to debit and/or credit the same to such account.

Depository Name: _____ Branch: _____

City: _____ State: _____

Routing Number: _____ Account Number: _____

This authorization is to remain in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Printed Name(s): _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Note: Your account will be charged on the 24th of each month, or the next business day following it. A \$1.00 service fee will be added per transaction.

**Please
 Attach a
 Voided
 Check**

Sample Customer Street City, State	Date _____ 1500
Pay to the Order of _____	\$
Amount _____	Dollars
Bank City, State	
For _____	Signature _____
1:000000000000 I:1500 000000000000	
↑ Routing Number	↑ Account Number