ENROLLMENT INFORMATION

SPECIALIZING
IN THE DENTAL BENEFIT NEEDS
FOR BONNEVILLE UNISERV MEMBERS

For Employees of:
Alpine School District
Carbon School District
Provo School District
Nebo School District

Plan Year 2009-2010

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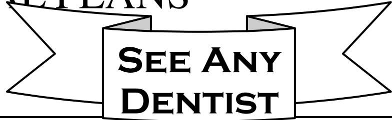
Now Featuring Online Enrollment!

For details visit http://www.totaldentaladmin.com/bonneville/
or call toll free 1-800-880-3536.

	Dental Eclipse II	Total Care TC-6000
Plan Type	Discount	DHMO
Coverage		
Network	In-Network	In-Network
Class 1 - Preventive	Approx 75%*	Approx 100%*
Class 2 - Routine	Approx 33%*	Approx 80%*
Class 3 - Major	Approx 33%*	Approx 55%*
Class 4 - Ortho	25% Discount (Children or Adults)	25% Discount (Children or Adults)
Maximums and Deductibles		
Deductible	None	None
Annual Maximum	Unlimited	Unlimited
Orthodontic Lifetime Maximum	Unlimited	Unlimited
Waiting Periods		
Basic	None	None
Major	None	None
Ortho	None	None
Special Features		
	No Waiting Periods No Maximums or Deductibles Adult & Child Orthodontics Large Provider Network	***No Waiting Periods*** ***No Maximums or Deductibles*** ***Adult & Child Orthodontics*** ***Specialty Care Coverage***
Rates		
Single	$3.00	$13.28
Two-Party	$5.00	$26.54
Family	$5.00 *Please refer to fee schedule for co-payment amounts	$43.88 *Please refer to fee schedule for co-payment amounts

PLAN SUMMARIES

COMPARISON OF DENTAL PLANS



Elite Choice		TDA-Companion	
Indemnity		Indemnity	
In-Network	Out-Of-Network	In-Network	Out-Of-Network
Approx 100%*	Approx 75%*	100%	100%
Approx 80%*	Approx 50%*	80%	80%
Approx 55%*	Approx 35%*	50%	50%
25% Discount	No Coverage	50%	50%
(Children or Adults)		(Children 50% In/out Adults 25% Discount In only)	
None		$100.00 Per Person (Lifetime)	
$1,500.00		$1,000.00	
Unlimited		$1,000.00	
None		None	
None		12 month waiting period (waived for takeover benefits)	
None			
No Waiting Periods		***See Any Dentist***	
Out-of-Network Benefit		*or enjoy discounts from over 1350 dentists!*	
Adult & Child Orthodontics		Preventive & Basic covered at 100%	
Large Provider Network		Lifetime Deductible	
$25.38		$36.53	
$49.73		$75.64	
$80.96		$122.99	
*Please refer to fee schedule for co-payment amounts and out-of-network payments.			

THE DENTAL ECLIPSE II

❖ **THE DENTAL ECLIPSE II**

The Dental Eclipse II is a discount plan designed to give you significant savings on quality dental care. This program significantly increases your dental office selection options with over 250 dentists to choose from.

Low Monthly rates:	**Single**	**$3.00**
	Family	**$5.00**

Sample Illustration of Savings

Dental Eclipse II versus No Dental Insurance

Procedure (quantity)	Dental Eclipse Copayment	No Dental Insurance	Savings	Savings %
Exam & X-ray (2 per person)	$250.00	$872.00	$622.00	71%
Cleaning (2 per person)	$250.00	$508.00	$258.00	51%
Resin 2 Surface Filling (3)	$210.00	$360.00	$150.00	42%
Crown, Porcelain with Metal (2)	$910.00	$1,388.00	$478.00	34%
Office Visit Charge (16)	$0.00	$912.00	$912.00	100%
Premium for 12 Months (Family)	$84.00	$0.00	-$84.00	-100%
Total	**$1,704.00**	**$4,040.00**	**$2,336.00**	**58%***

Sample based on typical family of 5

Percentage of savings represents this illustration only. Actual savings may vary per individual treatment plan.

THE DENTAL ECLIPSE II

WHAT ARE THE BENEFITS?

- No Deductibles
- No Claim Forms
- No Annual or Lifetime Maximums
- Reduced Fees
- Orthodontic Coverage (Braces)
- No Waiting Periods
- Pre-existing Conditions Covered

After your benefits become effective, eligible members will receive oral exam, x-rays, and cleanings for $50.00. Additional comprehensive dental services of procedures are provided at dramatically REDUCED rates see the schedule of services and co-payments. Members pay ONLY the amount listed for any procedure.

Look at the savings with the Dental Eclipse II Plan!

Dental Service	Usual Fee	Your Plan Co-pay	Savings in Dollars
Oral Exam	$41.00	$10.00	$31.00
Bitewing X-Rays	$34.00	$15.00	$19.00
Office Visit	$43.00	$ 0.00	$43.00
Fluoride(to age 14)	$21.00	$ 0.00	$21.00
Cleaning (adult)	$50.00	$25.00	$25.00
Savings (74%)	**$189**	**$50**	**$139**

**Usual fee is an average of dental fees throughout the state. The actual fee and savings may vary

Low Monthly Rates for Alpine, Nebo, & Provo School Districts:		
	Single	$3.00
	Family	$5.00

WHAT IS THE DENTAL ECLIPSE II PLAN?
TOTAL DENTAL ADMINISTRATORS, INC. (TDA) has developed " The Dental Eclipse II," a discount dental plan to give you significant savings on quality dental health care. TDA has contracted with established members of the dental profession to deliver quality dental care services in accordance with the Schedule of Covered Services & Co-payments.

WHERE DO I RECEIVE MY DENTAL CARE?
You choose from the enclosed list of participating Dental Eclipse II Plan Providers, the one most convenient for you. All covered family members must go to the same Dental Eclipse Plan Provider. The member may change facilities with a 30-day written notice and approval of the Plan.

WHO IS ELIGIBLE?
You and your spouse are eligible, including children under age 19 or full-time students up to 26 years of age. Coverage of a child over age 19 will be continued while incapable of self-sustaining employment by reason of developmental disability or physical handicap.

WHAT OTHER CHARGES WILL I PAY?
You will pay the member co-payments as listed on the Schedule of Covered Services. Any co-payments will be paid directly to your authorized Plan Dentist at the time of your treatment. You should discuss all future payments and costs before new appointments are made. The Dental Office staff will help you plan your dental treatment and payments. You will receive a 20% discount for all procedures not listed in the Schedule of Covered Services. Procedures performed by Endodontists, Periodontists, Pedodontists, and Oral Surgeon is provided at a 20% discount.

IS SPECIALTY CARE COVERED?
YES, fees for Participating Plan Specialist (Endodontists, Periodontists, and Oral Surgeons) where available, will be discounted by 20%.

WHAT IF I HAVE OTHER DENTAL COVERAGE?
Dental Eclipse II is not dental insurance or a pre-paid dental plan and is not designed to coordinate with any other dental programs. If you have dental insurance or a pre-paid dental plan, all fees will be based on the usual and customary fees normally charged or the pre-paid plan's schedule of co-payments

LIMITATIONS & EXCLUSIONS

1) Dental care, which in the opinion of the attending dentist, is not necessary to the patient's dental health.
2) Oral surgery requiring the setting of fractures or dislocations.
3) Treatment for Myofunctinal therapy, except as provided herein.
4) Dispensing of drugs and medications not normally supplies in a dental office.
5) Treatment of malignancies, cysts, neoplasms or congenital malformations.
6) The cost of hospital care for any dental procedures(s).
7) Loss or theft of dentures or bridgework.
8) Services that cannot be performed because of the general health of the Member.
9) Services provided by a non-plan provider.
10) Services covered by Worker's Compensation, employer liability laws, no cost services provided by any municipality, county or other governmental agency or when coverage is provided by any other group plan (insurance or prepaid).

ORTHO PLAN EXCLUSIONS & LIMIITATIONS

1) No benefits will apply for a treatment program which began before the Subscriber enrolled in the Orthodontic Plan.
2) No benefits will apply for lost or broken appliances.
3) Extractions are not included as a benefit.
4) Additional fees may be charged by the dentist for:
   Care required in excess of 24 months from the time of banding, Gross non-cooperation, Accidents occurring during the period of treatment, Cases involving surgical orthodontics, Cases involving myofunctional therapy or T.M.J
5) If the Subscriber relocates to an area and is unable to receive treatment from a member orthodontist, coverage under this program ceases and it becomes the obligation of the Subscriber to pay the usual and customary fee of the Orthodontist where the treatment is completed.
6) Choice of Orthodontist, initially, after treatment begins or upon change or residence is limited to Orthodontists participating in this program or who would accept the fees outlined.
7) If the Subscriber becomes ineligible during the course of treatment, coverage under this program ceases and it becomes the obligation of the Subscriber to pay the entire remaining balance.

THE DENTAL ECLIPSE II

SCHEDULE OF BENEFITS AND CO-PAYMENTS

Member Services	Member Co-Payment
Diagnostic & Preventative	
Office Visit	$0.00
Oral Exam	$15.00
Fluoride (to age 14)	$15.00
Prophylaxis (cleaning—adult)	$35.00
Prophylaxis (cleaning-- child)	$25.00
Single Periapical x-ray	$11.00
Bitewing x-ray (4 films)	$25.00
Intraoral x-ray (incl. Bitewings)	$58.00
Panoramic x-ray	$50.00
Sealant (per tooth)	$21.00
Restorative Dentistry (Fillings-Cavities)	
Amalgam Restorations-Primary	
One Surface	$50.00
Two Surfaces	$62.00
Three Surfaces	$79.00
Four Surface	$97.00
Amalgam Restorations-Permanent	
One Surface	$50.00
Two Surfaces	$62.00
Three Surfaces	$79.00
Four Surface	$97.00
Composite Restorations-Anterior	
One Surface	$62.00
Two Surfaces	$81.00
Three Surfaces	$97.00
Four Surface	$116.00
Composite Restorations-Posterior	
One Surface	$68.00
Two Surfaces	$91.00
Three Surfaces	$112.00
Crown and Bridge	
Porcelain Crown/Porcelain with Metal Crown	$530.00
Stainless Steel Crown (permanent or primary)	$118.00
Full Crown	$510.00
Acrylic with Metal Crown	$550.00
Porcelain with Metal Pontic	$480.00
Recement Crown	$38.00
Crown Buildup (including pins)	$99.00
Crown Post & Core	$175.00
Periodontics**	
Gingivectomy or Gingivoplasty per Quad	$226.00
Gingival Flap Procedure (including root planning)	$266.00
Osseous Surgery per Quad (incl. flap entry & closure)	$450.00
Periodontal Scaling and Root Planning per Quad	$106.00
Full Mouth Debridement	$71.00
Periodontal Maintenance Following Active Therapy	$64.00

Member Services	Member Co-payment
Oral Surgery**	
Extraction (Simple)	$60.00
Extraction (Surgical)	$100.00
Soft Tissue Impaction	$130.00
Partial Bony Impaction	$164.00
Full Bony Impaction	$195.00
Root Removal (Exposed Roots)	$96.00
Surgical Exposure of Impacted Tooth	$224.00
Endodontics (Root Canal Therapy)**	
Pulp Capping (Direct)	$28.00
Therapeutic Pulpotomy	$67.00
Root Canal Anterior	$317.00
Root Canal Bicuspid	$378.00
Root Canal Molar	$500.00
Prosthetics (Dentures)	
Complete Upper/Lower Denture	$693.00
Immediate Upper/Lower Denture	$765.00
Partial Resin Upper/Lower	$567.00
Partial Cast Metal Base Upper/Lower	$710.00
Removable Unilateral Partial Denture	$373.00
Denture Adjustment	$30.00
Repair Broken Complete Denture Base	$63.00
Replace Missing or Broken Teeth	$68.00
Add Tooth to Existing Partial Denture	$85.00
Add Clasp to Existing Partial Denture	$95.00
Rebase	$235.00
Reline Denture (Chairside)	$132.00
Reline Denture (Lab)	$180.00
Tissue Reconditioning per Denture	$55.00
Other Services	
Emergency Palliative Treatment	25% Discount
Local Anesthetic	$11.00
Analgesia/Nitrous Oxide	$20.00
Office Visit (After Regular Hours)	$47.00
Missed/Canceled Appt. (without 24 hr notice)	$40.00
Orthodontics (Braces)	
Comprehensive Orthodontic Treatment (24 months)	
Under age 19	20 – 25% Discount
Age 19 & Over	20 – 25% Discount
Screening Exam	20 – 25% Discount
Initial Workup & X-Rays	20 – 25% Discount
Final Workup & X-Rays	20 – 25% Discount
Lost or Broken Metal Bands	20 – 25% Discount
Interceptive Pre-Ortho Guidance (per Visit)	20 – 25% Discount
Lost or Broken Head Gear	20 – 25% Discount
Lost or Irreparable Retainer	20 – 25% Discount
Partial Treatment/Functional Ortho Treatment	20 – 25% Discount

**Any procedure not listed in the above schedule or performed by a specialist is available to members at 20% discount of the Dentist's usual fees

PLAN TC-6000

❖ **TOTAL CARE PLAN TC-6000**

We are pleased to announce that there will be no rate increase. The TC-6000 provides you and your family with quality care at reasonable and predictable prices. Services are provided by a panel of quality dentists. Special features include; no deductibles, pre-existing conditions are covered, no annual or lifetime maximums, preventative care covered in full once every 6 months, and specialty care is a covered benefit.

Low monthly premiums:	**Single**	**$13.28**
	Two Party	**$26.54**
	Family	**$43.88**

Sample Illustration of Savings

Total Care TC-6000 versus No Dental Insurance

Procedure (quantity)	TC-6000 Copayment	No Dental Insurance	Savings	Savings %
Exam & X-ray (2 per person)	$0.00	$872.00	$872.00	100%
Cleaning (2 per person)	$0.00	$508.00	$508.00	100%
Resin 2 Surface Filling (3)	$120.00	$360.00	$255.00	71%
Crown, Porcelain with Metal (2)	$700.00	$1,388.00	$688.00	50%
Office Visit Charge (16)	$160.00	$912.00	$752.00	82%
Premium for 12 Months (Family)	$566.16	$0.00	-$566.16	-100%
Total	**$1,546.16**	**$4,040.00**	**$2,493.84**	**62%***

Sample based on typical family of 5

Percentage of savings represents this illustration only. Actual savings may vary per individual treatment plan.

Welcome to Total Care

Total Care is a comprehensive "Managed Care" Group Dental Program marketed, managed and administered by Total Dental Administrators, Inc. (TDA). TDA "Your Total Dental Benefit Specialist", has contracted with established private practicing dentists to provide you convenient, affordable and quality dental care.

TOTAL CARE DENTAL COVERAGE

Dental coverage includes dental services and treatment for:

- Diagnostic
- Preventive
- Restorative
- Endodontics
- Periodontics
- Prosthodontics
- Oral surgery
- TMJ
- Orthodontics
- Cosmetic

Refer to the enclosed Schedule of Benefits and Co-payments for a detailed listing of covered procedures.

TOTAL CARE ADVANTAGES

- No deductibles
- No claim forms
- No annual or lifetime benefit maximums
- No industry exclusions
- Covers Pre-existing conditions
- Covers Orthodontics (Braces)
- Local service

LOW MONTHLY RATES

Single	$13.28
Two Party	$26.54
Family	$43.88

HOW TO ENROLL

1. Complete the enclosed enrollment card. Include information about your spouse and/or child(ren) if you are applying for dependent coverage.

2. Select the general dental office you and your dependents wish to use from the enclosed Participating Provider Directory. Each participating dental facility listed in the Provider Directory has a Dental Office Code number listed to the left of the dental office. Be sure to use the **CODE** number to identify your selection on the Enrollment Form.

3. Premium payment is made by payroll deduction, if employee contributions are required. Turn your enrollment card into your Employer's personnel office or benefits department for processing.

FOR MORE INFORMATION CALL:

(801) 268-9740 or 1-800-880-3536
TDA, Inc.
969 East Murray Holladay Road Suite 4E
Salt Lake City, UT 84117

PLAN TC-6000

SAMPLE COST COMPARISON

ADA Code	Procedure	Usual and Customary Fee*	TC-6000 Copayment	Savings in Dollars	Percent Savings
Preventive					
D0210	Complete series x-rays	$ 110.00	$ 0.00	$ 110.00	100%
D0150	Initial Oral Exam	$ 60.00	$ 0.00	$ 60.00	100%
D1110	Adult - Prophylaxis (Cleaning)	$ 67.00	$ 0.00	$ 67.00	100%
D9430	Office Visit	$ 66.00	$ 10.00	$ 56.00	85%
Restorative					
D2140	Amalgam - One Surface	$ 84.00	$ 16.00	$ 68.00	81%
D2330	Resin - One Surface	$ 100.00	$ 30.00	$ 70.00	70%
Crown and Bridge					
D2720	Acrylic w/metal Crown	$ 753.00	$250.00	$ 503.00	67%
D2750	Crown porcelain Hi Noble Metal	$ 798.00	$375.00**	$ 423.00	53%
Endodontics					
D3310	RCT-1 Canal	$ 524.00	$180.00	$ 344.00	66%
D3330	RCT-3 Canals	$ 827.00	$340.00	$ 487.00	59%
Oral Surgery					
D7114	Extraction, erupted tooth exposed roots	$ 124.00	$ 40.00	$ 84.00	68%
D7220	Soft Tissue Impaction	$ 191.00	$ 80.00	$ 111.00	58%
Prosthetics					
D5110/20	Complete Upper/Lower Denture	$1177.00	$590.00***	$ 587.00	50%
Periodontics					
D4260	Osseous surgery/quad	$ 860.00	$380.00	$ 480.00	56%
Orthodontics					
D8080	24 Month Orthodontic Treatment	$4300.00	25% Discount	$1075.00	25%

*Usual fee is an average of dental fees throughout the state. The actual fee and savings may vary.
D2750 copayment is $250 + Lab Fee – **approximate lab fee of $125. **Lab fees may vary.**
***D5510/20 copayment is $190 + Lab Fee – **approximate** lab fee of $400. **Lab fees may vary.**

DENTAL PLAN INFORMATION

This Employee Plan Booklet explains the Benefits, Limitations, Exclusions, provisions and conditions of your Coverage through the Group Agreement your organization has with TDAUT, Inc. The Group Agreement is the document which specifies any rights to Benefits you may have. If the explanations in this Employee Plan Booklet can be interpreted differently from the provisions of the Group Agreement, the Group Agreement shall always control. You may examine the Group Agreement by contacting your organization or by contacting TDAUT, Inc. at:

969 East Murray Holladay Road Suite 4E
Salt Lake City, Utah 84117
Telephone: (801) 268-9740 or Toll Free 1-800-880-3536

Please read this document with care so that you will have a full understanding of the Plan and what it could mean to you and your family.

This document is void and of no effect if you are not entitled to or have ceased to be entitled to the dental coverage.

I ELIGIBILITY

A. You are eligible if you are a full-time employee, working within an eligible class.
B. Eligible dependents include your spouse and your unmarried child(ren), who are dependent on you for their support, to age 26; Newborn and adopted children are covered from the moment of birth or date of placement; Children for whom a court order of support applies.
C. The date of eligibility is determined by your Organization. Newborn children are covered the first day of the month following the date of birth and legally adopted children, foster children, and stepchildren are covered the first day of the month following placement, as long as TDAUT is notified within thirty (30) days and any Prepayment fee is paid within that period. Check with your employer Organization if you have any questions about when coverage begins."
D. Dependents of an Enrollee who are in active military service are not eligible for coverage under the Plan.

The eligibility of all Covered Persons, for the purpose of receiving benefits under the Plan, shall, at all times, be contingent upon the applicable monthly premium payment having been made for such Covered Persons by the Group on a current basis.

PLAN TC-6000

ADA CODE	PROCEDURE DESCRIPTION	CO-PAYMENT
DIAGNOSTIC		
D0120	Periodic oral exam (twice in any 12 consecutive months)	N/C
D0140	Emergency oral exam (during office hours)	$25
D0150	Initial oral exam (once in any 12 consecutive months	N/C
D0180	Comprehensive Periodontal Eval (once in any 12 consecutive months	N/C
D0210	Intraoral - complete including bitewing x-rays (once in a 3 year period	N/C
D0220	Single periapical x-ray	N/C
D0230	Each addition film	N/C
D0270/72	Bitewing x-rays (single & two films)	N/C
D0274	Bitewing x-rays (once in a 6 mo period)	N/C
D0277	Verticle Bitewing x-rays (once in a 6 mo period).	N/C
D0330	Panoramic film-including bitewing x-rays (once in a 3 year period)	N/C
D0470	Diagnostic casts	N/C
D9310	Consultation	N/C
D9430	Office Visit	$10
D9999	Sterilization	N/C
PREVENTIVE		
D1110	Prophylaxis-Adult (once in a 6 mo period)	N/C
D1120	Prophylaxis-Child (once in a 6 mo period)	N/C
D1201	Fluoride treatment with Prophylaxis-Child	N/C
D1203	Fluoride treatment (once in 12 mo period to age 15)	N/C
D1310	Dietary planning	N/C
D1330	Preventive dental education, home care	N/C
D1351	Sealant per tooth	$12
D1510	Space maintainer -fixed unilateral	$30+Lab Fee
D1515	Space Maintainer -fixed bilateral	$50+Lab Fee
D1520	Space Maintainer -removable unilateral	$30+Lab Fee
D1525	Space Maintainer -removable bilateral	$50+Lab Fee
D1550	Recement space maintainer	$15
RESTORATIVE		
D2140	Amalgam - 1 surface perm	$16
D2150	Amalgam - 2 surface perm	$25
D2160	Amalgam - 3 surface perm	$37
D2161	Amalgam - 4 or more surfaces perm	$43
D2330	Resin - 1 surface anterior	$30
D2331	Resin - 2 surfaces anterior	$40
D2332	Resin - 3 surfaces anterior	$51
D2335	Resin - 4 or more surfaces anterior	$62
D2390	Resin – based composite crown, anterior	$90
D2391	Resin - 1 surface posterior	$33
D2392	Resin - 2 surface posterior	$64
D2393	Resin - 3 surface posterior	$79
D2394	Resin - 4 or more surfaces posterior	$99
D2510	Inlay metallic - 1 surface	$145
D2520	Inlay metallic - 2 surfaces	$180
D2530	Inlay metallic - 3 surfaces	$225
D2543	Onlay metallic (3 surfaces)	$220
D2544	Onlay metallic (4 or more surfaces)	$250
D2710	Acrylic (plastic) crown - lab processed	$110
D2720/22	Acrylic w/metal crown	$250
D2740	Porcelain crown	$275+Lab Fee
D2750/52	Porcelain w/metal crown	$250+Lab Fee
D2790	Full crown	$250+Lab Fee
D2810	3/4 metal crown	$250+Lab Fee
D2910/20	Recement crown, inlay, facing only	$20

ADA CODE	PROCEDURE DESCRIPTION	CO PAYMENT
RESTORATIVE (Continued)		
D2930	Stainless steel crown	$55
D2932	Prefabricated resin crown	$75
D2940	Sedative filling	$22
D2950	Crown buildup, including any pins	$65
D2951	Pin retention per tooth	$10
D2952	Cast post and core	$85
D2954	Prefabricated post and core	$75
D2960	Labial veneer laminate - chairside	$250
D2970	Temporary crown (Fractured Tooth)	N/C
D2980	Repair crown	$45
D3960	Cosmetic Bleaching, Per Arch	$115
D3961	Cosmetic Bleaching, Both Arches.	$220

ENDODONTICS**
(**Treatment from a Plan specialist MUST** be pre-approved by the Plan, TDAUT, **PRIOR** to any services rendered.)

ADA CODE	PROCEDURE DESCRIPTION	CO PAYMENT
D3110	Pulp capping/direct	$20
D3120	Pulp capping/indirect	$17
D3220	Therapeutic pulpotomy	$40
D3230	Pulpal Therapy (Resorbable Filling) Ant Prim	$45
D3240	Pulpal Therapy (Resorbable Filling) Post Prim	$45
D3310	RCT anterior	$180
D3320	RCT bicuspid	$250
D3330	RCT molar	$340
D3346	Retreat Previous RCT anterior	15-20% Discount
D3347	Retreat Previous RCT bicuspid	15-20% Discount
D3348	Retreat Previous RCT molar	15-20% Discount
D3351	Apexification/Recalcification-Initial	15-20% Discount
D3352	Apexification/Recalcification-Interiml	15-20% Discount
D3353	Apexification/Recalcification-Final	15-20% Discount
D3410	Apicoectomy per tooth (anterior only)	$250
D3421	Apicoectomy per tooth (bicuspid)	15-20% Discount
D3425	Apicoectomy per tooth (molar)	15-20% Discount
D3426	Apicoectomy per tooth (each add)	15-20% Discount
D3430	Retro fill per tooth	$85
D3450	Root amputation	$95
D3920	Hemisection	$125

PERIODONTICS **
(**Treatment from a Plan specialist MUST** be pre-approved by the Plan, TDAUT, **PRIOR** to any services rendered.)

ADA CODE	PROCEDURE DESCRIPTION	CO PAYMENT
D4210	Gingivectomy or gingivoplasty/quad	$200
D4211	Gingivectomy or gingivoplasty/tooth	$60
D4240	Gingival flap procedure inc. rt. Planning 4+ teeth	$250
D4241	Gingival flap procedure inc. rt. Planning 1-3 teeth	$150
D4260	Osseous surg/quad (flap entry & closure) 4+ teeth	$280
D4261	Osseous surg/tooth (flap entry & closure) 1-3 teeth	$250
D4320	Provisional splinting - intracoronal	$100
D4321	Provisional splinting - extracoronal	$100
D4341	Periodontal scaling & root planing/quad 4+ teeth	$85
D4342	Periodontal scaling & root planing/tooth 1-3 teeth	$55
D4355	Full mouth debridement	$50
D4381	Local Delivery–Chemo to Tissue	20% Discount
D4910	Periodontal maintenance following active therapy	$55

REMOVABLE PROSTHODONTICS

ADA CODE	PROCEDURE DESCRIPTION	CO PAYMENT
D5110	Complete upper denture(3 adj. w/in 60 days)	$190+LabFee
D5120	Complete lower denture(3 adj. w/in 60 days)	$190+LabFee
D5130	Immediate upper denture(4 adj. w/in 60 days)	$220+LabFee
D5140	Immediate lower denture(4 adj. w/in 60 days)	$220+LabFee

ADA CODE	PROCEDURE DESCRIPTION	CO-PAYMENT
REMOVABLE PROSTHODONTICS (Continued)		
D5211-12	Upper or lower partial - resin base	$190+LabFee
D5213-14	Upper or lower partial - cast metal base w/resin saddles (including any conventional clasps, rests & teeth)	$220+LabFee
D5281	Removable unilateral partial denture	$250
D5410/22	Denture adjustment (upper, lower, complete or partial)	$35
D5510	Repair broken complete denture base	$20+Lab Fee
D5520	Replace missing or broken teeth complete denture base	$20+Lab Fee
D5610	Repair resin saddle or base	$25+Lab Fee
D5620	Repair cast framework	$25+Lab Fee
D5630	Repair or replace broken clasp	$30+Lab Fee
D5640	Replace broken teeth (per tooth)	$20+Lab Fee
D5650	Add tooth to existing partial denture	$25+Lab Fee
D5660	Add clasp to existing partial denture	$25+Lab Fee
D5670/71	Replace all teeth and acrylic-cast metal	20% Discount
D5710/21	Rebase (upper, lower, complete or partial)	$25+Lab Fee
D5730/41	Reline chairside (Upper, lower, complete or partial)	$70
D5750/61	Reline lab (Upper, lower, complete or partial)	$45+Lab Fee
D5850	Tissue reconditioning per denture	$30
FIXED PROSTHODONTICS		
D6010/95	Implant	20-25% Discount
D6210/12	Cast pontic	$250+Lab Fee
D6240/42	Porcelain w/metal pontic	$250+Lab Fee
D6245	Porcelain ceramic pontic	$275+Lab Fee
D6250/52	Acrylic pontic	$250+Lab Fee
D6545	Cast metal retainer for acid etch bridge (Maryland Bridge - per unit)	$175
D6720/22	Acrylic w/metal crown	$250+Lab Fee
D6740	Porcelain ceramic crown	$275+Lab Fee
D6750/52	Porcelain / metal crown	$250+Lab Fee
D6780	3/4 metal crown	$250+Lab Fee
D6790/92	Full metal crown	$250+Lab Fee
D6920	Connector Bar	$45
D6930	Recement bridge - per cemented unit	$30
D6940	Stress breaker, simple	$25+Lab Fee
D6950	Precision attachment	$150
D6980	Bridge repair	$25+Lab Fee

ORAL SURGERY**

(**Treatment from a Plan specialist MUST** be pre-approved by the Plan, TDAUT, **PRIOR** to any services rendered.)

ADA CODE	PROCEDURE DESCRIPTION	CO-PAYMENT
D7111	Extraction, coronal remnants – decidusous tooth	$30
D7140	Extraction, erupted tooth or exposed roots	$40
D7210	Surgical extraction	$75
D7220	Soft tissue impaction	$80
D7230	Partial bony impaction	$95
D7240	Complete bony impaction	$115
D7240	Complete bony impaction with complications	$125
D7250	Surgical root recovery	$60
D7270	Tooth reimplantation & stabilization	$125
D7280	Surgical exposure of impacted tooth	$160
D7286	Biopsy of oral tissue - soft	$35+Lab Fee
D7310	Alveoloplasty/quad w/extraction	$80
D7320	Aveoloplasty/quad w/o extractions	$200
D7470	Removal of exostosis - maxilla or mandible	$265
D7510	Intra - oral I & D or abscess	$65
D7911	Simple suture (includes post op. visit)	N/C
D7960	Frenectomy	$140

ADA CODE	PROCEDURE DESCRIPTION	CO-PAYMENT
ORTHODONTICS		
D8010-8999	Orthodontics	15-25% Discount*
TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
	TMJ Treatment	15-25% Discount
OTHER SERVICES		
D9110	Emergency palliative treatment	$35
D9210	Local anesthetic	N/C
D9230	Analgesia / Nitrous oxide	$20
D9440	Office visit (after regular scheduled hours)	$35
D9940	Nightguard (occlusal guard) limited to one in a 12 month period)	$155
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$90
D9999	Missed/canceled appointment (without 24 hour notice)	$25

SPECIAL LIMITATIONS

•This Schedule Of Benefits And Co-payments is for non-precious metals only. If gold is used, there will be an additional charge according to the current market value of gold.

•Procedures or services not listed will be provided at Usual & Customary fees.

* Orthodontic coverage is the discount filed with TDAUT. Please see provider listing for details.

** **ENDODONTIC, PERIODONTIC AND ORAL SURGERY TREATMENTS FROM A PLAN SPECIALIST MUST BE PRE-APPROVED BY THE PLAN ADMINISTRATOR, TDAUT, PRIOR TO ANY SERVICES RENDERED.**

*** **Pedodontic coverage is the discount filed with TDAUT (20-25% off the participating pedodontists regular fee).**

III **CO-PAYMENTS -** The Co-payment amount in the Schedule Of Benefits and Co-Payments, contained herein are payable by you directly to the Dental Office as treatment is received. You should discuss all future payments and costs before new appointments are made. The Dental Office staff will help you plan your dental treatment and payments.

IV **SPECIALTY CARE -** Sometimes your selected dentist will identify a problem that is best treated by a specialist. In this case, your dentist will refer you, where available, to a fully qualified specialist in the Total Care Dental Network who specializes in the care you need. Depending on your plan of coverage (refer to your Schedule of Benefits and Co-Payments), treatment provided by a specialist may require Plan authorization. Your selected Plan Provider will initiate this authorization.

V **EXTENDED CARE -** Upon termination of eligibility or termination of the Group Agreement, the Plan will complete any procedures started, but only the procedures in progress.

VI **EFFECTIVE DATE OF COVERAGE**

A. Initial enrollment must be made within thirty (30) days following the date of hire or the Employer's period of probation. If enrollment is received prior to the fifteenth (15th) day of the month, coverage will begin on the first day of the following month. If TDAUT does not receive the completed application as required above, the Employee must wait until the next open enrollment period.

B. A spouse and child(ren), newly acquired through marriage, must make application within thirty (30) days of marriage. If said application is received prior to the fifteenth (15th) day of the month, coverage will begin on the first day of the following month. Except for newborn natural children and adopted children, who are enrolled within sixty (60) days from the date of the birth of the natural child or sixty (60) days after placement of the adopted child, family members, who do not enroll during the initial enrollment period, cannot enroll until the next annual open enrollment period.

VII **PARTICIPATING PLAN PROVIDERS (DENTISTS)**

A. Benefits Obtained From Plan Providers - Except for out-of area emergency care, benefits are available only from your selected Plan Provider.

B. List of Plan Providers - You may obtain a current list of Plan Providers from the Plan's Administrative Office located at 969 East Murray Holladay Road, Suite 4E, Salt Lake City, Utah 84117, telephone no. (801) 268-9740 or 1-800-880-3536.

C. Choosing a Plan Provider -You may choose any Plan Provider from the list of Plan Providers referred to above. Upon request, the Plan Administrator will assist you in selecting a Plan Dentist; but may not recommend any particular dentist. All covered family members must go to the same Plan Provider. You must choose a Plan Provider at the time you enroll. You must have a Plan provider to receive benefits.

D. Changing Plan Providers - You may change Plan Providers. If you notify the Plan, in writing, by the fifteenth (15th) day of the month, the change will be effective on the first of the following month. Should your Plan Provider stop participation, the Plan reserves the right to transfer you to another Plan Provider of your choosing.

All Plan Providers (Dentists) furnishing services to a Member do so as independent contractors. TDAUT shall not be liable for any claim or demand for damages arising out of or in any manner connected with any injuries suffered by a Member while receiving dental services.

VIII **EMERGENCY CARE**

A. If you are less than fifty (50) miles from your Plan Provider, you should always attempt to obtain emergency care from your Plan Provider **FIRST**.

B. If you are seeking emergency care during normal business hours and your selected Plan Provider is not accessible, you should contact the Plan for assistance at (801) 268-9740 or 1-800-880-3536.

C. If your Plan Provider is not accessible and after you have made a reasonable attempt to contact the Plan for assistance or you are more than fifty (50) miles from your Plan Provider, then you should seek emergency dental care for the relief of pain, bleeding or swelling from any licensed dentist. Under such circumstances, the Plan will pay up to a maximum of $50.00 per contract year per person. A written itemized statement for these services must be presented to TDAUT, Inc. for reimbursement. If it is necessary to have additional treatment, it must be done by your Plan Provider.

IX **SCHEDULING AN APPOINTMENT -** After your Plan becomes effective, you can schedule an appointment by contacting your selected participating Provider. Your dentist will offer you an appointment generally within thirty (30) days of your call - or within 24 hours for emergency care. Most dental appointments are scheduled Monday through Friday during regular working hours. Each Plan Provider is an independent practitioner who establishes his or her own hours. Some have evening and/or weekend hours. Call your Plan Provider to ask about office hours and the availability of emergency dental services.

X **PLAN IDENTIFICATION CARD -** Although an I.D. card will be issued to you, it is not necessary in order to receive dental care form your Plan Provider. Your name will appear on an eligibility list, which is sent to your selected dentist each month.

XI **WORKERS' COMPENSATION EXCLUSION -** Expenses for which payment is required under applicable Workers' Compensation statutes are not eligible for payment under this dental plan.

XII **COORDINATION OF BENEFITS -** This Coordination of Benefits (COB) provision applies to this Plan when a Member and/or Subscriber has other dental care coverages.

In the event benefits apply under two or more dental care coverages, the following provisions apply:

A. If the other dental care coverage does not contain a coordination of benefits provision, the benefits of that coverage will be determined before any benefits under this Plan.

B. If the other dental care coverage contains a coordination of benefits provision, the rules establishing the order of benefit determination are:

1. The benefits of the plan, which covers the person as an employee, member or subscriber, that is, other than as a dependent, are determined before those of the plan, which cover the person as a dependent.
2. For dependent child/parents living together:
   - i. The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year.
   - ii. If both parents have the same birthday, the benefits of the plan, which covered the parent longer, are determined before those of the plan, which covered the other parent for a shorter time.
   - iii. If the other plan does not have the rule described in XII-B-1,2,3, but instead has a rule based on another order, and if, as a result, the coordinating plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
3. Dependent child/parents separated, divorced, or not living together:
   - i. first, the plan of the custodial parent of the child;
   - ii. then, the plan of the spouse of the custodial parent of the child;
   - iii. then, the plan of the non-custodial parent; and
   - iv. finally, the plan of spouse of the non-custodial parent

a. If the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or health insurance coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

b. If the specific terms of a court decree state that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses or health insurance coverage of the child and the child's residency is split between the parents, the order of benefit determination rules outlined in Subsection R590-131-4 B.2. Dependent Child/Parents Married or Living Together shall apply. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

v. If there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses, if any, is:

a. the plan of the custodial parent;
b. the plan of the spouse of the custodial parent;
c. the plan of the non-custodial parent; and then
d. the plan of the spouse of the non-custodial parent.

4. Active/Inactive Employee, Member or Subscriber. The benefits of a plan, which covers a person as an active employee, member, and subscriber, are determined before those of a plan, which cover that person as an inactive employee, member, or subscriber. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this provision is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.

i. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

ii. The start of a new plan does not include:

a. a change in the amount or scope of a plan's benefits;
b. a change in the entity which pays, provides or administers the plan's benefits; or
c. a change from one type of plan to another, such as, from a single employer plan to that of a multiple employer plan.

iii. The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

C. If the individual is covered under two (2) dental care coverages when none of the above applies, the benefits of the plan which has covered the individual for the longer period of time shall be primary.

The Plan may, without consent or notice to any Member, release to or obtain from any insurance company or other organization or person, any information, which may be necessary regarding coverage, expense and benefits. Any Member claiming benefits under this Group Dental Plan must furnish the Plan such information as may be necessary for the purpose of administering this provision.

In the event the Plan provides benefits to or on behalf of a Member and/or Subscriber in excess of the amount which would have been payable by reason of the Member's and/or Subscriber's coverage under another health and/or dental care program, the Plan shall be entitled to recover the amount of such excess from the Member and/or the Subscriber.

XIII **THIRD PARTY RESPONSIBILITY -** In the event a Member and/or Subscriber sustains any illness or injury for which a third party may be responsible, the Plan, up to the amount of benefits paid or provided, shall be entitled to the proceeds of any settlement or judgement which results in a recovery from the third party; but only under the conditions that the covered Member and/or Subscriber is made whole first.

XIV **CONTINUATION OF COVERAGE -** You and your dependents are entitled to continue coverage, should you and/or your dependents' eligibility under the Plan cease. You must provide written notification of request for continuation of coverage with appropriate membership dues (premium) within sixty (60) days of the date your eligibility ceases. For continuation under the **COBRA** Act, if applicable, contact your Employer for details.

XV **TERMINATION -** Benefits under this Plan shall cease upon any of the following events:

A. On the date of the expiration of the period for which the last payment was made.

B. Upon the date of entry into full-time military service.

C. On the last day of the month during which termination notice occurs, or thirty (30) days from the date that the termination notice is received by the Member and/or Subscriber, whichever date is later, in the event that a Member and/or Subscriber fails to maintain a satisfactory dentist-patient relationship, i.e. the Plan Provider no longer desires to treat the Member and/or Subscriber.

D. In the event premiums are delinquent, services and benefits under the Plan shall be suspended effective on the last day of the month during which the delinquency occurred.

E. On the date the Plan contract terminates, if not renewed.

XVI **DENTAL RECORDS -** The dental records of the Member and/or Subscriber concerning services performed herein shall remain the property of the Plan dentist.

XVII **CUSTOMER SERVICE INQUIRES -** Plan Members and/or Subscribers customer service is available by calling TDAUT at (801) 268-9740 or toll-free 1-800-880-3536 during normal business hours. All group dental plan inquires, including grievance procedures are handled by TDAUT.

XVIII **EARLY TERMINATION PENALTY -** While employed with the Group, the Subscriber agrees to remain enrolled as a Member of the Group Dental Plan for a minimum of one year. Less than one-year membership may result in the Subscriber being billed usual service fees minus premium and Co-payments paid.

PRINCIPAL EXCLUSIONS AND LIMITATIONS

1. Prophylaxis is limited to one every six (6) months.
2. Fluoride application is limited to one per year to age fifteen (15).
3. Supplement bitewing x-rays are limited to one series of four films in any six (6) consecutive months.
4. Complete mouth or panorex x-rays are limited to once every thirty-six (36) months.
5. Sealants are covered to the age of seventeen (17) and are limited to permanent molars only.
6. Periodontal treatment (sub-gingival curettage and root planing) are limited to five quadrants in any twelve (12) consecutive months.
7. Replacement of a restoration is covered only when it is dentally necessary.
8. Oral examinations are limited to twice in any period of twelve (12) consecutive months.
9. Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
10. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
11. Full upper and/or lower dentures are not to exceed one each in any five (5) year period. Replacement will be provided by the Plan for an existing full or partial denture only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
12. Denture relines are limited to two (2) in any year.
13. Services for injuries or conditions which are covered under Workers' Compensation or Employers' Liability Laws.
14. Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
15. Temporomandibular joint treatment (TMJ), except as provided herein.
16. Elective or cosmetic dentistry, except as provided herein.
17 Oral surgery requiring the setting of fractures or dislocations. Orthonognathic surgery or extractions solely for orthodontic purposes.
18. Treatment of malignancies, cysts or neoplasms or congenital malformations, except congenital anomaly of a tooth or teeth covered from birth.
19. Dispensing of drugs.
20. Hospital charges of any kind.
21. Loss or theft of dentures or bridgework.
22. Any procedure of implantation or of an experimental nature.
23. General anesthesia or IV/conscious sedation.
24 Services that cannot be performed because of the general health, physical or behavioral limitations of the patient.
25. Fees incurred for broken or missed appointments (without 24 hours notice) are the Member's responsibility.
26. Dental expenses incurred in connection with any dental procedure started prior to the effective date of coverage.
27. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
28. Any procedure performed for the purpose of correcting contour, contact or occlusion. Any procedure to correct tooth structure lost due to attrition, erosion or abrasion.
29. Any procedure that is not specifically listed as a covered benefit.
30. Provider may refuse treatment to any patient who continually fails to follow a prescribed course of treatment.
31. Any dental treatment which, in the opinion of the Plan's dental consultant has a poor prognosis.
32. Nightguard (occlusal guard) limited to one each twelve (12) months.
33 Services performed by a dentist who is not a Participating Dentist , except for emergency care as provided herein.
34. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

ORTHODONTIC PLAN EXCLUSIONS AND LIMITATIONS

1. No benefits will apply for a treatment program which began before the Member/Subscriber enrolled in the Orthodontic Plan.
2. No benefits will apply for lost or broken appliances.
3. Extractions are not included as a benefit.
4. Additional fees, for which you are responsible, may be charged by the dentist for:
   a. Care required in excess of 24 months from the time of banding.
   b. Gross non-cooperation.
   c. Accidents occurring during the period of treatment.
   d. Cases involving surgical orthodontics.
   e. Cases involving myofunctional therapy of TMJ.
5. If the Member and/or Subscriber relocates to an area and is unable to receive treatment from a member Orthodontist, coverage under the Plan ceases and it becomes the obligation of the Member and/or Subscriber to pay the usual and customary fee of the Orthodontist where the treatment is completed.
6. Choice of an Orthodontist is limited to Orthodontists participating in the Plan or to Orthodontists who will accept the fees outlined in the Plan.
7. If the Member and/or Subscriber becomes ineligible for benefits under this Plan for treatment, coverage under the Plan ceases and it becomes the obligation of the Member and/or Subscriber to pay the remaining balance due the Orthodontist.

ELITE CHOICE

❖ **THE ELITE CHOICE PLAN!**

This option offers you the option of receiving your dental care from a participating plan dentist (in-network) or from any dentist you choose (out-of network). Seeing an in-network provider will give you a rich benefit. Benefits include no deductibles, $1,500 annual maximum, no lifetime maximums on orthodontics and no waiting periods.

Low Monthly rates:	**Single**	**$25.38**
	Two Party	**$49.73**
	Family	**$80.96**

Sample Illustration of Savings

Elite Choice versus No Dental Insurance

Procedure (quantity)	Elite Choice Copayment*	No Dental Insurance	Savings	Savings %
Exam & X-ray (2 per person)	$20.00	$872.00	$852.00	98%
Cleaning (2 per person)	$10.00	$518.00	$508.00	98%
Resin 2 Surface Filling (3)	$130.00	$385.00	$255.00	71%
Crown, Porcelain with Metal (2)	$700.00	$1,388.00	$688.00	50%
Office Visit Charge (16)	$0.00	$912.00	$912.00	100%
Premium for 12 Months (Family)	$938.64	$0.00	-$938,64	-100%
Total	**$1,798.64**	**$4,040.00**	**$2,241.36**	**54%****

Sample based on typical family of 5

*At a participating provider

*****Percentage of savings represents this illustration only. Actual savings may vary per individual treatment plan.***

ELITE CHOICE

BENEFITS

Welcome

to the **Elite Choice Group Dental Plan** underwritten by Companion Life Insurance Company.

The **Elite Choice Dental Plan** offers you the option of receiving your dental care from any dentist you choose (Out-Of-Network) or from a Participating Plan Dentist (In-Network); and you don't need to make that decision until you need dental care! However, should you elect to receive your dental care from an In-Network dentist, your out of pocket costs will be less.

The following is an outline of your dental coverage. For a complete listing of procedures please refer to the employee booklet/certificate you will receive after enrollment. Services not listed are available on a fee for service basis, no discount applies.

SAMPLE COST COMPARISON

Procedure	Usual and Customary Fee*	Elite Choice Copay	Savings	Savings Percent
Comprehensive Oral Eval	$ 53.00	$ 0.00	$ 53.00	100%
Intraoral Complete	$ 96.00	$ 0.00	$ 96.00	100%
Prophylaxis Adult (Cleaning)	$ 58.00	$ 10.00	$ 48.00	83%
Amalgam One Surface	$ 73.00	$ 16.00	$ 57.00	78%
Resin One Surface, Ant	$ 87.00	$ 30.00	$ 57.00	66%
Porcelain Crown	$ 704.00	$300.00	$404.00	57%
Crown Resin HighNobleMetal	$ 655.00	$250.00	$405.00	62%
Root Canal Anterior	$ 456.00	$170.00	$286.00	63%
Root Canal Molar	$ 719.00	$323.00	$396.00	55%
Extraction, Erupted Tooth	$ 96.00	$ 30.00	$ 66.00	69%
Removal of Impacted tooth Soft Tissue	$ 188.00	$ 75.00	$113.00	60%
Complete Denture	$1005.00	$375.00	$630.00	63%
Perio Scaling & Root Plng Per Quad	$ 187.00	$ 80.00	$107.00	57%

*Usual fee is an average of dental fees throughout the state. The actual fee and savings may vary

LOW MONTHLY RATES

Single	$25.38
Two-Party	$49.73
Family	$80.96

CODE	DESCRIPTION	In-Network Patient Co-pay	*Out-of-Network* Plan Pays to Dentist, Patient Responsible for Difference
	DIAGNOSTIC		
D0120	PERIODIC ORAL EVALUATION	$0.00	$19.00
D0140	LIMITED ORAL EVALUATION	$10.00	$22.00
D0150	COMPREHENSIVE ORAL EVAL	$0.00	$33.00
D0180	COMP PERIO ORAL EVAL	$0.00	$33.00
D0210	INTRAORAL-COMPLETE INCL BITEWINGS	$0.00	$58.00
D0220	INTRAORAL PA FIRST FILM	$0.00	$11.00
D0230	INTRAORAL-PA- EA ADDL FILM	$0.00	$9.00
D0272	BITEWINGS- TWO FILMS	$5.00	$13.00
D0274	BITEWINGS- FOUR FILMS	$5.00	$21.00
D0277	VERT BITEWINGS- 7-8 FILMS	$0.00	$30.00
D0330	PANORAMIC FILM	$0.00	$48.00
	PREVENTIVE		
D1110	PROPHYLAXIS-ADULT	$10.00	$30.00
D1120	PROPHYLAXIS-CHILD	$10.00	$18.00
D1201	TOP APPL OF FLUOR INCLD/PXS CHILD	$0.00	$32.00
D1203	TOP APPL OF FLUORIDE PXS EXCL-CHILD	$0.00	$13.00
D1351	SEALANT- PER TOOTH	$13.00	$8.00
D1510	SPACE MAINTAINER-FIXED-UNILATERAL	$80.00	$51.00
D1515	SPACE MAINTAINER - FIXED BILATERAL	$120.00	$54.00
D1520	SPACE MAINTAINER- REMOVABLE-UNILATERAL	$90.00	$73.00
D1525	SPACE MAINTAINER- REMOVABEL BILAT	$135.00	$88.00
D1550	RECEMENTATION OF SPACE MAINTAINER	$15.00	$13.00
	RESTORATIVE		
D2140	AMALGAM-ONE SURFACE	$16.00	$28.00
D2150	AMALGAM- TWO SURFACES	$24.00	$33.00
D2160	AMALGAM-THREE SURFACES	$35.00	$33.00
D2161	AMALGAM-FOUR OR MORE SURFS	$45.00	$39.00
D2330	RESIN-ONE SURFACE, ANT	$30.00	$28.00
D2331	RESIN-TWO SURFACES, ANT	$40.00	$35.00
D2332	RESIN-THREE SURFACES, ANT	$50.00	$41.00
D2335	RES-4 OR> SURF-INVL INC ANGLE ANT.	$60.00	$48.00
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	$106.00	$11.00
D2391	RESIN-BASED COMPOSITE - ONE SURF, POST	$35.00	$32.00
D2392	RESIN-BASED COMPOSITE - TWO SURF, POST	$65.00	$23.00
D2393	RESIN-BASED COMPOSITE - THREE SURF, POST	$80.00	$24.00
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURF, POST	$95.00	$22.00
D2510	INLAY-METALLIC-ONE SURFACE	$145.00	$190.00
D2520	INLAY METALLIC -TWO SURF	$170.00	$210.00

ELITE CHOICE

BENEFITS CONTINUED

CODE	DESCRIPTION	In-Network Patient Co-pay	*Out-of-Network* Plan Pays to Dentist, Patient Responsible for Difference
	RESTORATIVE CONTINUED		
D2530	INLAY-METALLIC THREE OR> SURFACES	$225.00	$213.00
D2710	CROWN- RESIN-LABORATORY	$110.00	$90.00
D2720	CROWN-RESIN -HIGH NOBLE METAL	$250.00	$148.00
D2721	CROWN-RESIN-PREDOMINANTLY BASE MET	$250.00	$114.00
D2722	CROWN-RESIN -NOBLE METAL	$250.00	$125.00
D2740	PORCELAIN CROWN	$295.00	$210.00
D2750	CROWN-PORCELAIN-HIGH NOBLE METAL	$365.00	$133.00
D2751	CROWN-PORCELAIN-PREDOM BASE METALIC	$365.00	$99.00
D2752	CROWN-PORCELAIN FUSED-NOBLE METAL	$365.00	$110.00
D2790	CROWN-FULL CAST HIGH NOBLE METAL	$365.00	$116.00
D2930	STAINLESS STEEL CROWN	$60.00	$44.00
D2932	PREFABRICATED RESIN CROWN	$60.00	$68.00
D2940	SEDATIVE FILLING	$15.00	$25.00
D2950	CORE BUILD-UP, INCL ANY PINS	$65.00	$34.00
D2951	PIN RET/TOOTH, PER TOOTH	$10.00	$11.00
D2952	CAST POST AND CORE	$80.00	$72.00
D2954	PREFAB POST/CORE	$75.00	$50.00
D2980	CROWN REPAIR	$45	$0.00
	ENDODONTICS		
D3110	PULP CAP-DIRECT	$17.00	$7.00
D3120	PULP CAP-INDIR	$20.00	$2.00
D3220	THERA PULPOTOMY	$50.00	$17.00
D3310	ROOT CANAL-ANTERIOR	$170.00	$115.00
D3320	ROOT CAN-BICUSPID	$225.00	$123.00
D3330	ROOT CANAL-MOLAR	$323.00	$126.00
D3410	APICOECTOMY/PERIRADICULAR SURG-ANTR	$227.00	$99.00
D3430	RETRO FILLING-PER ROOT	$75.00	$24.00
D3450	ROOT AMPUTATUION-PER RT	$85.00	$115.00
D3920	HEMISECTION/ROOT REMOVAL	$80.00	$76.00
D3960	BLEACHING OF TOOTH	$115.00	$28.00
	PERIODONTICS		
D4210	GINGIVECTOMY OR GINGIVOPLASTY-QUAD 4 OR MORE TEETH	$175.00	$51.00
D4211	GINGIVECTOMY OR GINGIVOPLASY-TOOTH 1 TO 3 TEETH	$50.00	$10.00
D4240	GING FLAP PROC INC ROOT PLNG/QUAD 4 OR MORE TEETH	$210.00	$56.00
D4241	GING FLAP PROC INC ROOT PLNG/TOOTH 1 TO 3 TEETH	$135.00	$30.00
D4341	PERIO SCALING AND ROOT PLNG-QUAD 4 OR MORE TEETH	$80.00	$26.00
D4342	PERIO SCALING AND ROOT PLNG-TOOTH 1 TO 3TEETH	$53.00	$16.00

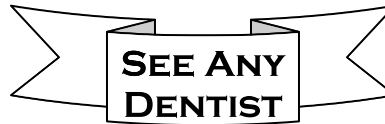
CODE	DESCRIPTION	In-Network Patient Co-pay	*Out-of-Network* Plan Pays to Dentist, Patient Responsible for Difference
	PERIODONTICS CONTINUED		
D4355	FULL MOUTH DEBRIDEMENT	$50.00	$21.00
D4910	PERIO MAINT PROC FOLLOWING ACT THER	$50.00	$14.00
	REMOVABLE PROSTHODONTICS		
D5110	COMPLETE DENTURE MAX	$375.00	$204.00
D5120	COMPLETE DENTURE-MAND	$375.00	$204.00
D5130	IMMEDIATE DENTURE-MAX	$395.00	$236.00
D5140	IMMEDIATE DENTURE-MAND	$395.00	$236.00
D5211	MAX PART DENTURE-RESIN BASE	$310.00	$178.00
D5212	MAND PART DENTURE-RESIN BASE	$310.00	$178.00
	ORAL SURGERY		
D7140	EXTRACTION, ERUPTED TOOTH OR ESPOSED ROOT	$30.00	$27.00
D7210	SURG REM ERUP TOOTH REQ FLAP/BONE	$65.00	$26.00
D7220	REMOV OF IMPACTED TOOTH-SOFT TIS	$75.00	$39.00
D7230	REMOV OF IMPACTED TOOTH-PAR BONY	$100.00	$52.00
D7240	REMOV OF IMPACTED TOOTH-COMP BONY	$125.00	$53.00
D7510	I&D ABSCESS INTRAORAL-SOFT TISSUE	$65.00	$36.00
	ORTHODONTICS		
D8000	ORTHODONTICS	25% Discount	NO COVERAGE
	MISCELLANEOUS		
	MISSED APPOINTMENT FEE	$15	
D9110	PALLIATIVE (ER) TX-DENT PAIN-MINOR	$30.00	$6.00
D9210	LOCAL ANESTHETIC	$0.00	$11.00
D9230	ANALGESIA	$20.00	$0.00
D9310	PROF CONSULT-DIAG SVC OTHER DENTIST	$10.00	$67.00
D9430	OFFICE VISIT-OBSER-REG HRS. NO SERVS	$15.00	$11.00
D9440	OFFICE VISIT-AFTER REGULAR HOURS	$35.00	$12.00
D9940	OCCLUSAL GUARD, BY REPORT	$130	$0.00
D9951	OCCLUSION ADJUSTMENT-LIMITED	$25.00	$21.00
D9952	OCCLUSION ADJUSTMENT-COMPLETE	$90.00	$171.00

PRINCIPAL EXCLUSIONS AND LIMITATIONS

Covered Expenses Will Not Include and No Benefits Will Be Payable:

1. in the first twelve months that a person is insured if the person is a Late Entrant; except for exams, cleanings and fluoride application. The benefits are limited to procedures numbered 0120, 0130, 0140, 0150, 1110, 1120, 1201and 1203.
2. for any treatment which is for cosmetic purposes, or to correct congenital malformations, other than medically necessary treatment of congenital cleft in the lip or palate, or both.
3. to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under this section, it will be a Covered Expense.
4. for initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Insured is covered under this section. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
5. for any procedure begun before the Insured was covered under this section.
6. for any procedure begun after the Insured's insurance under this section terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this section terminates.
7. to replace lost or stolen appliances.
8. for appliances, restorations, or procedures to:
   a. alter vertical dimension;
   b. restore or maintain occlusion;
   c. splint or replace tooth structure lost as a result of abrasion or attrition; or
   d. treat disturbances of the temporomandibular joint.
9. for any procedure which is not shown on the List of Dental Procedures.
10. for education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
11. for the completion of claim forms.
12. for sealants which are:
    a. not applied to a permanent molar.
    b. applied after attaining age 17.
    c. applied to a molar more than once.
13. subgingival curettage or root planing (procedure numbers 4220, 4340 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
14. because of an injury arising out of, or in the course of, work for wage or profit.
15. by an Insured because of a sickness, injury or condition for which he or she is eligible for benefits under any Worker's Compensation act or similar laws.
16. for charges for which the Insured is not liable or which would not have been made had no insurance been in force.
17. for services which are not recommended by a dentist or which are not required for necessary care and treatment.
18. because of war or any act of war, declared or not.
19. to an Insured if payment is not legal where the Insured is living when expenses are incurred.
20. Any services related to: equilibration; bite registration or bite analysis.
21. Crowns for the purpose of periodontal splinting.
22. Charges for: any implants; precision or semi-precision attachments, and any endodontic treatment associated with it; other customized attachments.
23. for endodontic treatment of the same tooth within a three (3) year period.
24. for root canal retreatment when it has not been demonstrated that unusual morphological or pathological conditions exist and when performed by a non-endodontic specialist.
25. for more than one filling for each tooth surface in a 24 month period.
26. for non-surgical periodontal treatment more than once in a two (2) year period.
27. for surgical periodontal treatment more than once in a three (3) year period.
28. for crown build-ups when less than three (3) of the five (5) tooth surfaces are destroyed.
29. for crown build-ups (pin, bonded, or post and core) more than once in a five (5) year period.

TDA-COMPANION



❖ **THE TDA-COMPANION PLAN**
This option ***allows you to go to any dentist***. Preventative services, simple extractions, and basic fillings are covered at 100% after a one-time lifetime deductible is met!

Low Monthly rates:	**Single**	**$36.53**
	Two Party	**$75.64**
	Family	**$122.99**

Sample Illustration of Savings

TDA-Companion versus No Dental Insurance

Procedure (quantity)	TDA-Companion Copayment*	No Dental Insurance	Savings	Savings %
Exam & X-ray (2 per person)	$0.00	$872.00	$872.00	100%
Cleaning (2 per person)	$0.00	$508.00	$508.00	100%
Resin 2 Surface Filling (3)	$52.80	$360.00	$307.20	85%
Crown, Porcelain with Metal (2)	$498.00	$1,388.00	$890.00	64%
Office Visit Charge (16)	$0.00	$912.00	$912.00	100%
Premium for 12 Months (Family)	$1,425.93	$0.00	-$1,425.93	-100%
Total	**$1,976.76**	**$4,040.00**	**$2,063.24**	**51%****

Sample based on typical family of 5
*At a participating provider
*****Percentage of savings represents this illustration only. Actual savings may vary per individual treatment plan.***

TDA-COMPANION

BENEFITS

Welcome to the **TDA-PPO Dental Plan** underwritten by Companion Life Insurance Company. The **TDA-PPO Dental** Plan offers you the option of receiving your dental care from any dentist you choose (Out-of-Network) or from a Participating Plan Dentist (In-Network); and you don't need to make that decision until you need dental care! However, should you elect to receive your dental care from an In-Network dentist your out of pocket costs will be less.

The following is a brief outline of your dental coverage. For additional information please refer to the employee booklet/certificate you will receive after enrollment or contact TDA.

		(In-Network)	(Out-of-Network)
Class I – Preventive	-Oral Examinations (two every twelve months) -Cleanings (two every twelve months) -X-Rays (bite-wings two every twelve months) -Palliative Emergency Treatment	100%	*100%
Class II – Basic Dentistry	-Restorations (fillings) -Simple Extractions	80%	*80%
Class III – Major Dentistry	-Endodontics (root canal therapy) -Periodontal Services (treatment of gum tissue) -Oral Surgery -Crowns -Dentures -Bridges -Other Prosthetic Services	50%	*50%
Class IV – Orthodontics		50%	*50%
Deductible: $100.00 Lifetime Deductible Per Person			
Maximum Benefit; $1,000 per person per calendar year for Class I, II & III expenses Lifetime Orthodontic Maximum: $1,000 per child under the age of 19.			

Class III Waiting Period: 12 Months
Class IV Waiting Period: 12 Months

*Subject to TDA's Allowable MPR Fees
(Maximum Plan Reimbursement)

Total Dental Administrators, Inc.
969 East Murray Holladay Road, Suite 4E
Salt Lake City, Utah 84117
Toll Free: (800) 880-3536 – Local (801) 268-9740
Fax: (801) 268-9873
Web: www.tdadental.com
Email: customerservice@totaldentaladmin.com

TDA-COMPANION

BENEFITS CONTINUED

Limitations

Covered Expenses Will Not Include and No Benefits Will Be Payable:

1) *For major services in the first 12 months that the Insured is covered, except as may be provided in the Takeover Benefits provision.*
2) For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.
3) To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.
4) For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar, (wisdom tooth) will not qualify the item for payment. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that applies specifically to replacement of teeth extracted prior to the period of coverage.
5) For addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.
6) For any expense incurred or procedure begun before the Insurer's current period of continuous coverage.
7) For any expense incurred or procedure begun after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before the insurance ends and (b) the item's final placement is within 90 days after insurance ends.
8) To duplicate appliances or replace lost or stolen appliances.
9) For appliances restorations or procedures to:
   a) Alter vertical dimensions;
   b) Restore or maintain occlusion
   c) Splint or replace tooth structure lost as a result of abrasion or attrition; or
   d) Treat jaw fractures or disturbances of the temporomadibular joint.
10) For educational training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
11) For broken appointments or the completion of claim forms.
12) For sealants which are:
    a) Not applied to a permanent molar;
    b) Applied before age 6 or after attaining age 16;or
    c) Reapplied to a molar within three years from the date of a previous sealant application. Frustrating
14) **For subgingival curettage or root planing (procedure numbers 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.**
15) Because of an Insured's injury arising out of, or in the course of, work for wage or profit.
16) For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Worker's Compensation act or similar laws.
17) For charges for which the Insured is not liable or which would not have been made had no insurance been in force.
18) For services which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonable prognosis.
19) Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
20) To an Insured if payment is not legal where the Insured is living when expenses are incurred.
21) For any services related to: equilibration, bite registration or bite analysis.
22) For crowns for the purpose of periodontal splinting.
23) For charges for: any implants; overdentures; precision or semi-precision attachments and associated endodontic treatment; other customized attachments; or specialized prosthodontic techniques or characterizations.
24) For charges for myofunctional therapy, orthognathic surgery or athletic mouthguards.
25) For procedures for which benefits are payable under the employer's medical expense benefits plan for employees and their dependents.

Predetermination of Benefits: As a service to protect the insured, Companion Life will provide predetermination of benefits for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps insured better understand their coverage. The insured should submit the treatment

Monthly Premium:

Employee only	$36.53
Employee plus one	$75.64
Employee plus two or more	$122.99

Administered and Marketed by:
Total Dental Administrators, Inc.
969 East Murray Holladay Rd., Suite 4E
Salt Lake City, Utah 84117
(801) 268-9740 – (800) 880-3536 – Fax (801) 268-9873

Underwritten by:
Companion Life Insurance Company
P. O. Box 10012
Columbia, SC 29202-3102
(800) 753-0404 – Fax (803) 735-0736
Rated Excellent by A.M. Best