Benefits Enrollment Guide

ELI | KIRK

Effective October 1, 2008

Eli Kirk 2008 Employee Benefits

Introduction

The benefits provided by Eli Kirk are an important part of your compensation package. They provide for ongoing medical and dental care, tax deferred savings and an important financial safety net in case you can no longer provide an income for yourself and/or your family. Please be advised, the purpose of this guide is to provide an overview of your benefit programs. If there is any discrepancy between the insurance carrier's certificate of coverage and this guide, the insurance carrier's certificate of coverage is the prevailing document.

Eligibility

Coverage begins for enrolled eligible employees the first of the month following 30 days of employment.

To obtain benefits you must satisfy the following:

- Be a full-time employee working 30 hours or more per week
- You may enroll your spouse and dependent children to age 26 on the medical and dental plans
- Dependents are eligible if less than 26 years of age, never married, and currently qualify as dependents under IRS guidelines

Open Enrollment

The plan year for medical, dental and Flexible Spending Account begin October 1st, 2008.

During open enrollment you may enroll in or make changes to the health insurance program. Open enrollment is the only time that you may add or change benefits during the year unless you have a life event. Make sure that you understand the offerings and enroll yourself and your dependents in the programs that you would like for the upcoming plan year.

Life Events

The following events allow you to change your benefits outside the open enrollment period:

- You get married, divorced or legally separated
- You add a dependent child through birth, adoption or change in custody
- Your spouse or a dependent dies
- Your spouse or dependent(s) loses eligibility for coverage
- Your spouse loses or qualifies for coverage through his/her employer

When you experience a qualifying event, you have 30 days to complete and submit an appropriate change form to secure your new benefits.

For additional support and service contact your FirstWest Benefit Solutions Service Team:

Kym Wilson, CSR
kym.wilson@fwbs.com
801-224-9600 x118

FirstWest Benefit Solutions
1139 So. Orem Blvd.
Orem, UT 84058

Client Service Call Center Support Team
801-224-9600
Monday - Friday
8:30 am - 5:00 pm

FirstWest BENEFIT SOLUTIONS
www.fwbs.com

Eli Kirk Medical Benefits

Select Value

Select Value does not require the selection of a primary care physician. You must use in-network providers. There is no out-of-

Employee Cost Per Month
See Attached Rate Sheet Employer Pays 50% of Monthly Cost

SelectHealth - Select Value

		Participating In-Network
Preventive Care Office Visits		
Adult & Pediatric Immunizations		Covered 100%
Elective Immunizations		20%
Office Visits & Office Surgeries		
Primary Care Provider (PCP)		$15
Secondary Care Provider (SCP)		$25
Preventive Care		See Office Visits
Intermountain InstaCare Facility / Urgent Care		$25
Intermountain KidsCare Facility		$15
Deductible	Calendar Year	$500 / $1,000
Out-of-Pocket Maximum		$3,000 / $6,000 Includes Deductible
Lifetime Maximum		$2,500,000
Prescriptions	30 Day Supply	$10 / 25% / 50%
Prescriptions Mail Order	90 Day Supply	$10 / 25% / 50%
Pre-Existing Condition Limitation**		12 Months
Diagnostic Tests	Minor	Covered 100%
	Major	20% AD
Inpatient Hospital		20% AD
Surgery Inpatient		20% AD
Surgery Outpatient		20% AD
Maternity		20% AD
Durable Medical Equipment		20% AD
Emergency Room		$100 AD
Mental Health Inpatient	10 Days Per Year	50% AD
Mental Health Outpatient	25 Visits Per Year	50% AD

AD = After Deductible

*You pay the difference between billed and allowed charges.

**Certificate of Creditable Coverage is required to eliminate or reduce the pre-existing condition waiting period, if any. There is never a pre-existing condition waiting period for maternity benefits.

Medical Insurance
SelectHealth
800-538-5038
www.selecthealth.org

Eli Kirk Medical Benefits

Select Med Plus

Select Med Plus does not require the selection of a primary care physician. **An out-of-network benefit is available, however, benefits are enhanced if you use in-network pro-**

Employee Cost Per Month
See Attached Rate Sheet
Employer Pays 50% of Monthly Cost

SelectHealth - Select Med Plus

		Participating In-Network	Non-Participating* Out-of-Network
Preventive Care Office Visits			
Adult & Pediatric Immunizations		Covered at 100%	Not Covered
Elective Immunizations		20%	Not Covered
Office Visits			
Primary Care Provider (PCP)		$15	40% AD
Secondary Care Provider (SCP)		$25	40% AD
Preventive Care		See Office Visits	Not Covered
Intermountain InstaCare / Urgent Care		$25	40% AD
Intermountain KidsCare Facility		$15	Not Available
Deductible	Calendar Year	$500 / $1,000	$750 / $1,500
Out-of-Pocket Maximum		$3,000 / $6,000 Includes Deductible	$4,000 / $8,000 Includes Deductible
Lifetime Maximum		$2,500,000	$1,000,000
Prescriptions	30 Day Supply	$10 / 25% / 50%	
Prescriptions Mail Order	90 Day Supply	$10 / 25% / 50%	
Pre-Existing Condition Limitation***		12 Months	
Chiropractic	15 Visits Per Year	Not Covered	50% AD
Diagnostic Tests	Minor	Covered 100%	40% AD
	Major	20% AD	40% AD**
Inpatient Hospital		20% AD	40% AD**
Surgery Inpatient		20% AD	40% AD**
Surgery Outpatient		20% AD	40% AD**
Maternity		20% AD	40% AD**
Durable Medical Equipment		20% AD	40% AD**
Emergency Room		$100 AD	$200 AD
Mental Health Inpatient	10 Days Per Year	50% AD	50% AD**
Mental Health Outpatient	25 Visits Per Year	50% AD	50% AD

AD = After Deductible

*You pay the difference between billed and allowed charges.

**Pre-Certification is required for certain services. Refer to plan summary for details.

***Certificate of Creditable Coverage is required to eliminate or reduce the pre-existing condition waiting period, if any. There is never a pre-existing condition waiting period for maternity benefits.

Medical Insurance
SelectHealth
800-538-5038
www.selecthealth.org

Eli Kirk Dental Benefits

TDA - Companion Plan Employee Cost Per Pay Period	
Employee	$21.55
EE + 1	$39.06
EE + Family	$66.96

Total Dental Administrators - Companion Plan

		In-Network	Out-of-Network
Class I - Preventive	Plan Pays Oral Exams, Cleanings, X-Rays, Palliative Emergency Treatment	100%	100%
Deductible	Per Person	$100 (Lifetime Deductible)	
Class II - Basic Services	Plan Pays Restorations (Fillings), Extractions	80%	80%
Class III - Major Services	Plan Pays Crowns, Dentures, Endodontics, Periodontal Services, Bridges, Other Prosthetic Services, Oral Surgery	50%	50%
Annual Maximum	Per Person / Per Year	$1,000	
Class IV - Orthodontia	Children Under Age 19	50%	50%
Orthodontia Lifetime Maximum		$1,000	

12 Month waiting period for Major Services and Orthodontia (applies to new hires only). Applies to enrollees who do not have 12 months prior coverage.

TDA - Total Care TC-6000 Employee Cost Per Pay Period	
Employee	$8.02
EE + 1	$16.03
EE + Family	$26.49

Total Dental Administrators - Total Care TC-6000

		In-Network
Class I - Preventive Services	Plan Pays	100%* (After $10 Co-Pay)
Deductible		None
Class II - Basic Services	Plan Pays	Approx. 80%*
Class III - Major Services	Plan Pays	Approx. 55%*
Annual Maximum		None
Class IV - Orthodontia		25% Discount
Orthodontia Lifetime Maximum		None
Endodontics / Periodontics		Based Upon Fee Schedule*

*Please see enclosed Total Care TC-6000 Fee Schedule for benefit details.

Dental Insurance
Total Dental Administrators
800-880-3536
www.totaldentaladmin.com

Eli Kirk Flexible Spending Account

We invite you to participate in an Employee Benefit that may increase your spendable income and lower your taxes. A Flexible Spending Account allows you to pay for your portion of group benefits, un-reimbursed medical expenses and dependent/child care with **pre-taxed dollars**. With Flexible Spending, your expenses are deducted from your paycheck before state, federal, and social security taxes. By paying these expenses with pre-taxed dollars, you will reduce your taxable income **and take home a larger portion of your paycheck!**

Three Components of the Flexible Spending Account:

1. Group Benefit Premiums– Your portion of medical and dental premiums will be deducted from your paycheck on a pre-taxed basis.
2. Medical Expense Reimbursement– Each year, you may set aside up to $1,500 pre-taxed dollars to pay for qualifying out-of-pocket medical, dental, vision, prescription drug, and other expenses, including deductibles, coinsurance payments and copayments for yourself and your dependents.
3. Dependent Care Reimbursement– Each year, you may set aside up to $5,000 pre-taxed dollars (or $2,500 if you are married and filing individually) to pay for eligible dependent care expenses. This includes child care, elder care, or other eligible dependent care.

Facts You Should Know:

- Participation is voluntary
- Participation in the plan simply allows you to pay for qualified expenses with pre-taxed dollars
- Your future W-2 (tax withholding) statements reflect your net taxable income (gross income minus your pre-taxed payments). Because you will be paying less in social security taxes, participation in the Flexible Spending Account may slightly reduce your future social security benefits

Flexible Spending Account
National Benefit Services
800-274-0503
www.nbsbenefits.com

Example of Savings Using A Flexible Spending Account

	Without Flexible Spending	With Flexible Spending
Gross Income	$20,000	$20,000
Pre-Taxed Expenses for Health/Dependent Care	$0	$2,500
Taxable Income	$20,000	$17,500
Less Taxes, FICA	$4,600	$3,850
After-Tax Expenses for Health	$2,500	$0
Spendable Income	$12,900	$13,650
Your Savings With Flexible Spending	$0	$750

Plan year begins October 1st each year and ends the following September 30th.

IMPORTANT HIPAA NOTICE

Notice of Special Enrollment Rights and Pre-Existing Condition Limitations
Required Under the Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) offers protection for millions of American workers that improve portability and continuity of health insurance coverage by limiting exclusions for pre-existing medical conditions, providing the possibility for credit against some or all of the pre-existing condition waiting period that might be imposed by a health plan, and providing special enrollment rights when other coverage is lost or when an employee gets married or adds a dependent.

Pre-existing Condition Exclusions

- A pre-existing condition (PEC) is one for which medical advice, diagnosis, care, or treatment is recommended or received in the 6-month period prior to an individual's enrollment date; the enrollment date is the first day of coverage or the first day of the waiting period for coverage. PEC exclusions cannot apply to pregnancy or to a newborn or a child adopted or placed for adoption if the child is enrolled within 30 days of the event, and the child has no subsequent break in coverage exceeding 63 days. PEC exclusions may not be applied to genetic conditions without a diagnosis.
- Group health plans and health insurance issuers may limit or exclude coverage for an individual's pre-existing medical conditions for up to 12 months (18 months for late enrollees) beginning on an individual's enrollment date, which is first day of coverage or the first day of the eligibility waiting period for coverage (new hire waiting period).
- A late enrollee is a person who enrolls for coverage at any time other than during the initial eligibility period or during a special enrollment period; the PEC waiting period for a late enrollee begins on the same date coverage begins. The PEC waiting period for late enrollees does not include any portion of any eligibility waiting period imposed for late enrollees.
- Under HIPAA, a health plan must give individuals credit for the length of time they had prior continuous health coverage, and the credit must be applied to offset some or all of the PEC waiting period under the plan.

Creditable Coverage

- Continuous health coverage, or Creditable Coverage, means all combined time for which the individual was covered under any number of health plans without a break in coverage of 63 days or more.
- Any coverage that existed prior to a 63 day break in coverage is not creditable coverage; however, the eligibility waiting period (frequently called the new hire waiting period) cannot be counted against an employee when calculating the 63 day break in coverage. Therefore, if an employee has less than two months time without coverage at the time the employee is hired, the prior coverage should be creditable, even if the employee is required to wait several months to enroll and carries no coverage during the eligibility waiting period.
- Creditable coverage may accrue under a fully insured or self-insured group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, a public health plan, or certain other health plans.
- If some or all of Creditable Coverage had no benefit for mental health, substance abuse treatment, prescription medications, dental or vision benefits, pre-existing condition waiting periods may be imposed separately for each of these categories of benefits even if PEC credit is issued for other medical benefits.

If you or any of your dependents has Medicare or will become eligible for Medicare in the next 12 months, your employer requires you to notify human resources. Your employer may then provide you with information about the type of prescription drug benefits offered under the group health plan, which will help you determine whether to enroll for Medicare Part D.

Certificates of Creditable Coverage

- A Certificate of Creditable Coverage contains information about the length of time that individuals were covered under a health plan, and indicates the length of time of any waiting period for coverage that applies to the individuals.
- HIPAA requires health plans to provide certificates of creditable coverage automatically and free of charge to individuals who lose coverage, become eligible for COBRA, or lose COBRA coverage. Certificates should also be made available upon written request any time during coverage and for up to 24 months after coverage is terminated.
- Individuals are responsible to provide Certificates of Creditable Coverage to new health plans for determination of their rights to credit toward any PEC waiting period.
- Your health plan or health insurance issuer will assist in obtaining a Certificate from any prior plan or issuer, if necessary.

Special Enrollment Rights

- Individuals who lose eligibility for health coverage in certain situations, including separation from spouse, divorce, death, termination of employment and reduction in work hours, may be granted special rights to enroll for group coverage in the middle of a plan year; however, special enrollment rights only exist if the individual had other health coverage at the time that the group health plan was previously declined. If the other previous coverage was COBRA continuation coverage, special enrollment can only be requested after the COBRA continuation coverage is exhausted.
- Special Enrollment rights also apply if employer contributions toward a health plan are terminated; this is most generally applicable when a spouse's employer ceases to contribute toward the spouse's health plan.
- An employee, spouse, and/or new dependents are granted special enrollment rights upon marriage, birth, adoption or placement for adoption.
- Special enrollment rights are forfeited unless application for enrollment occurs within 30 days of the special event. A newborn, adopted child or child placed for adoption cannot be subject to a pre-existing condition exclusion period if the child is enrolled within 30 days of birth, adoption or placement for adoption and has no subsequent significant break in coverage.
- Special enrollment due to birth, adoption or placement for adoption allows coverage to begin on the date of the event. Special enrollment due to marriage, loss of eligibility for other coverage, or loss of employer contribution toward other coverage should begin no later than the first day of the month following the date a completed request for enrollment is received by the plan.
- Special enrollees are not treated as late enrollees; the maximum PEC waiting period for special enrollees is 12 months.

Appeals for Creditable Coverage

- Health plans that impose PEC exclusions must make timely determinations of the validity of requests for Creditable Coverage, and if any individual is to be subject to any PEC waiting period, the health plan must notify the individual. The notice must disclose the length of the residual PEC exclusion period which remains after the Creditable Coverage is applied, if any. If the health plan does not accept the validity of a request for Creditable Coverage, the notice must explain the basis of the determination, including the source and substance of any information on which the plan relied in making the decision, and the plan must notify the individual of any appeal procedure available. The health plan must also allow a reasonable opportunity for the individual to submit additional evidence of Creditable Coverage if any PEC exclusion period remains.

selecthealth.
AN INTERMOUNTAIN HEALTHCARE COMPANY

SelectHealth Small Employer Group Products
AGE BANDED RATES
Printed: 09/03/2008

PLAN SELECTED: Open Panel

ELI KIRK
250 W CENTER ST STE 320 PROVO, UT 846018414

Group#: G1004418 Effective Date: 10/01/2008

Open Panel **$500**
OPTIONAL PLAN BENEFITS:

Note: If Waiver of Deductible is not selected (NO) - The deductible will apply to all services.

CoIns/Copay: 80/20 15/25
Mental Health: 50/50 Coverage
Maternity: Yes
Waiver of Ded: Yes
Dental Coverage: No Coverage
RX Card: $0 DED ($10/25%/50%)
Supplemental Accident: No

Select Value

AGE	SINGLE	2-PARTY	FAMILY
Under 19	$158.14	$348.37	$524.81
20 - 24	$163.68	$358.73	$550.11
25 - 29	$179.89	$380.58	$604.20
30 - 34	$193.74	$400.13	$655.59
35 - 39	$223.30	$419.10	$718.26
40 - 44	$241.97	$451.69	$766.14
45 - 49	$276.76	$505.82	$803.08
50 - 54	$328.01	$615.02	$841.99
55 - 59	$395.37	$732.17	$932.79
60 - 64	$481.77	$910.79	$1,086.54
65+	$642.87	$1,206.04	$1,419.71

Select Care Plus

AGE	SINGLE	2-PARTY	FAMILY
Under 19	$189.09	$416.53	$627.49
20 - 24	$195.71	$428.91	$657.72
25 - 29	$215.09	$455.04	$722.41
30 - 34	$231.63	$478.41	$783.85
35 - 39	$266.99	$501.09	$858.78
40 - 44	$289.31	$540.06	$916.04
45 - 49	$330.91	$604.77	$960.22
50 - 54	$392.19	$735.36	$1,006.74
55 - 59	$472.73	$875.42	$1,115.28
60 - 64	$576.02	$1,088.99	$1,299.13
65+	$768.66	$1,442.01	$1,697.47

Select Med Plus

AGE	SINGLE	2-PARTY	FAMILY
Under 19	$171.90	$378.66	$570.44
20 - 24	$177.91	$389.92	$597.94
25 - 29	$195.53	$413.67	$656.74
30 - 34	$210.58	$434.92	$712.59
35 - 39	$242.72	$455.54	$780.72
40 - 44	$263.01	$490.96	$832.77
45 - 49	$300.83	$549.79	$872.92
50 - 54	$356.53	$668.51	$915.21
55 - 59	$429.75	$795.84	$1,013.90
60 - 64	$523.66	$989.99	$1,181.02
65+	$698.78	$1,310.92	$1,543.15

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Eli Kirk

2008-2009 Benefits Deduction Authorization Form

Full Name _____ Social Security Number_____--_____--_____

1. MEDICAL PLAN OPTIONS*

Employee Cost Per Pay Period (Age Banded Rates - See Attached)

		Single	Two-Party	Family	Cost Per Pay Period
[ ] A. SelectHealth	Value	[ ]	[ ]	[ ]	
	SelectMed Plus	[ ]	[ ]	[ ]	
	SelectCare Plus	[ ]	[ ]	[ ]	

(24 Per Year)

[ ] B. Waive Coverage

[ ] Single [ ] Two-Party [ ] Family

*Employees electing medical coverage must also complete an additional medical enrollment form

2. DENTAL PLAN OPTIONS*

Employee Cost Per Pay Period

	Employee	Employee+1	Employee+Family	Cost Per Pay Period
[ ] A. TDA - Companion Plan	[ ] $21.55	[ ] $39.06	[ ] $66.96	

	Employee	Employee+1	Employee+Family
[ ] B. TDA - TC-6000	[ ] $8.02	[ ] $16.03	[ ] $26.49

[ ] C. Waive Coverage

[ ] Employee [ ] Employee+1 [ ] Employee+2 [ ] Employee+Family

*Employees electing dental coverage must also complete an additional dental enrollment form

3. TAX ADVANTAGED ACCOUNTS*

Per pay period

[ ] A. Health Flexible Spending Account for employees $ _____ **Cost Per Pay Period**
(Maximum contribution is $1,500 per plan year)

[ ] B. Dependent Day Care Account $ _____
(Maximum contribution is $5,000 per plan year)

*Employees electing 4A, or 4B must also complete additional enrollment forms

4. TOTAL PER PAY PERIOD EMPLOYEE DEDUCTIONS FOR BENEFITS (Lines 1-3)

EMPLOYEE AGREEMENT

I understand that the medical and dental benefits are part of the Section 125 premium conversion plan, and that elections for health flexible spending accounts and dependent day care funds are also part of the Section 125 plan; these elections will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g. marriage, divorce, death of a spouse or a child, birth or adoption or termination of spouse's employment). I understand that I must notify Human Resources of any change of status within 30 days of the event. I hereby agree to have the amounts indicated deducted from my payroll on a monthly basis. I further authorize my employer to change my deduction amounts if my premiums change mid-year due to age or enrollment status.

Employee's Signature _____ Date _____

First West Benefit Solutions

TOTAL CARE

A Division of Total Dental Administrators of Utah, Inc. (TDAUT, Inc.) domiciled in Utah

GROUP DENTAL PLAN
TC-6000

A Comprehensive DHMO Program with Specialty Care Coverage

TDA
Total Dental Administrators, Inc.

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

Retain this for your Enrollment and Employee Plan Booklet

Welcome to Total Care

Total Care is a comprehensive "Managed Care" Group Dental Program marketed, managed and administered by Total Dental Administrators of Utah, Inc. (TDAUT) domiciled in Utah and its parent company Total Dental Administrators, Inc. TDAUT "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

We have enclosed a premium rate form that applies to your specific group. Please contact your Employer or our Administrative Office should you have any questions.

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
TDAUT, Inc.
969 East Murray Holladay Road Suite 4E
Salt Lake City, UT 84117

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
II. SCHEDULE OF BENEFITS AND COPAYMENTS

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.)		
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.)		
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		
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.)		
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. SPECIALITY CARE SERVICES NOT LISTED ARE DISCOUNTED BY THE RATE FILED WITH TDAUT INC**

*** **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. Eligible dental care services from a specialist are those services specifically listed under the specialist category of the Schedule of Benefits and Co-payments.

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 health care 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.
35. Initial oral exam or Comprehensive periodontal evaluation are limited to once every twelve (12) months.

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.

TOTAL DENTAL ADMINISTRATORS, INC.

PROVIDER DIRECTORY

PLAN TC-1000, TC-3000, TC-4000, & TC-6000

Total Dental Administrators, Inc. (TDA)
969 East Murray Holladay Road #4E
Salt Lake City, UT 84117
(801) 268-9740 or 1-800-880-3536
www.totaldentaladmin.com

UTAH DIRECTORY OF TOTAL DENTAL ADMINISTRATORS MEMBER DENTISTS

This Directory lists the many quality dentists that are contracted with Total Dental Administrators (TDA) to provide dental care services for Total Dental Administrators Plan Members. You can use this convenient directory to choose a dentist and to get an idea of the scope of Total Dental's extensive member dentist network.

Choosing Your Dentist: When you join Total Dental Administrators, your first step will be to choose a Total Dental Administrators Dentist (TDAD). Your TDAD personal dentist will provide or coordinate all of your dental care. If you don't know which dentist to choose as your TDAD, start by looking through the dental offices listed in this booklet, find one that has a location convenient for you. If you need additional information or help selecting a TDAD, our member services representatives are always happy to help. The phone numbers are 801-268-9740 or toll free 1-800-880-3536.

Decide which dental office you prefer, then write the corresponding code (appears left of the dental office) in the appropriate box on your enrollment form. Any time you need dental care, (except out-of-area emergency care) be sure to call your TDAD first. Each dental office is independently owned and operated.

This directory is current as of September 14, 2005. Please remember dentist and dental office status may change occasionally, please call to verify dentists participation. If you have any questions or would like information regarding a dentist's background, education, and experience, please call TDA Member Services.

ALPINE			
40490	Randall Stucki, DDS	58 East 100 South	(801) 492-7778
AMERICAN FORK			
40526	Blaine Bateman, DDS	218 N. Center St.	(801) 756-9310
40450	Curtis Cutler, DDS	183 S. 500 E.	(801) 763-9080
40302	Neal Evans, DDS	290 N. 300 East	(801) 756-2346
40303	Joseph D. Liddle, DDS	120 N. Center St.	(801) 756-3377
40359	L.Craig Rosvall, DDS	218 N. Center St	(801) 756-6581
40450	Willow Creek Dental	183 S. 500 E.	(801) 763-9080
FARMINGTON			
40529	Scott W. Corry, DDS	88 East State St.	(801) 451-2341
40529	David R. King, DMD	88 East State St.	(801) 451-2341
40529	B. Berrett Packer, DDS	88 East State St.	(801) 451-2341
40529	C. Craig Packer, DDS	88 East State St.	(801) 451-2341
HARRISVILLE			
40515	Michael A. Russell, DDS	2240 N. Highway 89	(801) 782-4745
HERRIMAN			
40500	Aspen Family Dental	5734 W. 13400 S.	(801) 302-0222
40500	Jeffrey T. Lambert, DDS	5734 W. 13400 S.	(801) 302-0222
HIGHLAND			
40522	James Alcorn, DMD	5455 W. 11000 N.	(801) 492-0055
LEHI			
40369	Jerry V. Brown, DDS	588 East Main Street	(801) 768-8028
40524	Cliff Doman, DMD	3300 N. Running Ck	(801) 768-0404
40498	D. Terry Ferrell, DDS	325 East 100 North	(801) 766-3700
LOGAN			
40417	Logan Dental Associates	40 W Cache Vlly Blvd #2A	(435) 787-8207
40417	Darren Davis, DDS	40 W Cache Vlly Blvd #2A	(435) 787-8207
40417	Paul Harris, DDS	40 W Cache Vlly Blvd #2A	(435) 787-8207
40417	Anthony Larson, DDS	40 W Cache Vlly Blvd #2A	(435) 787-8207
MAGNA			
40457	Oquirrh Dental	8031 W. 3500 S.	(801) 250-0668
40457	Michael Haynie, DDS	8031 W. 3500 S.	(801) 250-0668
MIDVALE			
40309	Gerald Berg, DDS	7001 S. 900 E, #450	(801) 561-0061
MURRAY			
40459	Professional Smile Cntr	575 E 4500 S #B-250	(801) 266-5455
40459	Larry Broadbent, DMD	575 E 4500 S #B-250	(801) 266-5455
40530	Hanhngan Nguyen-Tran	445 E. 4500 S. #150	(801) 671-8714
NORTH OGDEN			
40311	Northview Dental Assoc.	2201 North 400 East	(801) 782-6681
40311	Scott Craven, DDS	2201 North 400 East	(801) 782-6681
40311	Kent Linsley, DDS	2201 North 400 East	(801) 782-6681
40311	Paul Mackley, DDS	2201 North 400 East	(801) 782-6681
40311	Mark Mackley, DDS	2201 North 400 East	(801) 782-6681
40311	Michael Matheson, DDS	2201 North 400 East	(801) 782-6681
40311	Brandi L. Oberg, DDS	2201 North 400 East	(801) 782-6681
OGDEN			
40364	Paul L Child, DDS, FAGD	3785 Harrison Blvd	(801) 621-2116
40312	Byron Talbot, DDS	5640 S Wasatch #B	(801) 479-4830
40431	E. Judd West Jr., DDS	3860 Jackson # 6	(801) 627-0420
OREM			
40519	Family Legacy Dental	845 N. 100 W. #100	(801) 227-5080
40519	MV Sheffield Lloyd, DDS	845 N. 100 W. #100	(801) 227-5080
40513	Jeffrey Morrison, DDS	344 W. 920 N.	(801) 225-2640
40412	Mall Dental Group	I-163 University Mall	(801) 426-6255
40412	Kenneth A. Molen, DDS	I-163 University Mall	(801) 426-6255
40528	Steven Sachs, DDS	1442 E. 820 N.	(801) 225-4701
40519	Andrew Smith, DMD	845 N. 100 W. #100	(801) 227-5080
40493	Jeremy White, DDS	594 E. 800 S. #G	(801) 765-1443
PAYSON			
40514	Doug Ball, DDS	78 East 100 South	(801) 465-0550
40408	Stephen Eldredge, DDS	107 S. 500 W.	(801) 465-3111
40514	Professional Dental	78 East 100 South	(801) 465-0550
40514	Richard Leishman, DDS	78 East 100 South	(801) 465-0550
40487	Mark B. Warren, DDS	11 N. 400 W.	(801) 465-1390
40509	John P. Weber, DDS	41 N. 400 W.	(801) 465-4277
PLEASANT GROVE			
40525	Doug Ball, DDS	465 E. 1000 S.	(801) 785-6000
40525	Peter DeBuck, DMD	465 E. 1000 S.	(801) 785-6000
40386	David G. Erekson, DDS	198 South Main	(801) 785-9847
40525	Richard Leishman, DDS	465 E. 1000 S.	(801) 785-6000
40525	Professional Dental	465 E. 1000 S.	(801) 785-6000
40318	LaRell C. Van Dyke, DDS	610 South Loader	(801) 785-7024
PROVO			
40492	Robert L. Hamblin, DDS	3200 N. Canyon Rd #F	(801) 377-7200
40468	Nathan F Hanson, DDS	3685 N. 100 E., Ste B	(801) 356-1211
40516	Jay D. Scott, DDS	3330 N. University Av	(801) 375-1965
40383	John P. Weber, DDS	777 N 500 W #202	(801) 356-8420
40321	Gaydon Winger, DDS	1275 N. Univ Ave.	(801) 375-2273

RIVERTON

40473	Joel L. Howarth	2845 W 12600 S	(801) 561-1559
40399	B. Charles Pugh, DDS	12694 S. 1700 W.	(801) 254-1278

SALT LAKE CITY

40530	All Smiles Dentistry	445 E. 4500 S, #150	(801) 671-8714
40459	Larry Broadbent, DMD	575 E 4500 S #B-250	(801) 266-5455
40471	Cadenza Family Dental	1345 E 3900 S #204	(801) 272-2949
40352	C. Ray Coleman, DDS	3165 W 4700 S	(801) 966-9956
40452	Courtland Cottrell, DDS	3920 S 1100 E # 270	(801) 266-5005
40456	Kent Dastrup, DDS	1953 W California Av	(801) 886-9341
40508	Benjamin Griffiths, DDS	3970 S. 700 E. #17	(801) 288-1888
40325	Aaron S. Goldberg, DDS	1050 E. 3300 S.	(801) 487-2206
40472	Darin Hartvigsen, DDS	1011 N Catherine St	(801) 596-3000
40456	Michael Haynie, DDS	1953 W California Av	(801) 886-9341
40465	Holladay Dental	1949 E. 5600 S.	(801) 277-8395
40442	Stephen B. Liddle, DDS	7069 Highland Drive	(801) 943-2222
40508	Old Farm Dental Care	3970 S. 700 E. #17	(801) 288-1888
40456	Over the Road Dental	1953 W California Av	(801) 886-9341
40459	Professional Smile Cntr	575 E 4500 S #B-250	(801) 266-5455
40456	Kris Rosander, DDS	1953 W California Av	(801) 886-9341
40466	J. Richard Smart, DDS	2180 E 4500 S #250	(801) 272-8609
40466	Smart Dental Care	2180 E 4500 S #250	(801) 272-8609
40464	Brian W. Smith, DDS	6360 S 3000 E #330	(801) 943-5443
40416	Randall Stucki, DDS, PC	1377 E 3900 S #202	(801) 274-7700
40471	Cindy Sumarauw	1345 E 3900 S #204	(801) 272-2949
40508	Brett Talbot, DMD	3970 S. 700 E. #17	(801) 288-1888
40530	Hanhngan Nguyen-Tran	445 E, 4500 S, #150	(801) 671-8714
40466	Sean R. Ulm, DMD	2180 E 4500 S #250	(801) 272-8609
40465	Ryan M. Workman, DDS	1949 E. 5600 S.	(801) 277-8395

SANDY

40330	Curtis Cutler, DDS	8757 S Highland Dr	(801) 947-0505
40512	Benjamin Gilstrap, DDS	9400 S. 880 E. #104	(801) 571-5081
40330	Willow Creek Dental	8757 S. Highland Dr	(801) 947-0505
40463	South Towne Dental	10450 S State#1210	(801) 576-7500
40463	Steve Kim, DDS	10450 S State#1210	(801) 576-7500
40504	Hal Bawden, DDS	10011 S. Centennial Pkw	(801) 256-0808

SOUTH JORDAN

40479	Willden Family Dental	10334 S. Redwood	(801) 446-4668

SPANISH FORK

40373	Kent B. Hansen, DDS	290 W. Center St.	(801) 798-7464
40376	Brent D. Hansen, DDS	290 W. Center St.	(801) 798-7464

SYRACUSE

40527	Jeff Hansen, DDS	1747 S. Heritage Lane	(801) 525-1725

TAYLORSVILLE

40352	C. Ray Coleman, DDS	3165 W 4700 S	(801) 966-9956

WEST JORDAN

40483	James Barclay, DDS	9217 S. Redwood #B	(801) 566-1873
40443	Richard Christensen, DDS	9225 S. Redwood #A	(801) 256-9911
40483	South Valley Dental	9217 S Redwood #B	(801) 566-1873
40448	Kib Stutznegger, DDS	1847 W 9000 S #103	(801) 255-7243
40503	Spencer Thurgood, DDS	2414 W. 7800 S.	(801) 566-0631

WEST VALLEY CITY

40521	Christopher DeMille, DMD	3550 S. 4800 W. #J	(801) 969-3025
40430	Kieu Le, DDS	1819 W 3500 S #1A	(801) 887-7264
40375	Kent B. Hansen, DDS	3280 W. 3500 S.	(801) 967-7089
40378	Brent D. Hansen, DDS	3280 W. 3500 S. #3	(801) 967-7089
40460	Lyndon C. MacKay, DDS	3550 S. 4800 W. #J	(801) 969-3025

TOTAL CARE MEMBER SPECIALISTS

ENDODONTISTS

OGDEN

Val Cox, DDS, MSD	3590 Harrison Blvd	(801) 393-9616

PARK CITY

Robert Flath, DDS	1830 Prospector Ave	(801) 649-6066

PROVO

John M Coats, DDS	3355 Univ Ave #100	(801) 356-3636
Robert Flath, DDS	3355 Univ Ave #100	(801) 356-3636
Randy Madsen, DDS	3355 Univ Ave #100	(801) 356-3636
Richard Pulsipher, DDS	3355 Univ Ave #100	(801) 356-3636

SALT LAKE CITY

John M. Coats, DDS	7138 Highland #109	(801) 942-8686
Robert K. Flath, DDS	7138 Highland #109	(801) 942-8686
Richard Pulsipher, DDS	7138 Highland #109	(801) 942-8686
Randy Madsen, DDS	7138 Highland #109	(801) 942-8686
Keith Sonntag, DDS	2180 E. 4500 S.	(801) 274-6900
Roger K. Warren, DDS	4252 S Highland Dr	(801) 278-3636
Randy Madsen, DDS	6095 S. Fashion Bl.	(801) 262-7770

TOOELE

John M. Coats, DDS	181 W. Vine St. #B	(435) 882-8800
Robert K. Flath, DDS	181 W. Vine St. #B	(435) 882-8800
Randy Madsen, DDS	181 W. Vine St. #B	(435) 882-8800
Richard Pulsipher, DDS	181 W. Vine St. #B	(435) 882-8800

ORAL SURGEONS

AMERICAN FORK

Gary L. Crawford, DDS	912 N. 2000 W.	(801) 756-0766
Niles W. Herrod, DDS	912 N. 2000 W.	(801) 756-0766
William McBee, DDS	912 N. 2000 W.	(801) 756-0766

BRIGHAM CITY

F. Zane Jessen, DDS	102 E. Forest St.	(435) 723-4144
G. Shane Jessen, DDS	102 E. Forest St.	(435) 723-4144

CLINTON

F. Zane Jessen, DDS	1448 N. 2000 W.	(801) 479-8200
G. Shane Jessen, DDS	1448 N. 2000 W.	(801) 479-8200

DRAPER

Robert Flint, DMD, MD	114 E. 12450 S.	(801) 576-5910

LAYTON

Paul Benson, DMD, MD	890 W. Heritage Pk	(801) 614-0999

LOGAN

Gregory A. Anderson, DDS	1395 N. 400 E. #B	(435) 755-5000
F. Zane Jessen, DDS	1230 N. 200 E.	(435) 750-5082
G. Shane Jessen, DDS	1230 N. 200 E.	(435) 750-5082

OGDEN

Blaine D. Austin, DDS	5742 S 1475 E #100	(801) 399-3701
Greg A. Roberts, DDS	5742 S 1475 E #100	(801) 479-9070
F. Zane Jessen, DDS	1508 E. Skyline Dr	(801) 479-8000
G. Shane Jessen, DDS	1508 E. Skyline Dr	(801) 479-8000
William D. Norris, DMD	3590 Harrison #2	(801) 392-7176

OREM

Christopher Burton, DDS	480 W. 800 N.	(801) 224-1200
Dennis Adamson, DDS	480 W. 800 N	(801) 224-1200

PARK CITY

Wade A. Peers, DDS	1612 W Ute Blvd.205	(435) 615-9840

PAYSON

Michael Harris, DDS, MD	1107 S Hwy 189	(801) 356-2226
David Park, DDS, MD	1107 S Hwy 189	(801) 356-2226

PLEASANT GROVE

Gary L. Crawford, DDS	912 N. 2000 W.	(801) 756-0766
Niles W. Herrod, DDS	912 N. 2000 W.	(801) 756-0766
William McBee, DDS	912 N. 2000 W.	(801) 756-0766

PROVO

O. Daniel Bluth, DDS	2230 Univ Prkwy 8A	(801) 370-0050
Gary L. Crawford, DDS	777 N. 500 W. #102	(801) 375-4707
Michael Harris, DDS, MD	3610 Univ Ave#150	(801) 356-2226
Niles W. Herrod, DDS	777 N. 500 W. #102	(801) 375-4707
William McBee, DDS	777 N. 500 W. #102	(801) 375-4707
David Park, DDS, MD	3610 Univ Ave#150	(801) 356-2226

SALT LAKE CITY

Blaine D. Austin, DDS	2180 E 4500 S #285	(801) 277-3942
Robert Flint, DMD, MD	4970 S 900 E, #C	(801) 263-3309

SALT LAKE CITY (CONTINUED)

F. Zane Jessen, DDS	2120 S. 700 E.	(801) 594-0050
G. Shane Jessen, DDS	2120 S. 700 E.	(801) 594-0050
Wade A. Peers, DDS	508 E. S Temple #114B	(801) 530-0027
David J. Smoot, DDS, DMS	6095 S. 300 E #120	(801) 264-8504
SANDY		
David Anderson, DDS, MD	7390 S. Creek Road	(801) 255-2422
F. Zane Jessen, DDS	9730 S. 700 E.	(801) 571-3311
G. Shane Jessen, DDS	9730 S. 700 E.	(801) 571-3311
SOUTH JORDAN		
David J. Smoot, DDS, DMS	2651 S Jordan Prkwy	(801) 264-8504
STANSBURY		
Michael Harris, DDS, MD	220 Millpond #107	(801) 356-2226
David Park, DDS, MD	220 Millpond #107	(801) 356-2226
VERNAL		
F. Zane Jessen, DDS	40 West 100 North	(435) 781-8211
G. Shane Jessen, DDS	40 West 100 North	(435) 781-8211
WEST JORDAN		
Scott Urban, DMD, MD	7611 S. Jordan Landing Bl	(801) 282-5363

ORTHODONTISTS

AMERICAN FORK		
Jeremy R. Watson, DDS	496 N. 900 W. #G	(801) 763-7977
DRAPER		
David V. Young, DDS	12226 S 1000 E #6	(801) 523-9333
FARMINGTON		
David V. Young, DDS	47 South 100 East	(801) 451-2841
KAYSVILLE		
Richard E. Randle, DDS	47 Crestwood Road	(877) 385-5764
MIDVALE		
Richard E. Randle, DDS	918 E. Ft. Union	(877) 385-5764
David V. Young, DDS	30 South Main	(801) 527-3585
MURRAY		
Gary A Carter, DDS MS	6052 S State St. #7	(801) 288-9100
OGDEN		
Richard E. Randle, DDS	3955 S Harrison Blvd	(877) 385-5764
OREM		
Gary A Carter, DDS MS	240 E. 1300 S.	(801) 227-0600
Richard E. Randle, DDS	196 W. Center St	(877) 385-5764
SALT LAKE CITY		
Paul M. Broadwater, DDS	2080 E 4800 S	(801) 278-7272
Eric H. Madsen, DDS, MS	2242 E 7000 S	(801) 943-2700
Richard Randle, DDS	1140 Brickyard Rd	(877) 385-5764
David Young, DDS	445 E 4500 S # 175	(801) 523-9335
SANDY		
Gary A. Carter, DDS, MS	45 W 10000 S, #106	(801) 288-9100
WEST JORDAN		
Richard Randle, DDS	1801 W 7000 S	(877) 385-5764
WEST VALLEY		
Richard Randle, DDS	2940 W. Lancer Wy	(877) 385-5764

ORTHODONTISTS

Provider offers a discount only – contact office for discount

LEHI		
Alan Jensen, DDS	216 East Main St.	(801) 768-2100
MOAB		
Alan Jensen, DDS	570 W. 400 N.	(435) 259-2232
MORGAN		
Karl M. Francis, DDS	200 E. 125 N	(801) 829-3831
OREM		
Wade D. Thompson, DDS	380 W. Center St.	(801) 375-7088
PAYSON		
Karl M. Francis, DDS	50 S. Medical Dr.	(801) 465-2529
Redrock Orthodontics	805 S. 500 W. #4	(801) 465-1118
Adam N. Lee, DDS	805 S. 500 W. #4	(801) 465-1118
SALT LAKE CITY		
Alan Jensen, DDS	1377 E. 3900 S.	(801) 272-9900
SPANISH FORK		
Karl Francis, DDS	367 West Center	(801) 798-8226
Redrock Orthodontics	325 W. Center St.	(801) 798-1118
Adam N. Lee, DDS	325 W. Center St.	(801) 798-1118

PEDODONTISTS

AMERICAN FORK		
Barry Barrus, DDS	483 E. 200 S.	(801) 756-7173
Scott Jensen, DDS	25 North 1100 East	(801) 492-1346
Laurin Rackham, DMD	483 E. 200 S.	(801) 756-7173
Nathan Smith, DDS	148 S. 1100 E.	(801) 756-6048
FARMINGTON		
John R. Anderson, DDS	1401 N. Highway 89	(801) 447-5437
Michael C. Tew, DDS	1401 N. Highway 89	(801) 447-5437
LAYTON		
S. Dale Hibbert, DDS	2112 Hillfield Rd. #1	(801) 774-0770
LEHI		
Jared D. Pearson	588 East Main St.	(801) 766-2111
OREM		
Barry Barrus, DDS	1834 S. State St.	(801) 224-0222
Family Legacy Dental	845 N. 100 West	(801) 227-5080
Bruce Howell, DDS	503 East 770 North	(801) 802-7200
Merien L. Robins, DDS	845 N. 100 West	(801) 227-5080
Laurin Rackham, DMD	1834 S. State St.	(801) 224-0222
PROVIDENCE		
Stanton C. Allen, DDS	169 Spring Ck Pkwy	(435) 787-2223
RIVERTON		
Dave Johnson, DMD, PC	2364 W 12600 S #1A&B	(801) 253-8866
ROY		
John R. Anderson, DDS	3485 W. 4800 S.	(801) 774-5437
Michael C. Tew, DDS	3485 W. 4800 S.	(801) 774-5437
SALT LAKE CITY		
Jeff Burg, DDS	678 E Vine ST Ste12	(801) 268-1135
Jeff Burg, DDS	1580 E. 3900 S.	(801) 272-8555
Ryan Johansen, DDS	6936 S. Promenade	(801) 943-3539
SANDY		
David Powell, DDS	10011 S Centennial	(801) 562-2222
Erik Rooklidge, DDS, PC	10011 S Centennial	(801) 562-2222
SARATOGA SPRINGS		
Barry Barrus, DDS	1376 N. Redwood	(801) 766-2112
Laurin Rackham, DMD	1376 N. Redwood	(801) 766-2112
SOUTH JORDAN		
Little People's Dental	10393 S 1300 W	(801) 446-8007
SOUTH OGDEN		
M. Wade Rallison, DDS	917 E Country Hill Dr #4	(801) 475-6433
SPRINGVILLE		
Darren D. Chamberlain, DDS	1795 W. 500 S. #B-3	(801) 489-1301
WEST JORDAN		
Michael Tew, DDS	3855 W. 7800 S.	(801) 282-1802

PERIODONTISTS

PROVO		
George M. Bailey, DDS	3585 Univ Ave #200	(801) 356-8802
SANDY		
Steven Skanchy, DDS	8938 South State	(801) 572-0333

TDA
Total Dental Administrators, Inc.

Eli Kirk

Welcome to the **TDA-Companion Group Indemnity Dental Plan** underwritten by Companion Life Insurance Company. The **TDA-Companion 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 (once every six months) -X-Rays (bite-wings once every six months) -Pallitave Emergency Treatment	100%	100%
Class II – Basic Dentistry -Restorations (fillings) -Extractions	80%	80%
Class III – Major Dentistry -Crowns -Dentures -Endodontics (root canal therapy) -Periodontal Services (treatment of gum tissue) -Bridges -Other Prosthetic Services -Oral Surgery	50%	50%
Class IV – Orthodontics	50%	50%
Deductible: $100.00 Lifetime Deductible Per Person		
Maximum Benefit; $1,000 per person per calendar year for all Class I, II & III expenses Lifetime Orthodontic Maximum: $1,000 per child under the age of 19 only.		

Class III Waiting Period: 12 Months
Class IV Waiting Period: 12 Months
(Waiting period applies to new hires only.)

*Subject to TDA's Allowable UCR Fee's
(Usual, Customary & Reasonable)

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.totaldentaladmin.com
E-mail: customerservice@totaldentaladmin.com

selecthealth SM
AN INTERMOUNTAIN HEALTHCARE COMPANY

selecthealth SM
BENEFIT ASSURANCE COMPANY

4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 801-442-5038/800-538-5038 **www.selecthealth.org**

Employee Application Small Employer

January 08

For instructions regarding this application, please refer to section J. "Enrollment Instructions" on page 4.

A. EMPLOYEE INFORMATION (PLEASE USE DARK INK AND PRINT LEGIBLY)

Last Name _____ First Name _____ Initial _____ Social Security# _____

Street Address _____ Unit# _____ Status ❑ Single ❑ Legally Married ❑ Separated ❑ Divorced

City _____ State _____ ZIP _____ Home Ph# (____) _____

Work Ph# (____) _____ Company Name _____ *Full-Time Hire Date _____

# of Hours Worked Weekly _____ Job Title _____

*Full-Time Hire Date is the first day physically at work, working 30 hours or more per week consistently. Providing an incorrect hire date could result in coverage being delayed or denied.

CHECK THE APPROPRIATE BOX ❑ New Group ❑ New Hire ❑ Open Enrollment ❑ Dependent Addition ❑ *Special Enrollment Event

Are you adding a dependent because of a court or administrative order? ❑ Yes ❑ No (If yes, please attach a copy of the notice to this form.)

*If you and/or your eligible dependent(s) are enrolling as a result of a special enrollment event, check all that apply:

❑ Birth/Adoption ❑ Marriage ❑ Involuntary Loss of Other Coverage

An Employee Application for a special enrollment event must be submitted within 31 days of the event.

B. PLAN INFORMATION (COMPLETE SECTIONS 1, 2, 3, OR 4 BELOW BASED ON THE PLAN DESIGN SELECTED BY YOUR EMPLOYER)

1 – Open Panel—If your employer has chosen the Open Panel option, select one of the following plan options:

❑ Select Value℠ ❑ Select Med Plus℠ ❑ Select Care Plus℠

2 – HealthSave—If your employer has chosen the HealthSave option, select one of the following plan options:

❑ Select Value HealthSave℠* ❑ Select Med Plus HealthSave℠*

❑ Select Care Plus HealthSave℠* **(see HSA section below)**

3 – Dual Option—If your employer has chosen Dual Option, select one of the following plan options:

❑ HMO/Plus Plan ❑ HealthSave Plan* **(see HSA section below)**

4 – Select Choice℠ Premier—If your employer has chosen Select Choice Premier, you will be enrolled on this plan.

❑ Select Choice Premier (see ** in section J.)

*Health Savings Account (HSA) (HealthSave Plans Only)—If your employer has chosen HealthEquity® (SelectHealth's preferred account vendor), **check one** ❑ Yes, set up my HSA with HealthEquity ❑ No, do not set up an HSA account for me

If you check yes, you must also complete the *HSA Enrollment and Authorization to Disclose Health Information to HealthEquity Form.*

C. EMPLOYEE AND DEPENDENT INFORMATION (LIST YOURSELF AND ELIGIBLE DEPENDENT(S) TO BE COVERED BELOW)

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SEX	BIRTH DATE (MM/DD/YY)	AGE	SOCIAL SECURITY#	OTHER INS.	NAME OF CARRIER
EMPLOYEE		M/F			*	Y/N	
SPOUSE		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	

*REQUIRED FOR HEALTHSAVE PLANS FOR HSA ADMINISTRATION

D. PRIOR COVERAGE INFORMATION

If you have had health insurance coverage within the last 63 days, your Pre-existing Condition Waiting Period limitation may be credited or waived upon receipt of your Certificate of Creditable Coverage from your prior healthcare plan. To determine if this applies to you, **enclose a copy of the Certificate of Creditable Coverage for each member to be covered** and provide the information requested below. Failure to provide this information could result in claims being delayed or denied. (Note: A photocopy of your ID Card from your current/previous carrier is not sufficient.)

Policyholder's Name _____ Name of Carrier _____

Policy# _____ Date Coverage Began _____ Date Coverage Ended _____

Submission of prior coverage information does not automatically waive the Pre-existing Condition Waiting Period limitation. However, failure to provide prior coverage information will result in limited or excluded benefits for a 12-month period (18 months for late enrollees).

E. EMPLOYEE SIGNATURE

Employee Signature _____ Date Signed _____ /_____ /_____

SELECTHEALTH USE ONLY

Effective Date _____ Renewal Date _____ NHWP ❑ 1 ❑ 2 ❑ 3 ❑ Other _____

Group# _____ Sub group# _____ ❑ HSA

PEC waiting period/start date _____

Agent/broker _____ GA _____

F. HEALTH INFORMATION

INSTRUCTIONS: Answer each question considering each individual applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections G. and H. for each "Yes" (Y) answer.

1. Is anyone currently receiving medical treatment..... **Y** **N**

2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other healthcare provider within the past **THREE YEARS**?..... **Y** **N**

3. Is any family member currently pregnant, or do they have reason to suspect they might be pregnant?..... **Y** **N**

4. Are you or your spouse financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption?..... **Y** **N**

5. Do you have any family members who are **not** applying for coverage? If yes, complete **(a)** below..... **Y** **N**

a) List the reason(s) why any family members are **not** applying for coverage, and describe their health status and where they are currently covered.

_____

_____

_____

_____

6. Has anyone ever chewed or smoked tobacco?..... **Y** **N**

7. Has anyone taken any medication, drugs, shots, or remedies in the past **TWELVE MONTHS**? If yes, complete Section H..... **Y** **N**

8. Within the past **FIVE YEARS** has any proposed member:

a) Been advised to be hospitalized, have tests, consultation, evaluation, surgery, or use medication(s) **but has not done so**?..... **Y** **N**

b) Been evaluated for fertility, is infertile, or had a miscarriage or complication(s) of pregnancy?..... **Y** **N**

c) Had gallbladder problems, ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, or other digestive problems?..... **Y** **N**

d) Had urinary problems or urinary incontinence?..... **Y** **N**

e) Had irregular bleeding, abnormal Pap smears/tests, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease, or any disorder of the reproductive system?..... **Y** **N**

f) Had migraines, been unconscious, or had epilepsy, seizures, or convulsions?..... **Y** **N**

g) Received any mental health counseling, psychotherapy, or had a mental or nervous disorder, depression, stress, or anxiety that required consultation or medication?..... **Y** **N**

h) Had cysts, growths (except for warts), breast lumps, augmentation, or reduction?..... **Y** **N**

i) Had a skin disorder that required medical attention?..... **Y** **N**

j) Had a thyroid disorder or a disorder of the lymph nodes or lymph system?..... **Y** **N**

k) Been treated for chest pain, high blood pressure, or high cholesterol?..... **Y** **N**

l) Had any disorder of the eyes, ears, nose, or throat that required treatment?..... **Y** **N**

m) Had any back, neck, spinal problems, or a joint disorder that required medical attention and/or interfered with normal daily activities?..... **Y** **N**

n) Had a problem for which they **have not** sought medical advice or treatment?..... **Y** **N**

9. Within the past **TEN YEARS,** has any proposed member:

a) Been hospitalized or had surgery?..... **Y** **N**

b) Had hepatitis, colitis, a colectomy or ileostomy, rectal disease, spleen problems, jaundice, or other digestive problems?..... **Y** **N**

c) Had gout, arthritis, fibromyalgia, lupus, any connective tissue disease or disorder, or any joint replacement?..... **Y** **N**

d) Been diagnosed with, had treatment or surgery for, or any indication of, but not limited to, ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis?..... **Y** **N**

e) Had any surgery or treatments for obesity, bulimia, anorexia, weight control, stomach stapling, or gastric bypass?..... **Y** **N**

f) Had tuberculosis, asthma, sleep apnea, pleurisy, emphysema, or any disorder of the lungs or respiratory system?..... **Y** **N**

g) Been treated for alcohol use or attended Alcoholics Anonymous® for their own alcohol consumption?..... **Y** **N**

h) Been treated for drug dependency, abuse, or reaction?. **Y** **N**

i) Been a user of any drug not prescribed, such as: opiates, stimulants, depressants, and/or hallucinogens? . **Y** **N**

10. Has any proposed member **EVER** had any indication of, diagnosis of, or treatment for:

a) Any birth defect, developmental or learning disability, physical, neurological, neuromuscular, or mental impairment(s)?..... **Y** **N**

b) Bipolar disorder, manic depression, schizophrenia, chronic organic brain syndrome, or any other organic brain or psychotic disorders?..... **Y** **N**

c) A kidney disorder, liver problems, cirrhosis, or pancreatic problems?..... **Y** **N**

d) Cancer or tumors?..... **Y** **N**

e) Diabetes?..... **Y** **N**

f) Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder?..... **Y** **N**

g) Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV), or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disease or disorder of the immune system?..... **Y** **N**

h) Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problems?..... **Y** **N**

11. Has anyone been unable to work or been unable to perform routine daily functions for more than two weeks (other than for pregnancy)?..... **Y** **N**

12. Does anyone have any conditions, symptoms, or problems not otherwise mentioned in connection with answering the above questions?..... **Y** **N**

13. To your knowledge, has anyone been denied for other health or life insurance or been issued a modified or rated policy?..... **Y** **N**

14. List the applicant's and the applicant's spouse's height and weight below. List weight as it is now and as it was **ONE YEAR AGO**.

a) Applicant's Height _____ ft. _____ in.

Applicant's Weight _____ now; _____ one year ago

b) Spouse's Height _____ ft. _____ in.

Spouse's Weight _____ now; _____ one year ago

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

G. ADDITIONAL INFORMATION (COMPLETE FOR EVERY YES (Y) ANSWER IN SECTION F.)

QUESTION#	FIRST NAME OF INDIVIDUAL	DIAGNOSIS OF ILLNESS INJURY, TREATMENT, TESTING OR MEDICAL TREATMENT	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REMAINING SYMPTOMS OR PROBLEMS	NAME AND PH# OF MEDICAL PROVIDER OR HOSPITAL

H. PRESCRIPTION MEDICATION INFORMATION

FIRST NAME OF INDIVIDUAL	NAME OF MEDICATION	DOSAGE	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REASON FOR MEDICATION	NAME AND PH# OF PRESCRIBING PROVIDER

I. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed eligible dependent(s), if applicable, for coverage with SelectHealth/SelectHealth BAC. In connection with both this Application and any plan coverage that may be obtained, I am acting as agent and/or as natural guardian for my dependent(s). Further, in dealing with SelectHealth/SelectHealth BAC, I appoint my employer to act as agent on behalf of myself and my dependent(s). I understand that coverage is dependent upon the satisfaction of applicable underwriting criteria and is subject to the terms and conditions of my employer's Master Group Contract with SelectHealth/SelectHealth BAC. I also understand no coverage will be in force until each person listed is approved by SelectHealth/SelectHealth BAC, that no benefits will be provided for any service which begins before coverage is effective, and that except as expressly provided in Master Group Contract, benefits will not extend beyond the termination of either my coverage or the Master Group Contract. I represent that all information provided on this Application, including the "Health Information" section, is true and complete. I understand that omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or void any coverage issued.

CONSENT AT ENROLLMENT. I understand that the Master Group Contract may limit the healthcare providers whose services will be covered. I understand that the Master Group Contract limits or excludes certain conditions or services and that pre-existing conditions applicable to myself or others included on this Application may not be covered. I agree that to the extent I do not abide by the terms of the Master Group Contract, healthcare services I obtain may not be covered. If the Master Group Contract provides that contributions be made, I authorize my employer to deduct them from my pay.

I hereby declare that to the best of my knowledge and belief, the information given on this Application, including the health information, is correctly recorded, true, and complete. If I subsequently become aware of information different from that provided on this Application, I agree to provide that additional information promptly to SelectHealth/SelectHealth BAC.

J. ENROLLMENT INSTRUCTIONS AND ADDITIONAL INFORMATION

You must read Section I. "Authorization and Acknowledgment" before signing this application. It contains policy and terms for agreement. All areas of the application should be completed in detail by you. It is your responsibility to read and understand this information and follow the instructions given. Please print legibly in ink. Illegible or incomplete applications will delay processing. The following instructions will help you complete this application. If you need further help, contact your employer, agent/broker, or an SelectHealth/SelectHealth BAC representative at **801-442-4908, option 2 or 800-442-3125, option 2.**

Sections A. and B. – EMPLOYEE INFORMATION AND PLAN INFORMATION

An Employee Application for a special enrollment event must be submitted within 31 days of the event in addition to the applicable documentation, which includes a copy of adoption and/or placement papers or marriage certificate. A Certificate of Creditable Coverage (to prove involuntary loss of other coverage) must be submitted as soon as reasonably possible.

Please note: In Section A., the definition of "Full-Time Hire Date" is as follows: First day physically at work, working 30 hours or more per week consistently. Providing an incorrect hire date could result in coverage being delayed or denied.

** Select Choice Premier is underwritten (insured) by SelectHealth Benefit Assurance Company (SelectHealth BAC) and is administered for SelectHealth BAC by SelectHealth, a separately licensed insurer affiliated with SelectHealth BAC.

Section C. – EMPLOYEE AND DEPENDENT INFORMATION

Complete this section with all requested information about you and/or your dependent(s).

If your spouse is enrolled, he or she may only be deleted from your coverage under the following circumstances:

- During your employer's annual open enrollment period;
- When your spouse agrees to be deleted from coverage by signing a change form; or
- When proof of a legal divorce or annulment is given (first and last page of the divorce decree and any page in between specifying coverage responsibilities for dependent children if you have elected family coverage).

To be eligible for coverage, children must be younger than age 26, unmarried, and dependent upon you for 50 percent of their financial support. (Financial dependency is not required for court or administrative ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

For coordination of benefit purposes, indicate whether or not each individual will be covered by other medical insurance while this health plan is in force. If you answered yes (Y), indicate the name of the other insurance carrier.

NOTE: You must list other health insurance information for each member applying for coverage in order for SelectHealth/SelectHealth BAC to coordinate benefits with other carriers when necessary. On the same line as the member to be covered, circle Y (Yes) or N (No) to indicate whether they will have other insurance coverage along with SelectHealth's plan. You must also list the name of the carrier.

Section D. – PRIOR COVERAGE INFORMATION

If you and/or your eligible dependent(s) have had health insurance coverage within the last 63 days, your Pre-existing Condition Waiting Period (if applicable) may be credited or waived. You must provide SelectHealth/SelectHealth BAC proof of prior coverage, such as Certificate of Creditable Coverage, for each member. You have the right to request a Certificate of Creditable Coverage from your prior healthcare plan. If necessary, SelectHealth/SelectHealth BAC will assist in obtaining such Certificates.

Section E. – EMPLOYEE SIGNATURE

You must read Section I. "Authorization and Acknowledgment." If you read, understand, and agree to the terms stated, sign and date this section.

Section F. – HEALTH INFORMATION

Answer each question for each individual applying for medical coverage. Circle any specific item(s) in the question that apply. For each Y (Yes) answer, **give complete and specific details** in sections G. and H.

Section I. – AUTHORIZATION AND ACKNOWLEDGMENT

You must read this section. If you read, understand, and agree to the terms stated, sign and date Section E. "Employee Signature."

UTAH

Companion Life

TDA Total Dental Administrators, Inc.

GROUP DENTAL ENROLLMENT FORM

☐ New Employee	☐ Add Coverage	☐ Change Dependent	☐ Address Change	☐ Cancel Coverage

Name of Employer: (Use Name from Group Billing Notice or Master Application)	Group Number:	Div:	Class:
Eli Kirk			

Plan Types:

☐ **Companion Plan** ☐ **Total Care TC6000** **Doctor#**

Social Security Number	**Effective Date** Month / Day / Year	**Date Employed Fulltime** Month / Day / Year	**Hours Worked Per Week**

Your Name (Last), (First), (MI)	**Date of Birth** Month / Day / Year	**Sex:** Male: ☐ Female: ☐

Home Address:

Home Phone Number: Work Phone Number:

Do you have any other Dental coverage? If so, Carrier .

Coverage Requested:

☐ **Employee Only**

☐ **Employee + 1**

☐ **Employee + 2**

☐ **Employee + 3 or more**

Complete for Dependent Coverage:				
	Spouse Name: (Last), (First), (MI) **Sex:**	**Date of Birth:** / /	**Do any of your dependents have any other dental coverage?**	**If so, Name of Carrier:**
		/ /	☐ Yes ☐ No	
CHILDREN	**1.** /	/ /	☐ Yes ☐ No	
	2. /	/ /	☐ Yes ☐ No	
	3. /	/ /	☐ Yes ☐ No	
	4. /	/ /	☐ Yes ☐ No	
	5. /	/ /	☐ Yes ☐ No	
	6. /	/ /	☐ Yes ☐ No	

Fraud Warning (Not Applicable in AZ): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance. I authorize my employer to deduct the contribution from my wages.

Date **Employee Signature:**

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date **Employee Signature:**

Underwritten by: COMPANION LIFE INSURANCE COMPANY
Columbia, South Carolina

Return To:
Total Dental Administrators, Inc.
2111 East Highland Avenue, Suite B-425
Phoenix, AZ 85016-4735
1-888-422-1995

10/1/2003

125 Cafeteria Plan Enrollment Form

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

(Please complete this form and return it to your Human Resource Department)

Personal Information
(Please Print)

Company Name

First Name _____ Last Name _____ Social Security Number ___ - ___ - ____

Street Address _____ Date Of Birth ___ / ___ / ____

City _____ State ____ Zip Code _____ Date Of Hire ___ / ___ / ____

Email Address (for claim payment notification) _____

Benefit Election

If you are part of a company health insurance plan your insurance premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction:

☐ **Health Care Expenses:** $ _____ PER YEAR
Please refer to the SPD for the maximum annual allowable election

☐ **Day Care Expenses:** $ _____ PER YEAR
Maximum annual allowable election is $5,000 OR $2,500 if married and filing taxes separately

☐ Initial Request

☐ New Year Request

☐ Waive Participation

Debit Card
(Health Care Expenses only)

Would you like a Debit Card? ☐ Yes ☐ No Please contact your Human Resource Department for Debit Card annual fee

Would you like a Debit Card for your Spouse? ☐ Yes ☐ No There is a one time $5 fee for a second Debit Card

For a spouse card, please enter his/her name and Social Security Number below:

First Name _____ Last Name _____ Spouse Social Security Number ___ - ___ - ____

Employee Signature

I hereby authorize the appropriate payroll reductions as my contribution(s) to the Cafeteria Plan until changed by me in writing. I recognize that such payroll reductions shall be adjusted automatically in the event of a change in the insurance premiums of the benefits I have selected. I will only use the Flexible Spending Account (including the use of a Debit Card) for eligible expenses under the plan, and understand I will be responsible to pay for any transactions not allowed by the plan. In addition, I authorize the release of medical and account information to my spouse (if applicable).

Employee Signature
X

Date

Direct Deposit Request

Your Financial Institution

☐ Checking Account
☐ Savings Account

Financial Institution Address

Account Number

Routing Number

IMPORTANT! Please attach a voided check with this form (not a deposit slip). Only for a savings account is a deposit slip acceptable.

I (We) authorize National Benefit Services, LLC. to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my (our) account indicated above and the financial institution named above.

Employee Signature
X

Date

NBS - 418(07/04)

National Benefit Services, LLC
8805 S. Sandy Parkway, Sandy, UT, 84070
PH (800)274-0503 Toll Free Fax (800) 478-1528

Direct Deposit Request Form

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

(Please complete this form and return it to your National Benefit Services, LLC)

Personal Information

Company Name

First Name | Last Name | Social Security Number (___-___-____)

Street Address

Has your address changed? ☐ Yes ☐ No

City | State | Zip Code

Email Address (for claim payment notification)

Direct Deposit Request

Your Financial Institution

☐ Checking Account
☐ Savings Account

Financial Institution Address

Account Number

Routing Number

IMPORTANT! Please attach a voided check with this form (not a deposit slip). Only for a savings account is a deposit slip acceptable.

I (We) authorize National Benefit Services, LLC. to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my (our) account indicated above and the financial institution named above.

Employee Signature

X

Date

Attach a Voided Blank Check

Attach a Blank Voided Check here

NBS - 418(03/07)

National Benefit Services, LLC
8805 S. Sandy Parkway, Sandy, UT, 84070
PH (800)274-0503 Toll Free Fax (800) 478-1528

Please return to National Benefit Services, LLC

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

Health Care Expense Account - Sample Expenses

Medical Expenses

Acupuncture
Addiction Programs and Products
Adoption (Medical expenses for baby birth)
Alternative Healer Fees
Allergy Relief (Oral Medications, Nasal Spray)
Ambulance
Antacids and Heartburn Relief
Arthritis Pain Relieving Creams
Anti-itch and Hydrocortisone Creams
Artificial Limbs
Athlete's Foot Treatment
Body Scans
Care for Mentally Handicapped
Chiropractor
Cold Medicines (i.e. Syrups, Drops, Tablets)
Contraceptives
Co-Payments
Crutches
Diabetes (i.e. Insulin, Glucose Monitor)
Eye Patches
Fertility Treatment
Fever & Pain Reducers (i.e. Aspirin, Tylenol)
First Aid (i.e. Bandages, Gauze, Creams)
Hearing Aids & Batteries
Hypnosis (For Treatment of Illness)
Incontinence Products (i.e. Depends, Serene)
Joint Support Bandages and Hosiery
Lab Fees
Laxatives
Monitoring Device (Blood Pressure, Cholesterol)
Motion Sickness Medication
Physical Exams
Pregnancy tests
Prescription Drugs
Psychiatrist/Psychologist (for mental illness)
Physical Therapy
Smoking Cessation Relief (i.e. Patches, Gum)
Speech Therapy
Stomach & Digestive Relief
(i.e. Pepto-Bismol, Imodium, etc.)
Tooth and Mouth Pain Relief (Orajel, Anbesol)
Urinary Pain Relief
Vaccinations
Vaporizers or Humidifiers
Wart Removal Medication
Weight Loss Program Fees (With doctor's note)
Wheelchair

Dental Expenses

Artificial Teeth
Co-Payments
Deductible
Dental Work
Dentures
Orthodontia Expenses
Preventive Care at Dentist Office
Bridges, Crowns, Etc.

Vision Expenses

Braille - Books & Magazines
Contact Lenses
Contact Lens Solutions
Eye Exams
Eye Glasses
Laser Surgery
Office Fees
Guide Dog and its Upkeep or other animal aid

What is NOT Eligible

For Additional Information, Visit www.nbsbenefits.com

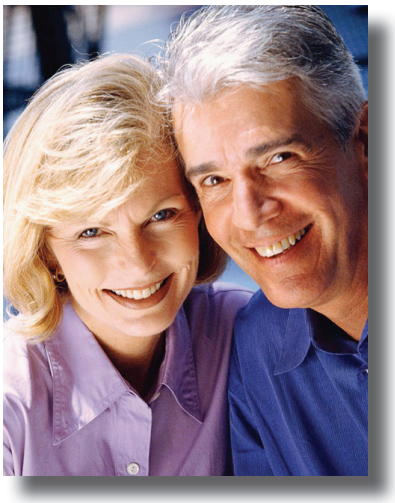
Health care expenses that do not qualify as a federal income tax deduction under IRS Code Section 213 do not qualify for payment through your spending account. The following list includes many of the common expenses that generally do not qualify for reimbursement.

These expenses may be eligible if they are prescribed by a physician (If medically necessary for a specific condition)

Personal Hygiene (i.e. deodorant, soap, body powder, shaving cream, sanitary products, etc.)
Breast Pump (if for convenience)
Cosmetic Surgery
Cosmetics (i.e. makeup, lipstick, cotton swabs, cotton balls, baby oil)
Counseling (i.e. marriage and family counseling)
Denture care (i.e. denture cleansers and denture adhesive creams)
Dental care - Routine (i.e. toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, breath strips, teeth whitening/bleaching, etc.)
Diapers
Exercise Equipment
Hair Care (i.e. hair color, shampoo, conditioner, brushes, hair loss products)
Health Club or Fitness Program Fees
Homeopathic Supplements or Herbs
Household or Domestic Help
Laser hair removal
Massage Therapy
Maternity Clothes
Nail care & personal grooming (i.e. scissors, nail files)
Nutritional and dietary supplements (i.e. bars, milkshakes, power drinks, Pedialyte)
Skin Care (i.e. sun block, moisturizing lotion, lip balm)
Sleep aids (i.e. oral medications, snoring strips)
Vitamins
Weight reduction aids (i.e. Slimfast, appetite suppressants)

National Benefit Services, LLC
P.O. Box 1906 Sandy, UT 84091-1906
Phone: (801) 532-4000 Fax: (800) 478-8528

What is a *Personal Medical Record?*



A Personal Medical Record is an online file that contains your medical history.

First, not all Personal Medical Records are the same.

Some records do not include comprehensive medical information and only stay with you as long as you're with the same insurance company.

But, the iHealthRecord:

- Keeps all your health information in one place. This means **accurate, comprehensive medical information** can be provided to physicians when needed.
- The iHealthRecord is a **secure and portable health record**. Use your record even if you move, travel or change insurances. Your information can be updated by your physician's office or yourself.
- Stores your **personal health information** and lets you choose who to share it with i.e. your physicians, family or caregiver.
- **Ensures your entire health information** is readily available in an emergency.
- Your iHealthRecord is **completely free!**

To learn more about the iHealthRecord,
visit www.centralutahclinic.com

Central Utah Clinic, PC
Your Health, Your Choice.℠

First West
BENEFIT SOLUTIONS

iHealthRecord™
In Partnership with America's Physicians