

TDA Elite Choice 2027 Dental Benefit Plan Information

The Annual Enrollment Period is October 19, 2026 through November 6, 2026

2026 MONTHLY PREMIUM RATES		2027 MONTHLY PREMIUM RATES	
Employee Only	\$43.60	Employee Only	\$43.60
Employee + 1 Dep	\$83.60	Employee + 1 Dep	\$83.60
Employee + 2 or More Deps	\$139.40	Employee + 2 or More Deps	\$139.40

TDA DENTAL PLAN HIGHLIGHTS

- \$2,000 annual maximum benefit per enrolled person
- 0 copay for preventive dental services
- No deductibles
- No waiting periods
- In-network copays
- Out-of-network coverage (plan allowance)

HOW THE PLAN WORKS

Each enrolled member has a \$2,000 Annual Dental Benefit Maximum and requires no deductible to be met. The "Patient Co-Pay" is the total amount you pay at the time of service for covered services from an in-network, participating dentist. The "Out-of-Network Claim Payment" amount is the maximum amount the Plan will pay to out-of-network, non-participating dentists for covered services. The non-participating dentist may balance bill you for amounts billed that exceed TDA's Out-of-Network Claim Payment. You will pay less out-of-pocket by receiving your dental care from an in-network, participating dentist.

WHO CAN ENROLL

Any employee or retiree of the State of North Dakota, North Dakota University System, North Dakota Local Public Health Units, or Garrison Diversion Conservancy District and who meets the eligibility requirements of your employer may enroll during the Annual Enrollment Period or anytime due to a "Qualifying Life Event".

WHAT DO I NEED TO DO

There is nothing you need to do if you are currently enrolled with TDA Elite Choice Plan. If you are enrolling for the first time or need to make any other changes to your TDA dental coverage, you must complete an Elite Choice Dental Plan Enrollment Form and a 2027 Pre-Tax Premium Deduction form and return them to your payroll contact. TDA is approved for pre-tax, monthly premium deductions. Enrollment in the TDA Elite Choice Dental Plan is for a 12-month period beginning January 1, 2027, unless you terminate employment or otherwise lose eligibility. This policy applies regardless if the premium is pre-taxed. Changes are allowed any time during the year for a "Qualifying Life Event" or the ineligibility of a dependent. Contact your Human Resources representative for more information.

FINDING CONTRACTED PROVIDERS

Visit: emihealth.com/providerSearch. Click on Dental. Select "TDA PPO" from the "Networks" drop-down box. Select your "State" from the drop-down box and click search. When the results appear, you can narrow your search by the options provided, including County, City, ZIP code, and Specialties.

Total Dental Administrators, Inc., an EMI Health Company
(800) 662-5851
www.emihealth.com

QUESTIONS?
Ron Holden (701) 721-3716
RHOLDEN@MINOT.COM

**** HR/Payroll Officers:** Please send Enrollment Applications/Change Forms to enrollment@emihealth.com

University of North Dakota #9901

☐ **ENROLLMENT APPLICATION** (Complete entire application.)
☐ **CHANGE FORM** (Complete entire application.)

LAST NAME	FIRST	INITIAL	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF EMPLOYMENT
ADDRESS/STREET NO.			CITY & STATE	ZIP CODE	HOME PHONE	BUSINESS PHONE
SPECIFIC JOB TITLE				E-MAIL ADDRESS		
EMPLOYMENT STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED (RETIREMENT DATE / /) ☐ COBRA						

BENEFIT OPTIONS

DENTAL

☐ Employee only
☐ Employee plus one dependent
☐ Employee plus two or more dependents

RELATIONSHIP TO EMPLOYEE CODE KEY:	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, birth, divorce, etc.).	SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
				MO	DAY	YR		
S: Spouse		1.						
B: Biological Child		2.						
SC: Step Child		3.						
A: Adopted		4.						
O: Other		5.						
		6.						
		7.						
		8.						

OTHER INSURANCE INFORMATION

Will you, your spouse, or dependents have other dental coverage in addition to this EMI Health coverage?
☐ Yes ☐ No

If so, what is the coverage classification? ☐ Single ☐ Couple ☐ Family

Name of Insured _____ Insured's Social Security Number OR Group/Policy Number _____

Name of Other Insurance Company _____ Insurance Company Phone Number _____

ELECTION TO PARTICIPATE - Please note: Plans may be subject to binding arbitration procedures

I hereby apply for coverage to which I may be entitled or to which I may become entitled under the terms of agreements, including binding arbitration provisions, in the policies issued by Educators Mutual Insurance Association and its subsidiaries (EMI Health) and/or other underwriting companies. I accept the terms of group agreement between my employer and the plans and appoint my employer to act as agent on my behalf. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage. The proposed coverage shall not take effect until this application has been accepted by the other underwriting companies, as applicable, and shall become effective only in accordance with the provisions of such agreements or group policies. I understand that I am not entitled to change my coverage elections during the plan year, unless I experience a special enrollment situation (i.e., marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). I also understand that if I experience such a qualifying event I may elect to terminate coverage for myself and/or my dependents by providing written notice to my employer within 31 days of the qualifying event. I authorize EMI Health to share PHI concerning me and my family, including adult dependents, with any health care provider or HSA/HRA administrator providing benefits. I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature of Applicant _____ Application Date _____

EMPLOYER SIGN OFF SECTION

☐ New Enrollment ☐ Special Enrollment ☐ Name/Address Change ☐ Beneficiary Change
☐ Change of Coverage ☐ Add Family Member ☐ Cancellation ☐ Delete Family Member
☐ Other: _____

Employer Signature _____ Effective Date _____

WAIVER OF GROUP COVERAGE

I choose not to participate in the following group benefits that have been offered and hereby waive such coverage. I understand that I may later apply for these benefits if I experience a special enrollment situation (i.e., marriage divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage), or during my employer's next open enrollment period.

☐ DENTAL

I am waiving this group coverage because I have other coverage: ☐ Yes ☐ No

Signature of Applicant for Waiver Only _____ Date _____