October 15, 2015

Total Dental Administrators, Inc. (TDA) is pleased to offer the Elite Choice dental plan option to you during the Annual Enrollment Season for Plan Year 2016.

TDA’s Elite Choice Dental Plan is scheduled to renew on January 1, 2016. The plan benefit Annual Maximum has increased to $2,000. Some class II & class III copayments have been adjusted for dental inflation. The 2016 rates will increase slightly and include the ACA premium tax.

<table>
<thead>
<tr>
<th></th>
<th>2015 Monthly Rates</th>
<th>2016 Monthly Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$27.98</td>
<td>$28.56</td>
</tr>
<tr>
<td>Employee + 1 Dependent</td>
<td>$53.34</td>
<td>$54.40</td>
</tr>
<tr>
<td>Employee + 2 or More Dependents</td>
<td>$89.16</td>
<td>$90.94</td>
</tr>
</tbody>
</table>

During your Annual Enrollment Season, which runs from October 19 through November 6, 2015, you will have the opportunity to make changes to your elected benefits.

If you are currently enrolled on the TDA Elite Choice Dental Plan and wish to remain on the plan, there is nothing you need to do. Your coverage will automatically renew on January 1, 2016.

However, if you wish to enroll, add or delete dependents, or make any other changes to the TDA Elite Choice Dental plan you must complete the following form:

1. TDA Elite Choice Dental Plan Enrollment Form

You are eligible to enroll on the TDA Elite Choice Dental plan if you are an employee or retiree of the State of ND, the University System, District Health Units and Garrison Diversion Conservancy District.

Highlights of the TDA Elite Choice Group Dental Plan are listed below:

<table>
<thead>
<tr>
<th>TDA ELITE CHOICE GROUP DENTAL PLAN</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>$50 per person / $150 per family</td>
</tr>
<tr>
<td>Class 1: Preventive &amp; Diagnostic</td>
<td>Copays</td>
<td>Deductible is Not Applicable Plan Pays Allowance to Provider Enrollee may be Balance Billed</td>
</tr>
<tr>
<td>Class 2: Restorative / Fillings</td>
<td>Copays</td>
<td>Deductible is Applicable Plan Pays Allowance to Provider Enrollee may be Balance Billed</td>
</tr>
<tr>
<td>Class 3: Crowns, Endo, Perio, Prosthodontics, Oral Surgery</td>
<td>Copay</td>
<td>Deductible is Applicable Plan Pays Allowance to Provider Enrollee may be Balance Billed</td>
</tr>
<tr>
<td>Balance Billing Allowed</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Waiting Periods</td>
<td>None</td>
<td>Six (6) months for Class 3 Services</td>
</tr>
<tr>
<td>Annual Benefit Maximum</td>
<td>Total Maximum of $2,000 per Covered Person</td>
<td></td>
</tr>
</tbody>
</table>
Please feel free to call or e-mail TDA’s representatives for assistance and questions.

Ron Holden  (701) 721-3716  rholden@minot.com or Chris Jehle (602) 320-3261 chrisjehle@cox.net
Attached are the TDA Elite Choice Dental plan Summary of Benefits Brochure, Enrollment form, Provider Directory and a Provider nomination form. You may also search for contracted providers on TDA’s Web site at www.tdadental.com

Thank you and we look forward to serving you in 2016.
GROUP DENTAL ENROLLMENT FORM

Name of Employer: University of North Dakota

Social Security Number: [Redacted]

Plan Types: (Select one)
- Elite Choice Dental Plan

Effective Date: [Redacted]

Date Employed Full Time: [Redacted]

Hours Worked Per Week: [Redacted]

Last Name: [Redacted]
First Name: [Redacted]
MI: [Redacted]

Date of Birth: [Redacted]

Sex: Male [ ] Female [ ]

Coverage Requested: [Redacted]
- Employee Only
- Employee + 1 Dependent
- Family

Home Address:
Street: [Redacted]
Apartment #: [Redacted]
City, State, Zip: [Redacted]
Home Phone: [Redacted]
Work Phone: [Redacted]

Do you have other Dental Coverage? If yes, Carrier:

Complete for Dependent Coverage:

Spouse Name-Last: [Redacted]
First: [Redacted]
MI: [Redacted]

Date of Birth: [Redacted]

Sex: [ ] [ ]

Name of Other Dental Carrier:

1. [ ] [ ]
2. [ ] [ ]
3. [ ] [ ]
4. [ ] [ ]
5. [ ] [ ]
6. [ ] [ ]

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. I hereby apply for enrollment and agree to remain in the Plan a minimum of one year, authorize the release of any information relating to dental care received under the Plan, and to all terms and conditions set forth in the Group Agreement.

Date: [Redacted]

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: [Redacted]

Employee Signature:

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