Individual & Family Dental Plan Options

Dental Health Maintenance Organizations: DHMO

The Affordable Option

888.326.3210
WWW.PREMIERLIFE.COM
Dental Health Maintenance Organization (DHMO)

DHMOs are excellent options for those who like to know exactly how much they will be charged for each dental service because these plans do not have deductibles, claims forms or dollar annual maximums. Not unlike a restaurant menu, all dental services are listed and have a pre-determined rate clearly stated and, best of all, these out-of-pocket costs are usually lower than those in a PPO.

Four Plans to Choose from:

The description of services below provides a very brief description of only some the procedures covered and is intended to be used as a summary only. The Individual Disclosure Form/Contract should be consulted for a detailed and complete description of covered services, limitations and exclusions.

<table>
<thead>
<tr>
<th>ADA CODES</th>
<th>DHMO PLAN PA1</th>
<th>DHMO PLAN PA2</th>
<th>DHMO PLAN PA3</th>
<th>DHMO PLAN PA4</th>
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</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>Periodic Oral Exam</td>
<td>$10</td>
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<td>$15</td>
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<td></td>
<td>Comprehensive Exam</td>
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<td></td>
<td>Full Mouth Series (FMX)</td>
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<td>Panoramic</td>
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<td></td>
<td>Periapical X-rays</td>
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<td>Bitewings- four films</td>
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<td></td>
<td>Adult Cleanings</td>
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<td>Child Cleanings</td>
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<td>Adult/Child Fluoride Treatment</td>
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<td>Basic Services</td>
<td>Sealants 1st and 2nd Molars</td>
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<td>Space Maintainers</td>
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<td>Restorations - Amalgam Fillings</td>
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<td>Extractions - Erupted tooth</td>
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<td>Surgical Removal - Erupted tooth</td>
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<td>Root Canal Therapy - Anterior</td>
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<td>Root Canal Therapy - Bi-cuspid</td>
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<td>Root Canal Therapy - Molar Scaling &amp; Root Planing - per quadrant</td>
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<td>Major Services</td>
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<td>Bridges - per unit</td>
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<td>Complete Denture - per arch</td>
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<td>Partial Denture - per arch</td>
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<td>75% of U&amp;C † †</td>
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<td></td>
<td>(Adult)</td>
<td>75% of U&amp;C † †</td>
<td>75% of U&amp;C † †</td>
<td>$2,900 † †</td>
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</table>

† based on 24 month treatment plan: additional ortho co-pays may apply, see Certificate of Insurance for full breakdown.

A brief summary of benefits are listed here. For a complete list, please visit us at WWW.PREMIERLIFE.COM

The Individual DHMO plans are only available in certain counties. For a complete listing of the counties where the Individual DHMO plans are offered, please visit www.premierlife.com or call Customer Service toll free at 855.280.2882.
Summary of Benefits, Limitations And Exclusions

Limitations of Benefits

General

1. General anesthesia or IV sedation is a covered benefit only when administered by the Contract Dentist or Contract Specialist, in conjunction with covered oral surgery or covered periodontal surgical procedure.
2. Benefits for retained primary teeth are limited to services applicable to a primary tooth.
3. Treatment or extract of primary teeth when exfoliation (normal shedding and loss) is imminent is not covered.
4. The frequency of certain Benefits is limited. All frequency limitations are listed in the Schedule of Benefits.
5. Benefits provided by a pediatric Dentist are limited to children through age seven following at least two attempts by the assigned Primary Care Dentist to treat the child and upon written preauthorization by Premier Access, less applicable Copayments.

Preventive & Diagnostic

1. Routine cleanings (prophylaxis), periodontal maintenance services and fluoride treatments are limited to 2 per 12 months. AdditUnal cleanings (routine and perUnental) are available at the Copayment indicated in the Schedule of Benefits.
2. Sealants: Plan benefit applies to un restored permanent molar teeth thru age 15.
3. Panoramic and full mouth x-rays are limited to one every three (3) years, unless medically necessary.
4. Bitewing x-rays are limited to 2 series every 12 months.

Restorative

1. FillingS (amalgams and composites) are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or lessSing restoratUn.
2. The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a filling.
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for childhood under 16 years of age are not covered.
4. An initial treatment plan which involves the removal and restabilSishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combinatUn of these is considered to be full mouth reconstruction under the Plan. The crowns, onlays, and/or fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not affect any other Benefits.
5. Contract Dentists may offer services that useS brand or trade names at an additUnal fee. The Enrollee must be offered the plan benefits of a high-quality laboratory processed crown/ pontic that may include: porcelain/ ceramic; porcelain with vase, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand) laboratory processed or in-office processed crowns/ pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec, the Contract Dentist may charge an additUnal fee not to exceed $325 in addition to the copayment specified in the Schedule of Benefits.
6. ProcUnal metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, procUnal abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalizedUn and characterizUn of complete and partial dentures are not covered.
7. Inlays, Onlays, or Indirectly fabricated post and core: Base metal is the benefit. If an inlay, onlay or indirectly fabricated post and core is made of high noble metal or noble metal, an additUnal fee up to $100 per tooth would be charged for the upgrade.
8. Crowns, Inlays, Onlays, Bridges, Dentures Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additUnal charge to the Enrollee of $150.
9. For a covered porcelain-fused-to-metal crown, a porcelain margin is considered to be a material upgrade with a maximum additUnal charge to the Enrollee of $75.
10. Replacement of any restoratUn/bridge/denture is limited to once every five (5) years. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge), or a removable full or partial denture is covered when:
   a) The existing restoratUn/bridge/denture is no longer funcUnal and cannot be made funcUnal by repair or adjustment; and
   b) Either of the following: i) the existing non-funcUnal restoratUn/ bridge/denture was placed five or more years preUn to its replacement; or ii) if an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

Prosthodontics

1. For all covered dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditUn. If needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.
2. Covered interim partial denture is limited to one (1) per twelve (12) months.
3. Dentures (full or partial): Replacement only after five years
4. Coverage for the placement of a fixed partial denture (bridge) requires that:
   a. No canSed prev. pontic (prosthetic tooth) be included; and i) the sole tooth to be replaced in the arch is a permanent tooth, which cannot be replaced by adding another tooth to an existing removable partial denture, or ii) the new bridge would replace an existing, non-funcUnal bridge, or iii) each abutment tooth to be crowned meets the benefit criteria for a covered crown (when there is insufficient tooth structure to support a filling).

Endodontics

1. The Copayments listed for endodontic procedures do not include the cost of the final restoratUn.
2. With the exceptUn of pulp caps, pulpotomies, pulpal debridements, and pulpal therapies with resorbable fillings, benefits for all endodontic procedures listed on the Schedule of Benefits are limited to permanent teeth.

PerUnential

1. Soft tissue management programs are limited to perUnental pocket charting, root planning, scaling, curettage, oral hygiene instructUn, perUnental maintenance and/or prophylaxis. If an Enrollee declines non-covered services (including irrigatUn) within a soft tissue management program, it does not eliminate or alter other covered services.
2. PerUnental scaling and root planning is limited to 4 quadrants during any 12 consecutive months.
3. Full mouth debridement is limited to 1 treatment during any 12 consecutive months.
4. PerUnental maintenance is limited to 2 per 12 months. AdditUnal perUnental maintenance is beyond 2 per 12 months is covered at the copayment specified in the Schedule of Benefits.

Oral Surgery

1. ExcisUn of the frenum is a benefit only when it causes limited mobiSity of the tongue, a large diastema between teeth or it interferes with a prosthetic appliance.
2. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists. ExtractUn of teeth, when teeth are asymptomatic/ non-pathologic (no signs of symptoms of pathology or infectUn), including but not limited to the removal of third molars and orthodontic extractUns.

For the complete list of Exclusions and Limitations, please visit us at WWW.PREMIERLIFE.COM
General Exclusions

1. Any procedure that is not specifically listed in the Schedule of Benefits.
2. Dental services received from any dental facility other than the assigned Primary Care Dentist, or a preauthorized dental specialist (oral surgeon, endodontist, peridontist, pediatric dentist or orthodontist), except for Emergency Services as described in the Disclosure Form/Contract.
3. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontics services.
4. Dental procedures started prior to the Enrollee’s effective date under this Plan or started after the Enrollee’s termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics.
5. Any procedure that has a poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
6. Services solely for cosmetic purposes (except for those procedures listed on the Schedule of Benefits) or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
7. Consultation fees or other diagnostic services for noncovered benefits.
8. Duplicate or non-existent x-rays.
9. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
10. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal mastication (chewing) function will be covered at the normal Schedule of Benefits.
11. Prescription and over-the-counter drugs.
12. Replacement of dentures, crowns, appliances or bridge work that have been lost, stolen or damaged due to abuse, misuse, or neglect.
13. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan’s Schedule of Benefits. Any services related to pathology laboratory fees are noncovered.
14. Procedures, appliances or restorations if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, reorientation of teeth, peridontal splinting, gnathologic recordings, or to diagnose or treat abnormal conditons of the temporomandibular joint (TMJ), with the exception of procedures D9951 and D9952 as shown on the Schedule of Benefits.
15. Myofunctional and parafuncional appliances and/or therapies.
16. Implant supported dental appliances and attachments, placement of implants, removal and all other services associated with a dental implant.

Orthodontics Limitations & Exclusions

For DHMO PA3 Plan and DHMO PA4 Plan that have discounted specialty services: Your Copayment for covered orthodontic services will be 75% of the Contract Dentist or Contract Specialist’s Usual Fee. If your Primary Care Dentist does not provide orthodontic care, you may receive care from any Premier Access Contract Specialist whose practice is limited to orthodontic care. A listing of Contract Specialists whose practice is limited to orthodontic care is available online at www.premierlife.com or by contacting Customer Service at 866.650.3660.

If you terminate your coverage from the Premier Access Plan after the start of the orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Primary Care Dentist or Contract Specialist’s (orthodontics) Usual Fee for the treatment plan. The Primary Care Dentist or Contract Specialist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Primary Care Dentist or Contract Specialist (orthodontics) as arranged.

1. Orthodontic treatment must be provided by your Primary Care Dentist or by a Premier Access Contract Specialist (orthodontics) I order for the Copayments listed in the Schedule of Benefits to apply.
2. If you have a pre-orthodontic treatment consultation (D8660) the Copayment specified in the Schedule of Benefits is $50; however, in the event that orthodontic treatment is not required or is declined by the Enrollee, a fee of $85 will apply for the visit. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.
3. Comprehensive orthodontic treatment consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee’s occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Specialist (Orthodontics) deems it suitable, a removable or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.
4. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additonal twenty-four (24) months of retention. Treatment extending beyond such time may be subject to an additonal charge of [[$125 per month]] or 75% of the Primary Care Dentist or Contract Specialist (orthodontics) Usual Fee.
5. The Copayment is payable to the Primary Care Dentist or Contract Specialist (orthodontics) who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Specialist to continue orthodontic treatment, the Enrollee:
   a. Will not be entitled to a refund of any amounts paid; and
   b. Will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
6. The retentive phase shall include the construct, placement, and adjustment of retainers.
7. Three recementation or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additonal recementation or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Primary Care Dentist’s or Contract Specialist’s (orthodontics) Usual Fee.
8. Active orthodontic treatment in progress on your effective date of coverage on the Premier Access Plan is not covered. Active orthodontic treatment means tooth movement has begun.
9. The following are not included as orthodontic benefits:
   a. Replacement of lost or broken appliances;
   b. Retreatment of orthodontic cases;
   c. Changes in orthodontic treatment necessitated by accident of any kind.
   d. Treatment involving:
      i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macrognathism;
      ii. Hormonal imbalances or other factors affecting growth or development;
      iii. Treatment related to temporomandibular joint disorders;
      iv. Composite or ceramic brackets, lingual adaptation of orthodontic bands, Invisalign and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

For the complete list of Exclusions and Limitations, please visit us at WWW.PREMIERLIFE.COM