PREMIER ACCESS
Medical • Dental • Vision

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.

	ADA CODES	DHMO PLAN PA1	DHMO PLAN PA2	DHMO PLAN PA3	DHMO PLAN PA4
Office Visit Copay		$10	$5	$15	$10
Preventive Services					
Periodic Oral Exam	D0120	$0	$0	$0	$0
Comprehensive Exam	D0150	$0	$0	$0	$0
Full Mouth Series (FMX)	D0210	$0	$0	$25	$0
Panoramic	D0330	$0	$0	$25	$0
Periapical X-rays	D0220	$0	$0	$5	$0
Bitewings- four films	D0274	$0	$0	$0	$0
Adult Cleanings	D1110	$20	$0	$25	$20
Child Cleanings	D1120	$20	$0	$25	$20
Adult/Child Fluoride Treatment	D1203	$0	$0	$25	$20
Basic Services					
Sealants 1st and 2nd Molars	D1351	$25	$5	$25	$25
Space Maintainers	D1525	$80	$80	$85	$85
Restorations - Amalgam Fillings	D2161	$28	$0	$60	$55
Extractions - Erupted tooth	D7140	$20	$5	$45	$40
Surgical Removal - Erupted tooth	D7210	$60	$30	$70	$70
Root Canal Therapy - Anterior	D3310	$240	$110	$240	$240
Root Canal Therapy - Bi-cuspid	D3320	$250	$185	$350	$350
Root Canal Therapy - Molar	D3330	$375	$265	$400	$400
Scaling & Root Planing - per quadrant	D4341	$75	$50	$85	$80
Major Services					
Crowns	D2750	$350	$245	$425	$425
Bridges - per unit	D6210	$350	$245	$425	$425
Complete Denture - per arch	D5110	$495	$325	$525	$495
Partial Denture - per arch	D5211	$485	$400	$485	$485
Orthodontia (Child)	D8080	75% of U&C † †	75% of U&C † †	$2,700 † †	$2,700 † †
(Adult)	D8090	75% of U&C † †	75% of U&C † †	$2,900 † †	$2,900 † †

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

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.

DHMO ENROLLMENT APPLICATION

Please complete in black ink.

Effective Date: _____
Source Code: _____

Coverage Type: ❑ DHMO PA1 ❑ DHMO PA3 ❑ DHMO PA2 ❑ DHMO PA4

Subscriber Information

Social Security Number: _____ Primary Language: _____
Last Name: _____ First Name: _____ MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____)_____ E-mail Address: _____
Date of Birth: _____ Sex: ❑ M ❑ F Married? ❑ Yes ❑ No Children? ❑ Yes ❑ No

MUST BE COMPLETED TO ENROLL IN PLAN *Primary Care Dentist Choice: I understand that I must select a Premier Access Contract Dentist from the list of facilities as my assigned Primary Care Dentist. If the selected facility is not available, non-contracted or closed to further enrollment, Premier Access reserves the right to assign me to another dental office as close as possible to my home. In the event that I cannot be assigned to a Primary Care Dentist, my Premium will be refunded.*

Primary Care Dentist Facility Choice 1 _____ Primary Care Dentist Facility Choice 2 _____

Dependent Information

** Dependent children are eligible for coverage to age 26. Dependent children age 26 or over remain eligible if unmarried and incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition and is chiefly dependent on the Subscriber for support.

Relation to Subscriber	Last Name	First Name & MI	Date of Birth**	Sex (M/F)	Disability (Y/N)	Primary Care Dentist Office ID #	Primary Care Dentist ID #
Spouse or Registered Domestic Partner							
Child							
Child							
Child							
Child							

DHMO PA1 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

DHMO PA2 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

DHMO PA3 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

DHMO PA4 PLAN		
I am enrolling (check one)	Annual	Monthly
☐ Myself only		
☐ Myself and Dependent (Spouse or Child)		
☐ Myself and Family (more than one dependent)		
☐ My dependent child only (to age 19)		
☐ My dependent children (more than one – to age 19)		
One Time Enrollment Fee		
TOTAL AMOUNT DUE		

Select Your Payment Method (check one) ❑ Annual Credit Card ❑ Annual Check/Money Order ❑ Monthly Credit Card Draft ❑ Monthly Bank Draft

CREDIT CARD INFORMATION - PLEASE CHARGE MY (check one)

❑ VISA ❑ Mastercard ❑ Discover ❑ American Express

Name as it appears on card: _____
Credit Card Number: _____
Expiration Date: _____

Authorization/Signature: _____ Date: _____

BANKING INFORMATION - PLEASE CHARGE MY (check one)

❑ Checking Account (include a voided check) ❑ Savings Account (include a voided deposit slip)

I hereby authorize Premier Access to debit the designated prepayment fee each month from the bank account indicated above. I understand that the amount of my monthly prepayment fee will be deducted from my account and that there will be a [$25] service charge for any returned drafts.

Authorization/Signature: _____ Date: _____

This enrollment form with signed authorizations and/or check or money order, as applicable, must be received by the 20th of the month for your coverage to be effective the first of the following month. Return enrollment form to **Premier Access at P.O. Box 659005, Sacramento, CA 95865-9005** or fax to: **877.648.7748** or enroll online at **WWW.PREMIERLIFE.COM**

Mandatory Binding Arbitration I understand that any dispute or contracting that may arise between me and Premier Access shall be submitted to binding arbitration held in accordance with the commercial arbitration rules of the American Arbitration Association in lieu of a jury or court trial, and that should any dispute arise, neither Premier Access or I may pursue any claims as a plaintiff or class member in any purported class or representative proceeding, and instead must pursue any such claims in an individual capacity. Both Premier Access and I expressly waive any right to initiate or arbitrate a class action against one another relative to any disputes relating to or arising in any way out of my enrollment with Premier Access or its affiliates. The arbitration proceeding will take place in Sacramento, California or, if that location is prohibitive or significantly inconvenient to the parties, at an alternative location selected by the American Arbitration Association.

Agency ID # 21447 **Broker ID # 11968**

Employee Signature: _____ **Date:** _____

To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this application. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if I made false statements with the intent to deceive or that has a material effect on the policy coverage and/or premium.

Dependent Only Enrollment: I understand that if I have indicated that coverage under the Plan is to be provided only for the dependent child(ren) named on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form/ Contract.

Authorization: I hereby authorize my medical or dental care institution or professional to release to a representative of Premier Access, any personal, privileged or medical records information including but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Premier Access provider agreements or local, state, or federal laws. This authorization is valid for the duration of coverage.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE. THEREFORE, PREMIER ACCESS INSURANCE COMPANY WILL NOT REQUIRE THAT AN HIV TEST BE REQUIRED AS A CONDITION OF OBTAINING COVERAGE. IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFETY CODE SECTION 120980, PREMIER ACCESS INSURANCE COMPANY COMPLIES IN ALL RESPECTS WITH THE PROHIBITION AGAINST THE UNAUTHORIZED DISCLOSURES OF AN HIV TEST.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison. In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Premier Access' ratio of health care expenses to premiums received for the last calendar year with respect to the Premier Access Individual & Family Plans was 60.0%.

Please note any communication assistance or special needs: _____

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* DHMO benefit plans are underwritten by Access Dental Plan, Inc. of CA, a Premier Access company and a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.

Summary of Benefits, Limitations And Exclusions

Limitations of Benefits

General

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

Preventive & Diagnostic

1. Routine cleanings (prophylaxis), perÚdontal maintenance services and fluoride treatments are limited to 2 per 12 months. AdditÚnal cleanings (routine and perÚdontal) are avaŠable at the Copayment indicated in the Schedule of Benefits.
2. Sealants: Plan benefit applies to unrestored 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. FŠlings (amalgams and composites) are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or faŠing restoratÚn.
2. The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a fŠling.
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for chŠdren under 16 years of age are not covered.
4. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combinatÚn of these is considered to be full mouth reconstructÚn under the Plan. The crowns, onlays, and/or fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusÚn does not affect any other Benefits.
5. Contract Dentists may offer services that utŠize brand or trade names at an additÚnal 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 rand, 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 additÚnal fee not to exceed $325 in additÚn to the listed Copayment. Contact the Customer Service department at [(866) 650-3660] if you have questÚns about the additÚnal fee or name brand services.
6. PrecÚus metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precisÚn abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalizatÚn and characterizatÚn 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 additÚnal fee up to $100 per tooth wŠl 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 additÚnal 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 additÚnal charge to the Enrollee of $75.
10. Replacement of any restoratÚn/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 restoratÚn/bridge/denture is no longer functÚnal and cannot be made functÚnal by repair or adjustment; and

b) Either of the following: i) the existing non-functÚnal restoratÚn/ bridge/denture was placed five or more years prÚr 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 conditÚning, 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 facŠity 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 cantŠevered posterÚr 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-functÚnal 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 fŠling).

Endodontics

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

PerÚdontics

1. Soft tissue management programs are limited to perÚdontal pocket charting, root planning, scaling, curettage, oral hygiene instructÚn, perÚdontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services (including irrigatÚn) within a soft tissue management program, it does not eliminate or alter other covered services.
2. PerÚdontal 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. PerÚdontal maintenance is limited to 2 per 12 months. AdditÚnal perÚdontal maintenance is beyond 2 per 12 months is covered at the copayment specified in the Schedule of Benefits.

Oral Surgery

1. ExcisÚn of the frenum is a benefit only when it causes limited mobŠity 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. ExtractÚn of teeth, when teeth are asymptomatic/ non-pathologic (no signs of symptoms of pathology or infectÚn), including but not limited to the removal of third molars and orthodontic extractÚns.

General Exclusions

1. Any procedure that is not specifically listed in the Schedule of Benefits.
2. Dental services received from any dental facŠity other than the assigned Primary Care Dentist, or a preauthorized dental specialist (oral surgeon, endodontist, perÚdontist, 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 prÚr to the Enrollee's effective date under this Plan or started after the Enrollee's terminatÚn from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impressÚn has been taken and orthodontics.
5. Any procedure that has a poor prognosis for a successful result and reasonable longevity based on the conditÚn 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 conditÚns that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformatÚns, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn chŠdren with congenital defects or birth abnormalities.
7. ConsultatÚns or other diagnostic services for noncovered benefits.
8. DuplicatÚn of x-rays.
9. All related fees for admissÚn, use, or stays in a hospital, out-patient surgery center, extended care facŠity, or other simŠar care facŠity.
10. Accidental injury. Accidental injury is defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) functÚn wŠl be covered at the normal Schedule of Benefits.
11. PrescriptÚn and over-the-counter drugs.
12. Replacement of dentures, crowns, appliances or bridgework 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 restoratÚns if the purpose is to change vertical dimensÚn, replace or stabŠize tooth structure loss by attritÚn, realignment of teeth, perÚdontal splinting, gnathologic recordings, or to diagnose or treat abnormal conditÚns of the temporomandibular joint (TMJ), with the exceptÚn of procedures D9951 and D9952 as shown on the Schedule of Benefits.
15. MyofunctÚnal and parafunctÚnal 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 wŠl 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 avaŠable 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 wŠl be responsible for any additÚnal charges incurred for the remaining orthodontic treatment. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason wŠl be based on the Primary Care Dentist's or Contract Specialist's (orthodontics) Usual Fee for the treatment plan. The Primary Care Dentist or Contract Specialist wŠl 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 consultatÚn (D8660) the Copayment specified in the Schedule of Benefits is $0; however, in the event that orthodontic treatment is not required or is declined by the Enrollee, a fee of $85 wŠl apply for the visit. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.
3. Comprehensive orthodontic treatment consists of repositÚning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusÚn as ideal as possible. This treatment usually requires complete fixed appliances, however, when the Contract Specialist (Orthodontics) deems it suitable, a European 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 additÚnal twenty-four (24) months of retentÚn. Treatment extending beyond such time may be subject to an additÚnal 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. WŠl not be entitled to a refund of any amounts paid; and
b. WŠl be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completÚn of the orthodontic treatment.

6. The retentÚn phase shall include the constructÚn, placement, and adjustment of retainers.
7. Three recementatÚns 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 additÚnal recementatÚns 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. Repair or 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. MaxŠlo-facial surgery, myofunctÚnal therapy, cleft palate, micrognathia, macroglossia;
      ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
      iii. Treatment related to temporomandibular joint disorders;
      iv. Composite or ceramic brackets, lingual adaptatÚn of orthodontic bands, Invisalign and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.