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:

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: ____________________  Coverage Type:  □ DHMO PA1  □ DHMO PA3
 Source Code: ____________________  □ DHMO PA2  □ DHMO PA4

Subscriber Information

<table>
<thead>
<tr>
<th>Social Security Number: ____________________</th>
<th>Primary Language: ____________________</th>
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<tr>
<td>Last Name: ____________________</td>
<td>First Name: ____________________</td>
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<tr>
<td>Street Address: ____________________</td>
<td>City: ____________________</td>
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Employee Signature: ____________________  Date: ____________________

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.

<table>
<thead>
<tr>
<th>Relation to Subscriber</th>
<th>Last Name</th>
<th>First Name &amp; MI</th>
<th>Date of Birth**</th>
<th>Sex</th>
<th>Disability</th>
<th>Primary Care Dentist Office ID #</th>
<th>Primary Care Dentist ID #</th>
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<tbody>
<tr>
<td>Spouse or Registered Domestic Partner</td>
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DHMO PA1 PLAN

<table>
<thead>
<tr>
<th>I am enrolling (check one)</th>
<th>Annual</th>
<th>Monthly</th>
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<tr>
<td>☐ Myself only</td>
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<td></td>
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<tr>
<td>☐ Myself and Dependent (Spouse or Child)</td>
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<tr>
<td>☐ Myself and Family (more than one dependent)</td>
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<tr>
<td>☐ My dependent child only (to age 19)</td>
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<td></td>
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<tr>
<td>☐ My dependent children (more than one – to age 19)</td>
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</tbody>
</table>

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.

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.

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 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 extraction 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 prior authorization 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. Additional cleanings (routine and periodontal) are available 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. Fillings (amalgams and composites) are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
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 children 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 combination 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 utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefit of a high-quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with vane, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade, the Copayment includes after the cost of the final restoration.

Prosthodontics
1. For all covered dentures and partial dentures, Copayments are available at the Copayment indicated in the Schedule of Benefits.
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 cantilevered posterior 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-functional 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 restoration.
2. With the exception of pulp caps, pulpotomies, pulpal debridements, and pulpal therapies with resorbable fillings, benefits for all endodontic procedures listed in the Schedule of Benefits are limited to permanent teeth.

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

Oral Surgery
1. Excision of the frenum is a benefit only when it causes limited mobility 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. Extraction of teeth, when teeth are asymptomatic/ non-pathologic (no signs of symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.

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, periodontist, 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. Consultations or other diagnostic services for noncovered benefits.
8. Duplication of 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 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) function will be covered at the normal
    Schedule of Benefits.
11. Prescription 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 restorations if the purpose is to change
    vertical dimension, replace or stabilize tooth structure loss by attrition,
    realignment of teeth, periodontal splinting, gnathologic recordings, or
    to diagnose or treat abnormal conditions of the temporomandibular
    joint (TMJ), with the exception of procedures D9951 and D9952 as
    shown on the Schedule of Benefits.
15. Myofunctional and parafunctional 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 PA1 Plan and DHMO PA2 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’s 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 $0; 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 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 additional twenty-four (24)
   months of retention. Treatment extending beyond such time may be
   subject to an additional 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 retention phase shall include the construction, placement, and
   adjustment of retainers.
7. Three recementations 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 additional
   recementations 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. Maxillo-facial surgery, myofunctional 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 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