premier access

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Premier Access	Plan Name: 600
Policy type: DHMO	Premier Access Phone Number: 888-715-0760
Effective Date: 07/01/2022	www.premierlife.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT [insert insurer website] OR CALL [insert insurer phone number].
THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	**In-Network**	**Out-of-Network**
Dental	None	Not Applicable

There is no deductible.

A deductible is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.

In-network services are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.

Out-of-network services are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	**In-Network**	**Out-of-Network**
Annual Maximum	None	Not applicable
Lifetime Maximum for Orthodontia	None	Not applicable

Annual maximum is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.

Lifetime maximum means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments. The Waiting Period for Type III Services is 0 months (waived for those with prior group coverage)

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions**
Oral Exam	Type I-Preventive Services	$0	Not Applicable	2 in 12 - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Bitewing X-ray	Type I-Preventive Services	$0	Not Applicable	2 in 12 - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Cleaning	Type I-Preventive Services	$0	Not Applicable	2 in 12 - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits

				and Limitations.
Filling	Type II- Basic Services	$0	Not Applicable	
Simple Extraction	Type II- Basic Services	$0	Not Applicable	
Root Canal	Type II- Basic Services	$25	Not Applicable	
Scaling and Root Planning	Type II- Basic Services	$0	Not Applicable	
Ceramic Crown	Type III- Major Services	$225	Not Applicable	
Removable Partial Denture	Type III- Major Services	$100	Not Applicable	
Orthodontia	Orthodontia	$1,975	Not Applicable	The benefit is available for adults and children.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT.
The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (FMX) and cleaning	Resin-based composite - one surface, posterior	Crown - porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $400	Total Cost of Care	In-network: $150	Total Cost of Care	In-network: $1,300
	Out-of-network: $550		Out-of-network: $200		Out-of-network: $1,750

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Deductible	In-network: None	Deductible	In-network: None	Deductible	In-network: None
	Out-of-network: Not Applicable		Out-of-network: Not Applicable		Out-of-network: Not Applicable
	In-network: None		In-network: None		In-network: None
Annual Maximum (Plan Will Pay)	Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	Out-of-network: Not Applicable
Patient Cost (copayment or coinsurance)	In-network: $0	Patient Cost (copayment or coinsurance)	In-network: $45	Patient Cost (copayment or coinsurance)	In-network: $225
	Out-of network: $550		Out-of network: $200		Out-of network: $1,750
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	In network: $0	In this example, Sam would pay (includes copays/ coinsurance and deductible, if if applicable):	In network: $45	In this example, Maria would pay (includes copays/ c oinsurance and deductible, if applicable):	In network: $225
	Out-of network: $550		Out-of network: $200		Out-of network: $1,750
Summary of what is not covered or subject to a limitation:	Full mouth and panoramic x-rays are now limited to once every 3 years, unless medically necessary. Prophylaxis services (cleanings) are now limited to	Summary of what is not covered or subject to a limitation:		Summary of what is not covered or subject to a limitation:	The plan covers porcelain restorations on posterior teeth for an additional copayment of $75 per unit. The plan now covers treatment plans in excess

	two per 12-month period.				of 5 units. There is an additional copayment of $125 per unit for any treatment for 7 or more units.