premier access

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Premier Access	Plan Name: Custom PPO Plan 2-124 (High)
Policy type: PPO	Premier Access's 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 WWW.PREMIERLIFE.COM OR CALL 888-715-0760
THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	**PCN Network**	**In-Network**	**Out-of-Network**
Dental	Individual Deductible per Calendar Year $25 (Family Deductible Maximum of 3 Family Members)	Individual Deductible per Calendar Year $25 (Family Deductible Maximum of 3 Family Members)	Individual Deductible per Calendar Year $50 (Family Deductible Maximum of 3 Family Members)

The deductible applies to all services except Preventive.

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	**PCN Network**	**In-Network**	**Out-of-Network**
Annual Maximum	$1,500	$1,500	$1,500
Lifetime Maximum for Orthodontia	$1,000	$1,000	$1,000

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**	**PCN-Network**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions**
Oral Exam	Type 1-Preventive Services	0%	0%	10%	2 in 12 - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Bitewing X-ray	Type 1-Preventive Services	0%	0%	10%	
Cleaning	Type 1-Preventive Services	0%	0%	10%	2 in 12 - Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits

					and Limitations.
Filling	Type II- Basic Services	10%	20%	30%	
Simple Extraction	Type II- Basic Services	10%	20%	30%	
Root Canal	Type II- Basic Services	10%	20%	30%	
Scaling and Root Planning	Type II- Basic Services	10%	20%	30%	
Ceramic Crown	Type III- Major Services	40%	50%	50%	
Removable Partial Denture	Type III- Major Services	40%	50%	50%	
Orthodontia	Orthodontia	50%	50%	50%	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: $250	Total Cost of Care	In-network: $150	Total Cost of Care	In-network: $950
	Out-of-network: $450		Out-of-network: $250		Out-of-network: $1,400

premier access

Deductible	In-network: $0	Deductible	In-network: $50	Deductible	In-network: $50
	Out-of-network: $0		Out-of-network: $50		Out-of-network: $50
	In-network: $1500		In-network: $1500		In-network: $1500
Annual Maximum (Plan Will Pay)	Out-of-network: $1500	Annual Maximum (Plan Will Pay)	Out-of-network: $1500	Annual Maximum (Plan Will Pay)	Out-of-network: $1500
Patient Cost (copayment or coinsurance)	In-network: 0%	Patient Cost (copayment or coinsurance)	In-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 50%
	Out-of network: 10%		Out-of network: 30%		Out-of network: 50%
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: $80	In this example, Maria would pay (includes copays/ c oinsurance and deductible, if applicable):	In network: $525
	Out-of network: $45		Out-of network: $125		Out-of network: $700
Summary of what is not covered or subject to a limitation:	Exam, x-rays and cleaning are subject to frequency limitations.	Summary of what is not covered or subject to a limitation:	Fillings paid once per tooth in 12 months if under age 19, and once per tooth in 36 months if over age 19.	Summary of what is not covered or subject to a limitation:	If plan does not include porcelain coverage on posterior teeth, a metal crown benefit will be paid.