PREMIER ACCESS
Dental and Vision

DHMO500 BENEFITS

DESCRIPTION	ADA code	DHMO 500 COPAY
Preventive Services		
Periodic Oral Exam	D0120	$0
Comprehensive Exam	D0150	$0
Full Mouth Series (FMX)	D0210	$0
Panoramic	D0330	$0
Periapical X-rays	D0220	$0
Bitewings- four films	D0274	$0
Adult Cleanings	D1110	$0
Child Cleanings	D1120	$0
Adult/Child Fluoride Treatment	D1203/1204	$0
Sealants 1st and 2nd Molars	D1351	$10.00
Space Maintainers	D1525	$25.00
Basic Services		
Restorations - Amalgam Fillings	D2161	$0
Extractions - Erupted tooth	D7140	$5.00
Surgical Removal - Erupted tooth	D7210	$25.00
Root Canal Therapy - Anterior	D3310	$55.00
Root Canal Therapy - Bi-cuspid	D3320	$120.00
Root Canal Therapy - Molar	D3330	$250.00
Scaling & Root Planing, per quadrant	D4341	$25.00
Major Services		
Crowns	D2750	$165.00
Bridges - per unit	D6210	$165.00
Complete Denture - per arch	D5110	$140.00
Partial Denture - per arch	D5211	$120.00
Orthodontia (Child)	D8080	$1975.00 †
(Adult)	D8090	$2175.00 †

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

Premier Access Dental and Vision provides you and your family with quality dental benefits at an affordable cost. The program is designed to encourage regular dentist visits to maintain oral health. When enrolling, you select a contracted dentist to provide services for you and your family. The size of a provider network is meaningless without the assurance of quality care. Our dental providers consist of dental facilities that have been carefully screened for quality.

Plan Benefit Highlights

- Posterior Composites
- Oral Cancer Screening
- Additional Cleanings
- Cosmetic Procedures such as Labial Veneers & External Bleaching
- Defined Fees for Metal Upgrades
- Unlimited Benefits*
- General Anesthesia and IV Sedation Covered

Why Choose Premier Access?

- ☑ A-Rated by AM Best
- ☑ Over 4000 Provider Access Points
- ☑ Over 20 years in the Managed Care Business

The Patient Charge Schedule is a summary of the covered services. Please check the Evidence of Coverage for full details. These services are covered only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Premier Access Dental and Vision as described in your plan documents. The benefits shown are performed as deemed appropriate by the attending Primary Care Dentist (PCD) subject to the limitations and exclusions of the program. Enrollees should discuss all treatment options with their PCD prior to services being rendered.

Our Member Services Department is available Monday thru Friday 8 a.m. to 6 p.m. to answer questions and provide any help you may need at 866.650.3660

* refer to your Evidence of Coverage for details

Exclusions and Limitations

The following dental Benefits are excluded:

1. Treatment which: a) is not included in the list of Covered Services; b) is not Dentally Necessary; or c) is Experimental or Investigational Service.
2. Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
3. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the policy.
4. Replacement of a lost or stolen appliance including but not limited to, full or partial dentures, space maintainers and crowns and bridges.
5. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions, unless specifically listed as a covered procedure on Schedule A.
6. Missed dental appointments. A fee of $25 may be charged by your Primary Care Dentist for failure to cancel an appointment without 24 hours prior notification.
7. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
8. Treatment for a jaw fracture.
9. Services or supplies provided by a dentist, dental hygienist, denturist or doctor who is: a) a close relative or a person who ordinarily resides with You or an Eligible Dependent; b) an employee of the employer; c) the employer.
10. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
11. Services and supplies obtained while outside the United States, except for Emergency Care.
12. Services or supplies resulting from or in the course of your or your Eligible Dependent's regular occupation for pay or profit for which you or your Eligible Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify Us of all such benefits.
13. Any Charges which are:

a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and supplies.
b. Not imposed against the person or for which the person is not liable.
c. Reimbursable by Medicare Part A and Part B. If an Eligible Person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her Benefits under this policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for Eligible Persons insured under employers who notify Us that they employ 20 or more employees during the previous business year, this exclusion will not apply to an actively at work employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this policy instead of coverage under Medicare.

14. Services and supplies provided primarily for cosmetic purposes, except as specified in Schedule A.
15. Services and supplies which may not reasonably be expected to successfully correct the Member's dental condition for a period of at least three years, as determined by Us.
16. Orthodontic services, supplies, appliances and orthodontic-related services, unless an orthodontic rider was included in the policy.
17. Extraction of asymptomatic, pathology-free third molars (wisdom teeth).
18. Therapeutic drug injection.
19. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
20. General anesthesia or intravenous/conscious sedation, except as specified in Schedule A.
21. Excision of cysts and neoplasms, except as specified in Schedule A.
22. Osseous or muco-gingival surgery, except as specified in Schedule A.
23. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes, except as specified in Schedule A.
24. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The covered charge for the services is based on the single dental procedure code that accurately represents the treatment performed.
25. Replacement of stayplates.
26. Dispensing of drugs not normally supplied in a dental office.
27. Malignancies.
28. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
29. The member will be responsible for the actual metal fees for any procedure involving the use of noble, high noble, or titanium metal.
30. Implant-supported dental appliances, implant placement, maintenance, removal and all other services associated with dental implants.
31. Dental services that are received in an Emergency Care setting for conditions which are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.
32. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.

Limitations of Other Coverage:

1. This dental coverage is not designed to duplicate any Benefits to which Members are entitled under government programs, including CHAMPUS, Medi-Cal or Workers' Compensation. By executing an enrollment application, a Member agrees to complete and submit to the Plan such consents, releases, assignments, and other documents reasonably requested by the Plan or order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.
2. Benefits provided by a pediatric dentist are limited to children under six years of age following an attempt by the assigned Primary Care Dentist to treat the child and upon Prior Authorization by Premier Access Dental and Vision, less applicable Copayments.

Diagnostic and Preventive Benefits Limitations

- Bitewing x-rays are now limited to two series within any 12-month period.
- Full mouth and panoramic x-rays are now limited to once every 3 years, unless medically necessary.
- Prophylaxis services (cleanings) are now limited to two per 12-month period.
- Dental sealants are now limited to children through the age of 15 years.

Restorative Dentistry

- Covered services now include posterior composite fillings.

Periodontics

- Periodontal maintenance is now limited to 2 treatments per 12 months.

Crown and Fixed Bridge

- The plan now covers treatment plans in excess of 5 units. There is an additional copayment of $125 per unit for any treatment for 7 or more units.
- The plan covers porcelain restorations on posterior teeth for an additional copayment of $75 per unit.

Prosthodontics

- The new plans include an exception to the 5 year replacement limitation to situations where there has been additional loss of natural functioning teeth.