premier access

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Premier Access
Type of Product Line: PPO
Effective Date: September 01, 2025 - August 31, 2026
Name of Product: D-PBC1D1M3O1
Plan Phone #: (888) 715-0760
Plan Website: 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 PLAN WEBSITE www.premierlife.com OR CALL (866) 715-0760.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	Individual Deductible per Calendar Year $50 (Family Deductible Maximum of 3 Family Members)	Individual Deductible per Calendar Year $50 (Family Deductible Maximum of 3 Family Members)
Orthodontia	[None]	[None]

- **The deductible applies to all services except Preventive.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan 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 plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	$2,000	$2,000
Lifetime or Annual Maximum for Orthodontia	$0	$0

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum.**
- **Lifetime maximum** means the maximum dollar amount your plan 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 or services for all or certain dental treatments. Your dental benefit package has no waiting period.

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	Preventive & Diagnostic	0%	0%	Limited to 2 oral exams per rolling 12 months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Bitewing X-ray	Preventive & Diagnostic	0%	0%	Limited to 8 bitewings per rolling 12 months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Cleaning	Preventive & Diagnostic	0%	0%	Limited to 2 prophylaxis per rolling 12 months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.

Common Dental Procedures	Category	In-Network	Out-of- Network	Benefit Limitations and Exclusions
Filling	Basic	20%	20%	Limited to 1 filling per tooth per rolling 12 months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Extraction, Erupted Tooth or Exposed Root	Basic	20%	20%	Limited to 1 extraction per tooth per lifetime. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Root Canal	Basic	20%	20%	Limited to 1 root canal therapy per 24 months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Scaling and Root Planing	Basic	20%	20%	Limited to 1 scaling and root planning procedure per quadrant per rolling 24 months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Ceramic Crown	Major	50%	50%	Limited to 1 crown per tooth per rolling 60 Months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Removable Partial Denture	Major	50%	50%	Limited to 1 prosthodontic appliance per arch per rolling 60 months period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Extraction, Erupted Tooth with Bone Removal	Basic	20%	20%	Limited to 1 extraction per tooth per lifetime. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Orthodontia	Orthodontia	Not Covered	Not Covered	Not Applicable.

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 product to other dental products 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 (full mouth x-ray) 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 Out-of-Network: $450	Total Cost of Care	In-Network: $150 Out-of-Network: $250	Total Cost of Care	In-Network: $950 Out-of-Network: $1,400
Deductible	In-Network: $0 Out-of-Network: $0	Deductible	In-Network: $50 Out-of-Network: $50	Deductible	In-Network: $50 Out-of-Network: $50
Annual Maximum (Plan Will Play)	In-Network: $2000 Out-of-Network: $2000	Annual Maximum (Plan Will Play)	In-Network: $2000 Out-of-Network: $2000	Annual Maximum (Plan Will Play)	In-Network: $2000 Out-of-Network: $2000
Patient Cost (copayment or coinsurance)	In-Network: $0 Out-of-Network: $0	Patient Cost (copayment or coinsurance)	In-Network: $20 Out-of-Network: $40	Patient Cost (copayment or coinsurance)	In-Network: $450 Out-of-Network: $675
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-Network: $0** **Out-of-Network: $0**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-Network: $70** **Out-of-Network: $90**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-Network: $500** **Out-of-Network: $725**
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.