

- No charge for dental exams for one full year
- Save 40% or more on almost all dental services
- No yearly dollar maximum of coverage
- No deductible & No claim forms
- Easy enrollment



It's Easy To Enroll

Just fill out the enrollment form on the other side of this brochure.

- Sign your name to authorize enrollment.
- Enclose a check or fill in the credit card information for the coverage type you choose.
- Your member card confirming enrollment will be sent within 15 days.

Enrolling Is Easy With These Low Annual Premiums

(All premiums are pre-paid)

- Individual \$75.00/year
- Individual & one dependent \$115.00/year
- Family \$150.00/year

Limitations And Exclusions

- All fees are for services as performed by an Access Dental general dentist
- Dispensing of drugs & general anesthesia
- Loss or theft of dentures or bridgework
- Temporomandibular Joint Syndrome (TMJ)
- Hospital dentistry
- Charges for gold are not included in co-payments

CERTIFICATE OF INSURANCE

Contains Detailed Limitations and Exclusions.

The Individual Plan Join, And Save On All Your Dental Care

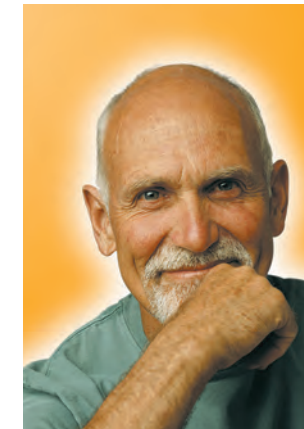
SERVICES	NON-MEMBER COST**	MEMBER COST	YOU SAVE
Examination	\$95	NC	\$95
X-rays	\$149	\$85	\$64
Annual Routine Cleaning	\$98	\$70	\$28
Deep Cleaning (Root Planing, per quad.)	\$266	\$165	\$101
1 Surface White Filling	\$203	\$155	\$48
2 Surface White Fillings	\$260	\$195	\$65
Full Precious Metal Crown Porcelain w/Precious Metal Crown	\$1105	\$990	\$115
Full Metal Crown* Porcelain w/Metal Crown*	\$1038	\$690	\$348
Full Upper/Lower Denture (each)	\$1803	\$1018	\$785
Root Canal, Anterior (front teeth)	\$822	\$563	\$259

*Non-precious metal

**Estimated usual customary fees in California

We've
Got You
Covered
With

The Individual Plan



Savings On
Typical
Procedures
Can Add Up
To Hundreds
Of Dollars



MAY 2009

Member Services 800.707.6453

or visit our web site at: www.premierppo.com

Individual Plan Benefit Schedule

Available at Access Dental Centers

COVERED SERVICES

DIAGNOSTIC & PREVENTATIVE

	Copays Required
Full mouth X-rays	85.00
Single film	21.00
Each additional film	17.00
Oral examination and diagnosis	No Charge
Office visits	No Charge
Recall Exam	No Charge
Prophylaxis (teeth cleaning and polishing) (one every six months)	70.00
Prophylaxis/fluoride (up to age 18)	67.00
Preventative dental education	No Charge

RESTORATIVE DENTISTRY (White Fillings)

Posterior restorations (Back Teeth)	
Cavities involving one tooth surface	155.00
Cavities involving two tooth surfaces	195.00
Cavities involving three tooth surfaces	255.00
Cavities involving four or more tooth surfaces	295.00
Sedative base	No Charge
Anterior restorations: (Front Teeth)	
One surface filling	127.00
Two surface fillings	151.00

CROWN AND BRIDGE

Porcelain fused to metal crown (non-precious)	690.00
Full metal crown (non-precious)	690.00
Stainless steel (primary)	207.00
Stainless steel (permanent)	233.00
Plastic core or amalgam build up	194.00
Recementation of crown (per unit)	76.00

ORAL SURGERY

Extractions-simple, with local anesthetic	135.00
Surgical extraction	235.00
Soft tissue impaction	295.00
Partially bony impaction	395.00
Full bony impaction	475.00
Nitrous anesthesia (if available)	41.00

COVERED SERVICES

PERIODONTICS (Treatment of Gums)

Emergency treatment/perio.	117.00
Root planing (curettage) per quad (considered as single procedure)	165.00

ENDODONTICS (Root Canal Therapy)

Emergency treatment/endo.	117.00
Pulp capping	59.00
Base/liner	No Charge
Pulpotomy	122.00
Root canals:	
Single rooted canal therapy	563.00
Bi-rooted canal therapy	687.00
Tri-rooted canal therapy	831.00

PROSTHETICS (Dentures)

Complete maxillary denture (upper)	1018.00
Complete mandibular denture (lower)	1018.00
Partial acrylic upper or lower with chrome cobalt alloy clasps-base free	1125.00
Denture reline (laboratory processed)	282.00
Office Reline-Cold cure	224.00
Broken denture repair (no teeth involved)	154.00
Replace teeth (each tooth)	130.00

OTHER CHARGES

After hour emergency (Excludes services)	100.00
Broken/cancelled appointment (without 24 hours notice)	35.00

Services listed are as performed by a general dentist, specialist services are on a fee-for-service basis. Any procedure not listed in the above schedule is available at 80% of the professional provider's usual and customary fee schedule.

POLICY CERTIFICATE

Detailed Limitations and Exclusions as well as other services offered are listed in full in the Policy Certificate.

The Individual Plan is underwritten by Premier Access Insurance Company.

If you have any questions or need help filling out the enrollment form, call **800.707.6453**

INDIVIDUAL ENROLLMENT FORM

Tear off and mail with payment INDIVIDUAL PLAN

Office No.

1. Name (Last) _____ (First) _____ (MI) _____ Sex: _____ Date Of Birth: _____
 Address _____ Soc. Sec. No. _____ Home Ph. _____
 City _____ State _____ Zip Code _____ Employer _____ Work Ph. _____
 Member only Member plus one dependent Family Access Office Location: _____ Email _____

Please List Eligible Dependents To Be Enrolled:

Spouse:	Sex	Birth Date	Child	Sex	Birth Date
_____	_____	____-____-____	Child	_____	____-____-____
_____	_____	____-____-____	Child	_____	____-____-____

2. ANNUAL PAYMENT: My annual premium is enclosed.
 I will be paying by: Cash Check Visa Mastercard Discover American Express
 Credit Card # _____ Exp. Date _____ Total Amount Enclosed \$ _____

3. I wish to enroll in the benefit plan as indicated. After payment of the annual prepayment fee, you may cancel the contract at any time. However, the plan will not refund any portion of the annual prepayment fee. I understand that all necessary covered dental services will be charged as described in the Plan Contract.
 Signature _____ Date _____

4. Send payment and enrollment form to: ACCESS DENTAL PO Box 659005, Sacramento, CA 95865-9005