PREMIER ACCESS
QUALITY DENTAL PLANS

QUICK REFERENCE GUIDE
CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Thank you for being a PREMIER ACCESS provider. We appreciate your effort in helping to provide quality service to our CHIP members. This guide is designed to assist with servicing PREMIER ACCESS CHIP members. We have included key information to help you service our members, as well as important contact information for Premier Access representatives.

Preauthorization Requirements

- Preauthorization is required for certain basic and major services (please refer to Plan Highlights section on reverse side).
- Preauthorization is waived under the following circumstance:
  A member requires sedation to examine and treat (same day): The claim filing for sedation and major treatment on a single date of service must include a statement that the child required sedation for exam/treatment. If x-rays are required for the procedure(s) to be performed, x-rays should be taken while the member is sedated for exam/treatment and submitted with the claim. Claim will be reviewed with the submitted x-rays.
- Voluntary preauthorization is available upon request for all other services.

When preauthorization is required, it must be obtained prior to treatment. Preauthorization requests require pre-treatment x-rays.
If proper authorization is not obtained prior to treatment, the member cannot be charged for the services. Preauthorization may be expedited on an exception basis, including rural treatment settings where the patient has traveled to an appointment..

Non-Covered Services: A non-covered service is a service that is not included in the Schedule of Benefits, is not medically necessary, or exceeds the member's annual dental benefit maximum. The provider is responsible for informing the member that a service is not covered before treatment is provided and that the member will be responsible for paying for the services. If the member chooses to receive the services after being informed, the member is responsible for payment up to the contracted fee.

Balance Billing: Members may not be balance billed for covered services. Services that exceed plan limits may be balance billed up to the contracted fee when the member is notified prior to services.

Emergency & Urgent Care: To be covered by Premier Access, emergency and urgent care services must meet the criteria provided below:

Emergency Care

A dental condition, including severe pain, manifesting itself by acute symptom of sufficient severity such that the absence of immediate attention could reasonably be expected to result in any of the following: placing the member's dental health in serious jeopardy, causing serious impairment to the member's dental functions, or causing serious dysfunction of any of the member's bodily organs or parts.

Urgent Care

Services needed to prevent serious deterioration of the patient's health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The urgent care service must be needed because the illness or injury will become much more serious if delayed for a regular doctor's appointment.

Appointment Wait Times: Emergency & urgent care appointments must be given within **24** hours of a member's call. If you are unable to see the member within 24 hours, advise them to contact Premier Access for assistance. **New patient and routine (non-emergency) appointments** must be given **within 3 weeks** from the date of the member's request.

Broken Appointments: Members may not be charged for broken/failed appointments.

Contact Information

DEPARTMENT	PURPOSE	CONTACT
Member Services	Check eligibility, verify benefits and covered services. Check claims status or status of referral/prior authorization requests.	Phone: 877-854-4242 Email: CustomerService@PremierLife.com
Claims and Preauthorizations	Submit claim or preauthorization requests. Electonic attachments can be submitted through **www.nea-fast.com**	Electronic claims: UHIN, Apex and Emdeon Payer ID: CX110 Mail: P.O. Box 659010, Sacramento, CA 95865-9010 Fax: 877-679-7197
Provider Services	Ask questions about your contract or obtain credentialing information	Phone: 888-620-2447 Email: ProviderRelations@PremierLife.com
	Provider Manual and administrative forms	www.PremierLife.com

Plan Highlights

There are four (4) CHIP dental plans. The member's Premier Access ID card will identify the correct plan. All plans have an Annual Dental Benefit Maximum of $1,000. Please refer to the CHIP Schedule of Benefits for a detailed description of covered procedures, limitations and exclusions and the appropriate coinsurance based on the member's plan. The member is responsible for the coinsurance and deductibles at the time of service.

Category	Preauthorization & Pre-op X-ray Requirements	X-ray Required with Claim*
PREVENTIVE & DIAGNOSTIC	No Preauthorization Required	X-rays required with claims for space maintainers (D1510, D1515, D1520, D1525)
EMERGENCY SERVICES	No Preauthorization Required	
BASIC SERVICES • *Sealants, benefits are limited to caries free molars through age 15 (one per 24 months)* • *Amalgam and composite restorations do not require preauthorization. Posterior composites are limited to the corresponding amalgam benefit. X-rays must be provided upon request.* • *Prefabricated Stainless Steel Crowns (Primary) do not require preauthorization; however, x-rays must be submitted with the claim. (Stainless steel crowns on permanent teeth are covered under Major services.)* • *Prophylactic removal of 3rd molars is not covered.* • *General Anesthesia and IV Sedation limited to covered oral surgeries and select endodontic and periodontal surgical procedures.* • *X-rays are not required for simple extractions but are required for all surgical extractions.* • *Orthodontic extractions are covered. X-rays required with claim.*	No Preauthorization Required	X-rays required with claims for the following procedure codes: D2930, D2933, D2934 (Preauthorization is not required) X-rays required with claims for the following oral surgery procedures: D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7280, D7283, D7310, D7311, D7320, D7321, D7960, D7971
Endodontics ***(Direct, Indirect Pulp capping, therapeutic pulpotomies do not require preauthorization)***	Preauthorization with Preoperative X-rays required for the following procedure codes: D3310, D3320, D3330, D3333, D3346, D3346, D3347, D3348, D3351, D3352, D3353, D3410, D3421, D3425, D3426, D3430, D3450, D3460, D3920	Post-operative x-rays required for the following procedure codes: D3310, D3320, D3330, D3346, D3346, D3347, D3348
Periodontics ***(Current periodontal charting is required with preauthorization requests)***	Preauthorization is required for the following procedure codes: D4210, D4211, D4355 Preauthorization with Preoperative X-rays required for the following procedure codes: D4245, D4249, D4260, D4261, D4263, D4264, D4266, D4267, D4270, D4271, D4273, D4275, D4321, D4341, D4342	
MAJOR SERVICES		
Crowns, Inlays, Onlays and Bridges	Preauthorization with Preoperative X-rays required for the following procedure codes: D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2910, D2931, D2950, D2952, D2953, D2954, D2957, D2960, D2961, D2962, D2999	
Dentures	Preauthorization with x-rays required for the following procedure codes: D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5820, D5821	
Fixed Prosthodontics	Preauthorization with x-rays required for the following procedure codes: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6250, D6545, D6602, D6603, D6604, D6605, D6606, D6607, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6720, D6721, D6722, D6750, D6751, D6752, D6780, D6781, D6782, D6790, D6791, D6792, D6794, D6930, D6940, D6970, D6972, D6973	
Implants	Preauthorization with x-rays is required for all Implant procedures. For implant procedures, an allowance will be made towards the cost of the appliance actually placed on the implant (crown, bridge, partial or complete denture). If such an allowance is made payment will not be made for any replacement until 5 years have elapsed.	
ORTHODONTIA	Lifetime maximum: $1,000. Refer to the Schedule of Benefits for member co-insurance under each plan.	

* For claims review purposes, x-rays may be requested for procedures that do not otherwise require x-rays for standard processing.