



Lifespan A  
Delta Dental Premier<sup>SM</sup>  
Plan Type: National Coverage



**Calendar Year Maximum:**  
Standard: \$1,200  
High: \$1,500

**Annual Deductible:**  
Standard: N/A  
High: N/A

**Orthodontic Lifetime Maximum:**  
Standard: N/A  
High: \$1,500

**P** Pre-treatment Estimate recommended  
**D** Deductible applies

Procedure	Standard	High	Frequency / Limitations
<b>Diagnostic</b>			
Oral Exam	100%	100%	Once per calendar year
Bitewing x-rays	100%	100%	One set per calendar year
Complete x-ray series or panoramic film A	100%	100%	Once every 60 months with the Standard Plan. Once every 36 months with the High Plan.
Single x-rays	100%	100%	As required
<b>Preventive</b>			
Cleanings	100%	100%	Twice per calendar year.
Fluoride treatment	100%	100%	For children under age 19, once per calendar year with the Standard Plan. Twice per calendar year with the High Plan.
Sealants	100%	100%	For children under age 14, once every 36 months on unrestored permanent molars.
Space Maintainers	80%	100%	Replacement limited to once every 60 months for lost deciduous (baby) teeth.
<b>Minor Restorative</b>			
Fillings	80%	100%	Amalgam (silver) fillings and composite (white) fillings. For composite fillings on back teeth the plan pays what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge. <b>*Composite fillings are covered on all teeth with the High Plan only.</b>
Repairs to existing partial or complete dentures	80%	100%	Once per calendar year
Recementing crowns or bridges	80%	100%	Once every 60 months
Rebasing or relining of partial or complete dentures	80%	100%	Once every 60 months
<b>Major Restorative</b>			
<b>P</b> Crowns over natural teeth, build ups, posts and cores	50%	100%	Replacement limited to once every 60 months
<b>Endodontics</b>			
Root canal therapy on permanent teeth	80%	100%	One procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
<b>Periodontics</b>			
Periodontal maintenance following active therapy	50%	100%	Two per calendar year
<b>P</b> Root planing and scaling	50%	80%	Once per quadrant every 24 months
<b>P</b> Osseous (bone) surgery	50%	80%	Once per quadrant every 36 months
<b>P</b> Gingivectomies	50%	80%	Once per site every 36 months
<b>P</b> Soft tissue grafts	50%	80%	Once per site every 60 months
<b>P</b> Crown lengthening	50%	80%	Once per site every 60 months
<b>P</b> Guided tissue regeneration and bone replacement graft	N/A	80%	Once per site every 24 months
<b>Prosthodontics</b>			
<b>P</b> Bridges and crowns over implants	50%	50%	Replacement limited to once every 60 months
<b>P</b> Partial and complete dentures	50%	50%	Replacement limited to once every 60 months
<b>Extractions and Oral Surgery</b>			
Extractions and other routine oral surgery	80%	100%	When not covered by a patient's medical plan
<b>P</b> Surgical placement of endosteal implant and abutment	N/A	50%	Once per tooth site per lifetime
<b>Orthodontics</b>			
<b>P</b> Elective braces and related services	A	50%	For dependent children under the age of 19. Subject to a lifetime maximum. No pre-approval required.
<b>Other Services</b>			
Palliative treatment (minor procedures necessary to relieve acute pain)	80%	100%	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	80%	100%	
Occlusal guards	N/A	50%	

**Dependent coverage:** Dependent children are covered up until the end of the month that they turn age 26.

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Summary Plan Description (SPD) for the full plan terms. The SPD includes any limitations or exclusions not seen here. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

**Time limits** on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

### Unless specifically covered by your dental plan, the following are not covered:

- Services that are not dentally necessary and appropriate according to our review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; orthodontics; and oral surgery. We will make a decision whether a service is dentally necessary based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a dentist. Our guidelines can be found on our website at [www.deltadentalri.com](http://www.deltadentalri.com). You can have your dentist send us a request for a pre-treatment estimate in advance of the service to see if the service meets our guidelines.
- Services greater than the annual maximum.
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that Delta Dental decides is employment-related.
- Services you would not have to pay for if you did not have this Delta Dental coverage.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a dentist who is a member of your immediate family.
- An illness, injury or dental condition for which benefits are, or would have been available, through a government program if you did not have this Delta Dental coverage.
- Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.
- Disorders related to the temporomandibular joints (TMJ), including occlusal orthotic device and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations needed because of teeth grinding or due to erosion, abrasion or attrition.
- Services done mainly to change or to improve your appearance.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Prescription drugs.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.
- General anesthesia or intravenous sedation given by anyone other than a dentist.

Delta Dental can adopt; and, apply, policies that we deem reasonable when we approve the eligibility of subscribers; and, the appropriateness of treatment plans and related charges.

**All claims must be filed within one year of the date of service.**