Delta Dental PPO Plus Premier
National Coverage

Schedule of Benefits for University of Arkansas System

a) **Original Effective Date:** 12:01 a.m. Central Standard Time, July 1, 1997
**Renewal Effective Date:** January 1 Each Year
**Benefits Effective:** January 1, 2012

b) **Group Number:** 9304 (effective 1-1-2005)

c) **Deductible:** $50 for benefits received in Coverage B and Coverage C with a maximum of $100 per family, per benefit period. There is no deductible on Coverage A.

d) **Annual Maximum Payment:** $1,500 Per Person Per Calendar Year.

e) **Benefit Period:** A benefit period for each eligible participant shall mean a calendar year, the period from January 1st to December 31st of each year.

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Delta Dental Preferred (PPO) or Delta Dental Premier</th>
<th>Non-Delta Dental Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A Charges – Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanings</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Exams</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>X-Rays</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Type B Charges – Basic Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>80%</td>
<td>72%</td>
</tr>
<tr>
<td>Extractions</td>
<td>80%</td>
<td>72%</td>
</tr>
<tr>
<td>Root Canals</td>
<td>80%</td>
<td>72%</td>
</tr>
<tr>
<td><strong>Type C Charges – Major Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Bridges</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Partialias</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Implants</td>
<td>50%</td>
<td>45%</td>
</tr>
</tbody>
</table>

You have the freedom to choose any licensed dentist for covered services. However, it works to your advantage to choose a dentist from one of the two different Delta Dental networks available to you. In order to obtain the deepest discounts and to incur the least amount of out-of-pocket expenses, please choose a dentist from the Delta Dental Preferred (PPO) network of providers.

**Evidence Based Dentistry:** Additional routine cleanings or periodontal maintenance procedures (up to four per year) are covered for covered members with diabetes, heart disease, who are pregnant or have a history of periodontal disease. The additional benefits may not be combined by those with more than one of the above conditions.
Covered Services:

**Coverages and Maximum Plan Allowances**

**Coverage A – Diagnostic and Preventative Services**

- In-Network: 100%
- Routine periodic examinations not more than twice in any benefit period, inclusive of an initial oral examination.
- Bitewing and periapical X-rays as required.
- Full-mouth X-rays once in any three (3) year period.
- Prophylaxis (cleaning).
- Topical application of fluoride once per benefit period for dependent children to age nineteen (19).
- Sealants once per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface, for dependent children to age nineteen (19).

**Coverage B – Basic Restorative Services**

- In-Network: 80%
- Minor emergency treatment for the relief of pain as needed by the participant.
- Amalgam (silver) and composite/resin (white) fillings.
- Endodontics, including pulpal therapy and root canal filling.
- Simple and surgical extractions.
- Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.
- Space maintainers for prematurely lost teeth of eligible dependent children to age sixteen (16).
- Stainless steel crowns used as a restoration to natural teeth for dependent children to age sixteen (16) when the teeth cannot be restored with a filling material.
- Surgical periodontics.
- Non-surgical periodontics.
- Periodontal maintenance; two (2) per benefit period following active periodontal treatment.
- Antibiotic injections when given by the dentist.

**Coverage C – Major Restorative Services**

- In-Network: 50%
- Crowns, inlays, onlays, and veneers are benefits for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
- Prosthodontics, including procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges.
- Repairs and recementing of crowns, inlays, bridgework or dentures.
- Complete or partial denture reline, including chair side or laboratory procedures to improve the fit of the appliance to the tissue.
- Complete or partial denture rebase, including laboratory replacement of the acrylic base of the appliance.
- Endosteal Implants

**Rider(s)**

- Carryover Benefit Rider
  - Carryover Benefit: $375
  - Claims Threshold: Less than $750
  - Carryover Benefit Maximum: $1,500

The benefit allowance for services of an out-of-network dentist will be reduced by 10% for eligible services as determined by Delta Dental after applying the applicable deductibles, co-payments and maximums. This means your out-of-pocket expense may be greater if you choose an out-of-network dentist.

Questions? Contact Delta Dental’s Customer Service Department at (800) 462-5410.

**Delta Dental’s network of participating providers may be found on our website at**


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