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, 2010

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></td>
<td><strong>In-Network</strong></td>
<td></td>
</tr>
<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>Partial</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.
### 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 [www.deltadentalar.com](http://www.deltadentalar.com).*