



**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.

Schedule of Benefits	DeltaPreferred (DPO) or DeltaPremier	Non-Delta Provider
	<i>In-Network</i>	<i>Out-of-Network</i>
Type A Charges – Preventive Care		
Cleanings	100%	90%
Exams	100%	90%
X-Rays	100%	90%
Type B Charges – Basic Care		
Fillings	80%	72%
Extractions	80%	72%
Root Canals	80%	72%
Type C Charges –Major Care		
Crowns	50%	45%
Bridges	50%	45%
Partials	50%	45%
Implants	50%	45%

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 DeltaPreferred network of providers.

Delta Dental's network of participating providers may be found on our website at www.deltadental.com.

The terms of the contract, along with any amendments or endorsements issued by DDPAR, will in all cases be controlling. Should the wording of the contract, along with any amendments or endorsements issued by DDPAR conflict with the schedule of benefits and rates, application, or proposal, the contract, along with any amendments or endorsements issued by DDPAR governs.

f) **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.
- Repairs and recementing of crowns, inlays, bridgework or dentures.

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.
- 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.
- 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.

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