DELTA DENTAL®

Delta Dental PPO Plus Premier
National Coverage

Schedule of Benefits for University of Arkansas

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 1 to December 31 of each year.

Schedule of Benefits	**DeltaPreferred (PPO) or DeltaPremier**	**Non-Delta Provider**
	In-Network	***Out-of-Network***
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 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.

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.

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.
- Endosteal Implants

g) Carryover Benefit Rider

- Carryover Benefit: $375
- Claims Threshold: Less than $750
- Carryover Benefit Maximum: $1,500
- Must have received at least one covered service during calendar year to qualify

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.