



**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 1<sup>st</sup> to December 31<sup>st</sup> of each year.

Schedule of Benefits	Delta Dental Preferred (PPO) or Delta Dental Premier	Non-Delta Dental Provider
	<i>In-Network</i>	<i>Out-of-Network</i>
<b>Type A Charges – Preventive Care</b>		
Cleanings	100%	90%
Exams	100%	90%
X-Rays	100%	90%
<b>Type B Charges – Basic Care</b>		
Fillings	80%	72%
Extractions	80%	72%
Root Canals	80%	72%
<b>Type C Charges –Major Care</b>		
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.
- Repairs and recementing of crowns, inlays, bridgework or dentures.
- Complete or partial denture relines, 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.deltadental.com](http://www.deltadental.com).***