### Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental PPO Network (includes OSU Student Dental Clinic)</th>
<th>Delta Dental Premier Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$0</td>
<td>$50 per person</td>
<td>$100 per person</td>
</tr>
<tr>
<td><strong>Annual Maximum Benefit</strong></td>
<td>$1,500 per person&lt;sup&gt;1&lt;sup&gt;3&lt;/sup&gt;</td>
<td>$1,200 per person&lt;sup&gt;1&lt;sup&gt;3&lt;/sup&gt;</td>
<td>$1,200 per person&lt;sup&gt;1&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Orthodontics has a separate lifetime maximum of $1,200

#### Preventive Services
(includes: cleanings, sealants, fluoride treatments, and space maintainers; bitewing, full-mouth and panoramic X-rays)

- 100% of allowed amount; no deductible; no balance billing<sup>2</sup>
- 100% of allowed amount; no deductible; no balance billing<sup>2</sup>
- 100% of allowed amount; no deductible; subject to balance billing

#### Emergency Palliative Treatments

- 100% of allowed amount; no deductible; no balance billing<sup>2</sup>
- 100% of allowed amount; no deductible; no balance billing<sup>2</sup>
- 100% of allowed amount; no deductible; subject to balance billing

#### Endodontics (root canals)

- 80% of allowed amount, no deductible; no balance billing<sup>2</sup>
- 75% of allowed amount; after deductible; no balance billing<sup>2</sup>
- 70% of allowed amount; after deductible; subject to balance billing

#### Oral Examinations

- 100% of allowed amount; no deductible; no balance billing<sup>2</sup>
- 100% of allowed amount; no deductible; no balance billing<sup>2</sup>
- 100% of allowed amount; no deductible; subject to balance billing

#### Oral Surgery (includes impacted tooth extraction)

- 80% of allowed amount, no deductible; no balance billing<sup>2</sup>
- 75% of allowed amount; after deductible; no balance billing<sup>2</sup>
- 70% of allowed amount; after deductible; subject to balance billing

#### Orthodontics

- 100% of allowed amount, up to $1,200<sup>1</sup> no deductible
- 50% of allowed amount, up to $1,200<sup>1</sup> no deductible
- 50% of allowed amount, up to $1,200<sup>1</sup> no deductible

Coverage is only available for children up to age 19; $1,200<sup>1</sup> lifetime maximum benefit. Benefits are pro-rated and paid over the course of the treatment.

#### Periodontics (gum disease)

- 80% of allowed amount, no deductible; no balance billing<sup>2</sup>
- 75% of allowed amount; after deductible; no balance billing<sup>2</sup>
- 70% of allowed amount; after deductible; subject to balance billing

#### Prosthodontics (includes dentures, fixed bridgework, and implants)

- 55% of allowed amount, no deductible; no balance billing<sup>2</sup>
- 50% of allowed amount; after deductible; no balance billing<sup>2</sup>
- 50% of allowed amount; after deductible; subject to balance billing

#### Restorative Services – Major (includes cast restorations and crowns)

- 55% of allowed amount, no deductible; no balance billing<sup>2</sup>
- 50% of allowed amount; after deductible; no balance billing<sup>2</sup>
- 50% of allowed amount; after deductible; subject to balance billing

#### Restorative Services – Minor (includes fillings, and repair of bridgework crowns, dentures, and onlays)

- 80% of allowed amount, no deductible; no balance billing<sup>2</sup>
- 75% of allowed amount; after deductible; no balance billing<sup>2</sup>
- 70% of allowed amount; after deductible; subject to balance billing

#### Temporomandibular Disorder (TMD)

No coverage under the Dental Plan. Limited coverage is available under the Ohio State medical plans.

#### X-rays, All Others (includes all diagnostic)

- 80% of allowed amount, no deductible; no balance billing
- 75% of allowed amount; after deductible; no balance billing
- 70% of allowed amount; after deductible; subject to balance billing

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1 You are responsible for all costs over the maximums.  
2 For any optional treatment (defined as a service that is more expensive than what is customarily provided or for which Delta Dental does not determine that a valid dental need is shown), you are responsible for the costs over the allowed amount, regardless of whether or not the service is provided in-network.  
3 Some services are excluded from the annual maximum. A list of these services can be found in the Dental Plan – Specific Plan Details Document.

**NOTE:** This Dental Plan Summary Chart should be used as a general guide only. Refer to the Dental Plan - Specific Plan Details Document online at hr.osu.edu/benefits/dental for further information. If the information in the summary chart differs from the Specific Plan Details Document, the Specific Plan Details Document will govern.