Siegwerk USA Co.

Group Number: 33499

Low Plan

SUMMARY OF COVERAGE	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible per person per calendar year	$30*	$60*	$60*
Annual Benefit Maximum per person per calendar year	$1,000		

BENEFIT CATEGORIES	Coinsurance paid by member		
Diagnostic & Preventive Services routine check-ups, teeth cleaning, bitewing x-rays, full mouth x-rays, fluoride	0%	0%	0%
Routine & Restorative Services cavity repair, tooth extractions, general anesthesia/sedation, routine oral surgery	10%	20%	20%
emergency treatment	0%	0%	0%
Posterior Composites tooth-colored filling on back teeth	10%	20%	20%
Endodontic Services root canals and therapy	20%	20%	20%
Periodontal Services non-surgical procedures, gum and bone diseases, surgical procedures, perio maintenance therapy	20%	20%	20%
High Cost Restorations repair crowns, recementing crowns	20%	20%	20%
Prosthetics bridges, dentures	50%	50%	50%
To Go℠	Annual benefit maximum carry over.		

*Deductible is waived for diagnostic and preventive care.

Deductible does not apply to emergency treatment.

Percentages shown are what the member pays. Eligible children to age 26. Full-time (unmarried) students eligible to age 26.

The information on this page summarizes your benefits. This is a general description of your benefits. If you do not see a service listed, please see your benefits document for a full description of coverage.