

## Fayette County Schools PPO Low Plan (00781801)

**Product:** DPPO

**Network:** DentaSelect Plus

**Benefit Year:** The 12 month period beginning January 1st and ending December 31st (calendar year)

**Annual Maximum Benefit:** \$1000 per Member

**Orthodontic Lifetime Maximum Benefit:** \$0 per Eligible Member

**Deductible:** Deductible for services provided by an In-Network Provider

\$50 per Member, per Benefit Year

\$150 per Family, per Benefit Year

Deductible for services provided by an Out-of-Network Provider

\$50 per Member, per Benefit Year

\$150 per Family, per Benefit Year

The deductible applies to Basic and Major Benefits only

Any deductible amount that is satisfied will be applied toward both the In-Network and Out-of-Network deductibles

Covered Dental Services	Deductible Applied	In Network		Out-of-Network	
		Percentage of Allowable Expense Paid by the Plan	Member Copayment	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None	100%	None
Basic Benefits	Yes	50%	50%	50%	50%
Major Benefits	Yes	25%	75%	25%	75%

Out of network claims are reimbursed at the Match level.

**Endodontic Services** are covered as Major Benefits.

**Periodontic Services** are covered as Major Benefits.

**Sealants** are covered as Preventive Benefits.

Dependent children are eligible for coverage until age 26.

A complete description of covered services, limitations and exclusions is available in the Certificate of Insurance.

Members who receive services from a non-participating provider are subject to balance billing.

**For more information, contact your benefits administrator  
or visit [DentalCarePlus.com](http://DentalCarePlus.com).**

**T H E P L U S I S S E R V I C E**