DentalVision

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Farm Bureau HEALTH PLANS Tennessee

DELTA DENTAL®

Highlights: *DentalVision, offered through Farm Bureau Health Plans, uses Delta Dental PPO Plus Premier and VSP Choice provider networks. Network payments are based on negotiated fees.*

If an Out-of-Network provider is used, the individual's liability will increase significantly.

Dental Benefits						
	0-12 Months		13-24 Months		25+ Months	
Maximum Payment per individual per year	$500		$1,000		$1,500	
Deductible (excludes diagnostic and preventative and orthodontic) per individual per year	$50/$150		$50/$150		$50/$150	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Diagnostic and Preventative						
Diagnostic and Preventative Services - Exams, cleanings, fluoride, and space maintainers	100%	80%	100%	80%	100%	80%
Covered Services						
Minor Restorative Services - Simple extractions, fillings, stainless steel crowns and crown repair	50%	40%	80%	60%	80%	60%
Emergency Palliative Treatment - To temporarily relieve pain						
Brush Biopsy - To detect oral cancer						
Sealants (under age 16) - To prevent decay of permanent teeth						
Endodontic Services - Root canals	25%	10%	25%	10%	50%	40%
Periodontic Services - To treat gum disease						
Oral Surgery Services						
Implants						
Relines and Rebases - To partial or complete dentures						
Prosthodontic Services - Fixed bridges, partial or complete dentures, bridge repair						
Major Restorative Services - Major crowns, cast restorations, veneers (limited)						
Bleaching/Whitening	25%	10%	25%	10%	50%	40%
Orthodontics (all ages)	0%	0%	50%	40%	50%	40%
Orthodontics Lifetime Maximum	N/A		$1,000		$1,000	

Deductible is per individual per calendar year up to $150 maximum for family coverage.

Benefit levels are based upon number of months specific individual is enrolled in coverage.

When services are received from a non-participating dentist, the percentages in this column indicate the portion of Delta Dental's PPO Plus Premier Dentist Schedule (or the non-participating dentist fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and the individual will be responsible for that difference.

Farm Bureau HEALTH PLANS Tennessee

vsp

Your Coverage With a VSP Provider			
Vision Benefits	**Description**	**Copay**	**Frequency**
WellVision Exam	• Focuses on eyes and overall wellness • KidsCare: Children have two, fully covered WellVision exams, if needed	$15	Every calendar year
Prescription Glasses		$35	See frames and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over allowance • KidsCare: Frames for children are covered up to the plan allowance every calendar year	Included in prescription glasses copay	Every other calendar year
Lenses	• Single vision, lined bifocal and lined trifocal lenses • Polycarbonate lenses for dependent children • KidsCare: Additional lenses for children are fully covered when needed. Minimum prescription change required.	Included in prescription glasses copay	Every calendar year
Lens Enhancements	• Standard progressive lenses • High index lenses	Covered in full	Every calendar year
	• Premium progressive lenses	$95 - $105	
	• Custom progressive lenses	$150 - $175	
	• Average savings of 20-25% on other lens enhancements		
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible individuals with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Services	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of last WellVision exam		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
	Low Vision Services • Professional services and materials for severe visual problems not corrected with regular lenses • Benefit maximum for all Low Vision Benefits of $1,000 every two (2) calendar years • Includes supplemental testing, evaluation, diagnosis, and prescription of vision aids where indicated. Covered in full using a network provider. Out-of-Network provider maximum benefit up to $125. • Supplemental Aids: Covered at 75% of cost		

VSP Provider Network: VSP Choice

Your Coverage With Out-of-Network Providers		
Exam		**Up to $45**
Frames		**Up to $70**
Contacts		**Up to $105**
Lenses	**Lined Trifocal**	**Up to $65**
	Progressive	**Up to $50**
	Single Vision	**Up to $30**
	Lined Bifocal	**Up to $50**

Walmart:

While not a full participating provider within this plan, Walmart will file a claim for vision benefits on an individual's behalf and accept assignment (payment) from VSP. The use of Walmart's eye care center may not result in the maximization of benefit in all cases. It will come close, offering a potential convenience for an individual.

When using Walmart as a provider, please ask the eye care associate for expected costs when the benefits are utilized.

Visit vsp.com for details about providers other than a VSP network provider. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and the DentalVision contract, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.