



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

If an out-of-network provider is used, the member's liability will increase significantly.



Dental Benefits

Maximum Payment (per person per year)	\$1500	
Deductible (per person per year)	\$100	
	Delta Dental PPO Dentist Plan Pays	Non-Participating Dentist Plan Pays*
Diagnostic & Preventive		
Diagnostic & Preventive Services - Exams, Cleanings	80%	80%
Emergency Palliative Treatment - To temporarily relieve pain	80%	80%
Brush Biopsy - To detect oral cancer	80%	80%
Radiographs - X-rays	80%	80%
Basic and Major Services		
Minor Restorative Services - Simple Extractions, Fillings, Stainless Steel Crowns and Crown Repair	80%	80%
Endodontic Services - Root Canals	50%	50%
Periodontic Services - To treat gum disease	50%	50%
Complex Extractions and Surgical Services	50%	50%
Implants	50%	50%
Relines and Rebases - To Partial or Complete Dentures	50%	50%
Prostodontic Services - Fixed Bridges, Partial or Complete Dentures, Bridge Repair	50%	50%
Major Restorative Services - Major Crowns, Cast Restorations, Veneers (limited)	50%	50%

- Oral exams and prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings). The patient should talk with his or her dentist about treatment.
- Bite-wing X-rays are payable once per calendar year and full mouth X-rays (which include bite-wing X-rays) are payable once in any three-year period.
- Implants are payable once per tooth in any five-year period for adults.

Deductible: Applies to all Dental Benefits.

Waiting Period: 180-day waiting period does not apply to Diagnostic and Preventive Services. If you enroll within the first six months of your 65th birthday or within six months of enrolling in Medicare Part B, you will not be subject to the 180-day waiting period for all other covered services.

* When services are received from a Non-Participating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO 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 member will be responsible for that difference.

Delta Dental of Tennessee Member Services: 1-800-223-3104 • DeltaDentalTN.com



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Visit vsp.com or call 800.877.7195 for more details and exclusive savings and promotions for VSP Members

Vision Benefits	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	<ul style="list-style-type: none"> Focuses on eyes and overall wellness 	\$15	Every calendar year
Prescription Glasses		\$35	See frames and lenses
Frames	<ul style="list-style-type: none"> \$100 allowance for a wide selection of frames \$120 allowance for featured frame brands 20% savings on the amount over allowance 	Included in Prescription Glasses Copay	Every other calendar year
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses 	Included in Prescription Glasses Copay	Every calendar year
Lens Enhancements	<ul style="list-style-type: none"> Standard Progressive Lenses High Index Lenses Average savings of 20-25% on other lens enhancements 	\$0	Every calendar year
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$100 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every calendar year
Extra Services	Glasses and Sunglasses Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers 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 <ul style="list-style-type: none"> Professional services and materials for severe visual problems not corrected with regular lenses. Benefit Maximum for all Low Vision Benefits of \$1000 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		
Exams		Up to \$45
Frames		Up to \$70
Contacts		Up to \$85
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 a member'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 a member. When using Walmart as a provider, please ask the eye care associate for expected costs when the benefits are utilized.