



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.



Highlights: *DentalVision, offered through Texas 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 preventive and orthodontic) per individual per year | \$50/\$150 | | \$50/\$150 | | \$50/\$150 | |
| | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO |
| Diagnostic and Preventive | | | | | | |
| Diagnostic and Preventive Services - Exams, cleanings, fluoride, and space maintainers | 100% | 80% | 100% | 80% | 100% | 80% |
| Radiographs - X-rays | | | | | | |
| Emergency Palliative Treatment - To temporarily relieve pain | | | | | | |
| Brush Biopsy - To detect oral cancer | 50% | 40% | 80% | 60% | 80% | 60% |
| Covered Services | | | | | | |
| Minor Restorative Services - Simple extractions, fillings, stainless steel crowns and crown repair | 50% | 40% | 80% | 60% | 80% | 60% |
| Sealants (under age 16) - To prevent decay of permanent teeth | | | | | | |
| Endodontic Services - Root canals | | | | | | |
| Periodontic Services - To treat gum disease | | | | | | |
| Complex Extractions and Surgical Services | | | | | | |
| Implant Repair - Implant maintenance, repair, and removal | | | | | | |
| Relines and Rebases - To partial or complete dentures | | | | | | |
| Prosthetic Services - Fixed bridges, partial or complete dentures, bridge repair | 25% | 10% | 25% | 10% | 50% | 40% |
| 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 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.

| Your Coverage With a VSP Provider | | | |
|-----------------------------------|--|--|---------------------------|
| Vision Benefits | Description | Copay | Frequency |
| WellVision Exam | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> \$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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Standard progressive lenses High index lenses | Covered in full | Every calendar year |
| | <ul style="list-style-type: none"> Premium progressive lenses | \$105 | |
| | <ul style="list-style-type: none"> Custom progressive lenses | \$175 | |
| | <ul style="list-style-type: none"> Average savings of 20-25% on other lens enhancements | | |
| Contacts (instead of glasses) | <ul style="list-style-type: none"> \$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) | Up to \$60 | Every calendar year |
| Diabetic Eyecare Plus Program | <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision exam | | |
| | Laser Vision Correction <ul style="list-style-type: none"> 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 \$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.