

Looking for double protection from the costs of dental and eye care? Round out your existing health care policy with solid dental and vision coverage bundled in one convenient package.

Indiana Farm Bureau Health Plans now offers Delta Dental PPO Plus Premier™ network, a combined dental and vision plan designed to meet your needs no matter what your age, at rates less than \$1.65 per person per day.

See how dental and vision coverage can complete your health care coverage.



Dental Benefits						
	0-12 Months		13-24 Months		25+ Months	
	PPO	Non PPO	PPO	Non PPO	PPO	Non PPO
Maximum Benefit per person per year	\$500		\$1000		\$1500	
Deductible (Excludes Diagnostic & Preventive and Orthodontic) per person per year	\$50/\$150		\$50/\$150		\$50/\$150	
Diagnostic & Preventive:						
Diagnostic & Preventive Services: Exams, Cleanings, X-Rays Fluoride, and Space Maintainers	100%	80%	100%	80%	100%	80%
Covered Services:						
Emergency Palliative Treatment - To temporarily relieve pain						
Sealants						
Brush Biopsy - To detect oral cancer	50%	40%	80%	60%	80%	60%
Minor Restorative Services - Simple Extractions, Filings, Stainless Steel Crowns and Crown Repair						
Endodontic Services - Root Canals						
Periodontic Services - To treat Gum Disease						
Oral Surgery Services - Complex Extractions and Surgical Services						
Major Restorative Services - Major Crowns, Cast Restorations, Veneers	25%	10%	25%	10%	50%	40%
Prosthetic Services - Fixed Bridges, Partial or Complete Dentures, Bridge Repair						
Relines and Rebase - To Partial or Complete Dentures						
Implants	25%	10%	25%	10%	50%	40%
Bleaching/Whitening	25%	10%	25%	10%	50%	40%
Orthodontics (all ages)	0%	0%	50%	40%	50%	40%
Orthodontics Lifetime Maximum	N/A		\$1000		\$1000	

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

Benefits levels are based upon number of months specific member is enrolled in coverage.

* Available for ages 1 year to 99 years.

When services are received from a non-participating dentist, the percentages in this column indicate the portion of Delta Dental 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 member 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
Frames	<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	Standard Progressive 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)	<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 members 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/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		

VSP Provider Network: VSP Choice

Your Coverage with Out-of-Network Providers		
Exams		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 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.

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.