ADVANCED CHOICE

Schedule of Benefits for Individuals and Families

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.

HEALTH PLANS

Teladoc HEALTH

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Ohio Farm Bureau Health Plans uses the UnitedHealthcare Choice Plus Network of providers. Please keep in mind that In-Network payments are based on negotiated fees; if an out-of-network provider is used, the individual's liability will increase significantly.

CALENDAR YEAR DEDUCTIBLE (CYD)

- Per Individual, Per Calendar Year
- Unless otherwise indicated, all benefits are subject to CYD

$1,500 Per Individual
$3,000 Per Individual

	In-Network	Out-of-Network
OUT-OF-POCKET (OOP) MAXIMUM • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year • This applies to In-Network provider services only • Copayments do not apply to the OOP and must still be paid after the OOP is met	$1,500 CYD: $5,000 Per Individual $1,500 CYD: $10,000 Per Family $3,000 CYD: $10,000 Per Individual $3,000 CYD: $20,000 Per Family	Unlimited

LIFETIME BENEFIT MAXIMUM — Unlimited

Services

	In-Network		Out-of-Network	
OFFICE VISIT (Not subject to CYD)	$1,500 CYD: $30 Copay* Per Visit $3,000 CYD: $40 Copay* Per Visit		CYD/Coinsurance	
TELADOC (Not subject to CYD)	$0 Copay Per Visit		No Coverage	
COINSURANCE (After CYD and based on maximum allowable charge)	**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS (No waiting period; In-Network benefits not subject to CYD)	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
Preventative Health Exam[1]	100%	0%	60%	40%
Annual Well Woman[2]	100%	0%	60%	40%
Routine Colonoscopy[3]	100%	0%	60%	40%
Annual Routine PSA[4]	100%	0%	60%	40%
PRESCRIPTION DRUG COVERAGE	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply	All But Copay	$4 Copay[5]	60%	40%
• Brand - Subject to deductible	80%	20%	60%	40%
• $7,500 Maximum Per Calendar Year				

EMERGENCY ROOM SERVICES
(Not resulting in admission) — $300 Deductible Per Visit (In addition to CYD and Coinsurance)

DENTAL - (All Individuals)

Routine dental services, including two exams, cleanings, X-rays and fillings per calendar year

- Subject to a six month waiting period
- There is a copayment per visit and a $500 calendar year maximum per individual per calendar year

VISION -

Pediatric (Under Age 19)

Benefits include eye exams, eyeglasses and contact lenses

- No waiting period
- Eye exams are covered at 100% once every calendar year, no dollar limit
- Eyeglass frames, lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible and coinsurance

Age 19 and Over

Benefits include eye exams, eyeglasses and contact lenses

- Subject to a six month waiting period
- Eye exams are covered once every calendar year with a $40 limit per individual
- Eyeglass frames, lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible and coinsurance

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FOOTNOTES

1. Preventative health exam for adults and children, including associated services, are provided by a physician, either directly during the exam or through appropriate referrals including:
   - Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
   - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA)
   - Preventative care and screening for women as provided in the guidelines supported by HRSA
   - Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC)
2. Annual Well Woman:
   - Routine well woman preventative exam office visit
   - Cervical cancer screening
   - Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35 and 39
   - Other USPSTF screenings with an A or B rating
     - Pap smears
     - Bone density measurement screening
3. One routine colonoscopy every ten years for individuals age 45 and older
4. Prostate cancer screening for men age 50 and older
5. Prescription copayments do not apply toward deductibles or out-of-pocket maximums

*OFFICE COPAYMENT GUIDELINES

Copayments will be applied to each office visit for the covered services performed in the office and provided and billed by a physician who is an In-Network provider. The remaining charges for covered services rendered during the office visit will be paid at 100% of the maximum allowable charge. If a physician who is an Out-of-Network provider is utilized for covered services, benefits will be determined on the basis of the Out-of-Network coinsurance percentage after deductible is met. Copayments will not be applied toward deductibles or out-of-pocket maximums.

Copayments do not apply to the following services: advanced radiological imaging, allergy testing and injections, biopsy interpretation, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all individuals, diagnostic services sent out, durable medical equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated in the contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/rehabilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract and deductibles and coinsurance will apply except where otherwise indicated.

MATERNITY BENEFITS

Maternity benefits will be provided after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits except for complications of pregnancy.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least 6 months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by or received from a provider of health care services, or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

CLASSIC CHOICE
Schedule of Benefits for Individuals

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.

OHIO FARM BUREAU HEALTH PLANS

Teladoc HEALTH

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Ohio Farm Bureau Health Plans uses the UnitedHealthcare Choice Plus Network of providers. Please keep in mind that In-Network payments are based on negotiated fees; if an out-of-network provider is used, the individual's liability will increase significantly.

CALENDAR YEAR DEDUCTIBLE (CYD) (Unless otherwise indicated, all benefits are subject to CYD)	$3,000 Per Individual $6,000 Per Individual

	In-Network	Out-of-Network
OUT-OF-POCKET (OOP) MAXIMUM • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year • This applies to In-Network provider services only • Copayments do not apply to the OOP and must still be paid after the OOP is met	$3,000 CYD: $10,000 Per Individual $6,000 CYD: $20,000 Per Individual	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
OFFICE VISIT (Not subject to CYD)	$3,000 CYD: $45 Copay* Per Visit $6,000 CYD: $45 Copay* Per Visit		CYD/Coinsurance	
TELADOC (Not subject to CYD)	$0 Copay Per Visit		No Coverage	
COINSURANCE (After CYD and based on maximum allowable charge)	**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS (No waiting period; In-Network benefits not subject to CYD)	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
Preventative Health Exam[1]	100%	0%	60%	40%
Annual Well Woman[2]	100%	0%	60%	40%
Routine Colonoscopy[3]	100%	0%	60%	40%
Annual Routine PSA[4]	100%	0%	60%	40%
PRESCRIPTION DRUG COVERAGE	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply	All But Copay	$4 Copay[5]	60%	40%
• Brand - Subject to deductible	80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual				

EMERGENCY ROOM SERVICES (Not resulting in admission)	$300 Deductible Per Visit (In addition to CYD and Coinsurance)

DENTAL - (No waiting periods)

Pediatric (Under Age 19)

- Preventative service as outlined by the United States Preventative Task Force (USPTF) and the Health Resources and Service Administration (HRSA)
- Other eligible dental services subject to CYD and coinsurance
- Limited orthodontic care

Age 19 and Over

- There is a $45 copay for preventative and restorative services
- Maximum benefit per calendar year is $500

Ohio Farm Bureau Health Plans are not insurance and are not regulated as insurance under Ohio law.

VISION -

Pediatric (Under Age 19)

Benefits include eye exams, eyeglasses and contact lenses

- No waiting period
- Eye exams are covered at 100% once every calendar year, no dollar limit
- Eyeglass frames, lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible and coinsurance

Age 19 and Over

Benefits include eye exams, eyeglasses and contact lenses

- Eye exams are covered once every calendar year with a limit of $40
- Eyeglass frames, lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible and coinsurance

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FOOTNOTES

1. Preventative health exam for adults and children, including associated services, are provided by a physician, either directly during the exam or through appropriate referrals including:
   - Screenings and counseling services with an A or B recommendation by the United States Preventative Services Task Force (USPSTF)
   - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA)
   - Preventative care and screening for women as provided in the guidelines supported by HRSA, and Immunizations recommended by the Advisory Committee of Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC)
2. Annual Well Woman:
   - Routine well woman preventative exam office visit
   - Cervical cancer screening
   - Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35-39
   - Other USPSTF screenings with an A or B rating
     - Pap smears
     - Bone density measurement screening
3. One routine colonoscopy every ten years for individuals age 45 and older
4. Prostate cancer screening for men age 50 and older
5. Prescription copayments do not apply toward deductibles or out-of-pocket maximums

*OFFICE COPAYMENT GUIDELINES

Copayments will be applied to each office visit for the covered services performed in the office and provided and billed by a physician who is an In-Network provider. The remaining charges for covered services rendered during the office visit will be paid at 100% of the maximum allowable charge. If a physician who is an Out-of-Network provider is utilized for covered services, benefits will be determined on the basis of an Out-of-Network coinsurance percentage after deductible is met.

Copayments do not apply to the following services: advanced radiological imaging, allergy testing and injections, biopsy interpretation, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all individuals age nineteen (19) and over, diagnostic services sent out, durable medical equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated in the contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/rehabilitative/habilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract and deductibles and coinsurance will apply except where otherwise indicated. Copayments will not be applied to the deductibles or basis of an Out-of-Network.

MATERNITY BENEFITS

Maternity benefits will be eligible as long as the pregnancy is not considered a pre-existing condition.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least six months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by or received from a provider of health care services, or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

HIGH DEDUCTIBLE HEALTH PLAN

Schedule of Benefits for Individuals and Families

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.

OHIO FARM BUREAU HEALTH PLANS

Teladoc HEALTH

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Ohio Farm Bureau Health Plans uses the UnitedHealthcare Choice Plus Network of providers. Please keep in mind that In-Network payments are based on negotiated fees; if an Out-of-Network provider is used, the individual's liability will increase significantly.

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)[1] • Unless otherwise indicated, all benefits are subject to the CYD • Family Deductible can be satisfied by one or more covered individual during a calendar year • In-Network and Out-of-Network deductibles are met separately	$2,250 Per Individual $3,750 Per Individual $4,500 Per Family $7,500 for 2-person, 3-person or Family with 4+ Individuals	$2,250 Per Individual $3,750 Per Individual $4,500 Per Family $7,500 for 2-person, 3-person or Family with 4+ Individuals
OUT-OF-POCKET (OOP) MAXIMUM[2] • Family OOP maximum can be satisfied by one or more covered individual during a calendar year • Once the OOP maximum is met, eligible benefits are provided at 100% for the remainder of the calendar year • Applies to eligible In-Network provider services only	$2,250 CYD: $4,500 $3,750 CYD: $5,625 $4,500 CYD: $9,000 $7,500 CYD: $11,250	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
COINSURANCE (After CYD and based on maximum allowable charge)	**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS (Subject to CYD)	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
Well Child Services[3]	80%	20%	Not Covered	
Routine Colonoscopy[4]	80%	20%	60%	40%
Annual Routine PSA[5]	80%	20%	60%	40%
Annual Routine OB/GYN Exam[6]	80%	20%	Not Covered	
Annual Routine Pap Smear[7]	80%	20%	60%	40%
Mammogram[8]	80%	20%	60%	40%
PRESCRIPTION DRUG COVERAGE[9] (Subject to CYD)	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic And Brand Prescriptions	80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual				
• Home Delivery Services Are Available				

TELADOC

Individual must pay 100% of current Teladoc consultation fee until CYD is met. Once CYD is met, no consultation fee for Teladoc.

FOOTNOTES

1. Deductible – the dollar amount of covered services that must be incurred and paid first by an individual each calendar year before plan benefits begin.
2. Once the OOP maximum is met, benefits are provided at 100% for an individual for the remainder of the calendar year. This applies to In-Network provider services only. There is no out-of-pocket maximum when Out-of-Network providers are used.
3. Benefits are available, subject to deductible and coinsurance, for an individual under the age of 7 (on plan deductibles $4,500 and $7,500) for physical examinations and appropriate immunizations/vaccinations when services are rendered by an In-Network provider. Exams not used during the time periods below do not carry over to the next time period.

Age	Number of exams
Under age 1	Four exams from birth to the child's first birthday
Age 1	Two exams from the child's first birthday to the child's second birthday
Age 2 through 6	One exam per year (determined by the child's birthday)

4. Benefits will be provided for one routine colonoscopy every ten years for individuals age 45 and older when provided by an In-Network or Out-of-Network provider, subject to the deductible and coinsurance.
5. Benefits will be provided, subject to deductible and coinsurance, for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.
6. Benefits will be available for one routine OB/GYN exam per calendar year, subject to deductible and coinsurance. Services must be rendered by an In-Network physician's office and billed by the In-Network provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by an In-Network physician's office and billed by the In-Network provider. Related pathology that the physician sends to an independent laboratory will be subject to deductible and coinsurance. No benefit is available for routine OB/GYN exams provided by an Out-of-Network provider.
7. Benefits will be provided for the interpretation of one routine pap smear per calendar year when services are rendered by an independent laboratory or other outpatient setting, subject to deductible and coinsurance.
8. For routine mammography screening provided such examinations are conducted upon the recommendation of the individual's physician. One baseline routine mammogram will be allowed for individuals between the ages of 35-39. One routine mammogram will be allowed annually for individuals age 40 and above. All routine mammography screens are subject to deductible and coinsurance.
9. Benefits will be provided, subject to deductible and coinsurance.

MATERNITY BENEFITS

Maternity benefits will be available after an individual's coverage on a 2-person, 3-person or family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least 12 months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by or received from a provider of health care services, or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

MAJOR MEDICAL

Schedule of Benefits for Individuals and Families

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OHIO FARM BUREAU EST. 1919 HEALTH PLANS

Teladoc HEALTH

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Ohio Farm Bureau Health Plans uses the UnitedHealthcare Choice Plus Network of providers. Please keep in mind that In-Network payments are based on negotiated fees; if an Out-of-Network provider is used, the individual's liability will increase significantly.

CALENDAR YEAR DEDUCTIBLE (CYD)[1] (Unless otherwise indicated, all benefits are subject to the CYD)	$7,500 Per Individual

	In-Network	Out-of-Network
OUT-OF-POCKET (OOP) MAXIMUM[2] • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year • This applies to In-Network provider services only	$15,000 Per Individual $30,000 Per Family	Unlimited

LIFETIME BENEFIT MAXIMUM	Unlimited

Services

	In-Network		Out-of-Network	
COINSURANCE (After CYD and based on maximum allowable charge)	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
	80%	20%	60%	40%
PREVENTATIVE CARE BENEFITS (Subject to CYD)	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
Well Child Services[3]	80%	20%	Not Covered	
Routine Colonoscopy[4]	80%	20%	60%	40%
Annual Routine PSA[5]	80%	20%	60%	40%
Annual Routine OB/GYN Exam[6]	80%	20%	Not Covered	
Annual Routine Pap Smear[7]	80%	20%	60%	40%
Mammogram[8]	80%	20%	60%	40%
PRESCRIPTION DRUG COVERAGE[9] (Subject to CYD)	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply	All But Copay	$4 Copay[9]	60%	40%
• Brand	80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual				
TELADOC (Not subject to CYD)	$0 Copay Per Visit		No Coverage	

FOOTNOTES

1. Deductible – the dollar amount of covered services that must be incurred and paid first by an individual each calendar year before plan benefits begin.
2. Once the OOP maximum is met, benefits are provided at 100% for an individual for the remainder of the calendar year. This applies to In-Network provider services only. There is no out-of-pocket maximum when Out-of-Network providers are used.
3. Benefits are available, subject to deductible and coinsurance, for an individual under the age of 7 for physical examinations and appropriate immunizations/vaccinations when services are rendered by an In-Network provider. Exams not used during the time periods below do not carry over to the next time period.

Age	Number of exams
Under age 1	Four exams from birth to the child's first birthday
Age 1	Two exams from the child's first birthday to the child's second birthday
Age 2 through 6	One exam per year (determined by the child's birthday)

4. Benefits will be provided for one routine colonoscopy every ten years for individuals age 45 and older when provided by an In-Network or Out-of-Network provider, subject to the deductible and coinsurance.
5. Benefits will be provided, subject to deductible and coinsurance, for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.
6. Benefits will be available for one routine OB/GYN exam per calendar year, subject to deductible and coinsurance. Services must be rendered by an In-Network physician's office and billed by the In-Network provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by an In-Network physician's office and billed by the In-Network provider. Related pathology that the physician sends to an independent laboratory will be subject to deductible and coinsurance. No benefit is available for routine OB/GYN exams provided by an Out-of-Network provider.
7. Benefits will be provided for the interpretation of one routine pap smear per calendar year when services are rendered by an independent laboratory or other outpatient setting, subject to deductible and coinsurance.
8. Benefits will be provided, subject to deductible and coinsurance, for routine mammography screening provided such examinations are conducted upon the recommendation of the individual's physician. One baseline routine mammogram will be allowed for individuals between the ages of 35-39. One routine mammogram will be allowed annually for individuals age 40 and above. All routine mammography screens are subject to deductible and coinsurance.
9. Prescription copayments does not apply toward deductible or out-of-pocket maximum.

MATERNITY BENEFITS

Maternity benefits will be available after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least 12 months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by or received from a provider of health care services, or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

DentalVision

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OHIO FARM BUREAU HEALTH PLANS

DELTA DENTAL®

Highlights: *DentalVision, offered through Ohio 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	50%	40%	80%	60%	80%	60%
Brush Biopsy - To detect oral cancer						
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	25%	10%	25%	10%	50%	40%
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						
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.

Benefits 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.

MH-OH-CM-DV-FM25-904

HEALTH PLANS

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	$105	
	• Custom progressive lenses	$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.

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