For your protection and peace of mind.

Total health care protection goes beyond medical coverage. Kansas Farm Bureau Health Plans recognizes your physical and financial well-being requires dental and vision coverage as well.

Our Delta Dental PPO Plus Premier™ network combines the Delta Dental PPO and Delta Dental Premier networks, which gives you the benefits of Delta Dental PPO and more. With this plan, even if your Delta Dental Premier dentist is not in the PPO network, you still receive the benefit of that dentist's contracted fee.

Monthly Rates:
Individual subscriber: $49.75
Subscriber plus additional person: $87.50
Family (3 or more people): $146.00

For more information,
call us toll-free at 833-282-5928,
visit www.kfbhealthplans.com
or speak with one of our agents.

KANSAS FARM BUREAU® Health Plans

www.kfbhealthplans.com

MH-KS-CM-FL20-004
2/21/23

For solid, affordable protection from the costs of dental and vision care

DentalVision has you covered!

KANSAS FARM BUREAU® Health Plans

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.

Kansas Farm Bureau Health Plans now offers Delta Dental PPO Plus Premier™ network and VSP Choice network for vision, a combined dental and vision plan designed to meet your needs no matter what your age.

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

DentalVision's dental benefits

DELTA DENTAL®

Dental Benefits	0-12 Months		13-24 Months		25+ Months	
	PPO Plus Premier	Non-Participating	PPO Plus Premier	Non-Participating	PPO Plus Premier	Non-Participating
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%
Periodontal Maintenance - cleanings following periodontal therapy						
Covered Services:						
Emergency Palliative Treatment - to temporarily relieve pain	50%	40%	80%	60%	80%	60%
Sealants - to prevent decay of permanent teeth						
Brush Biopsy - to detect oral cancer						
Minor Restorative Services - filings, stainless steel crowns and crown repair						
Simple Extractions - non-surgical removal of teeth						
Adjustments and Repairs - to bridges and dentures						
Endodontic Services - root canals	25%	10%	25%	10%	50%	40%
Periodontic Services - to treat gum disease						
Oral Surgery Services - complex extractions and surgical services						
Major Restorative Services - major crowns, cast restorations, veneers						
Implant Repair - implant maintenance, repair, and removal						
Relines and Rebase - to partial or complete dentures						
Prosthodontic Services - bridges, implants, and dentures						
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.

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.

MH-KS-CM-FM25-650

DentalVision's vision benefits

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	$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 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		
	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 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.