Benefits & Plans

The following tables show the benefit plan options offered through AgBenefits. Any benefit changes are subject to by the AgBenefits board of trustees and require verification that the benefit(s) or options are acceptable under state federal regulations.

Life and AD&D Plans

Minimum Life/AD&D Benefit	$10,000 per employee
Standard Life/AD&D Benefit	$25,000 per employee
Maximum Life/AD&D Benefit	$500,000 per employee
Age Reduction of Benefits Schedule	At age 65, 65% of the original amount; At age 70, 42% of the pre-age 65 original amount; At age 75, 27% of the pre-age 65 original amount; At age 80, 18% of the pre-age 65 original amount; Benefits cease at retirement
AD&D Coverage Type	Occupational coverage standard
Dependent Life *(optional)*	Low Option: $5,000 spouse benefit; $2,500 child benefit; and $1,000 infant benefit
	High Option: $10,000 spouse benefit; $5,000 child benefit; and $2,500 infant benefit

Medical Plans

Open Access/ No-Network

	$500 Deductible Plan	$750 Deductible Plan	$1,000 Deductible Plan	$2,000 Deductible Plan	$5,000 Deductible Plan
Calendar Year Deductible					
Per Member	$500	$750	$1,000	$2,000	$5,000
Per Family	$1,500	$2,250	$3,000	$5,000	$12,000
Coinsurance	80%/20%	80%/20%	80%/20%	80%/20%	100%/0%
Calendar Year Out-of-Pocket Maximum					
Per Member	$2,500	$3,250	$4,000	$5,000	$5,000
Per Family	$7,500	$9,750	$12,000	$12,000	$12,000
Office Visit Co-pay *(up to $500 per visit reimbursable at 100%; amount in excess subject to deductible and coinsurance)*					
	$20	$25	$30	$35	$40
Outpatient Diagnostic Procedures Co-pay *(after copayment, 100% up to $300m then subject to deductible and coinsurance)*					
	$10	$12.50	$15	$17.50	$20

Medical Plans *(continued)*

Maximums

	$500 Deductible Plan	$750 Deductible Plan	$1,000 Deductible Plan	$2,000 Deductible Plan	$5,000 Deductible Plan
Lifetime	None	None	None	None	None
Calendar Year	None	None	None	None	None
Preventive Care	None	None	None	None	None
Hospice	80%/20%	80%/20%	80%/20%	80%/20%	0%/100%
Home Health Care	60 visit per calendar year	60 visit per calendar year	60 visit per calendar year	60 visit per calendar year	60 visit per calendar year
Skilled Nursing	None	None	None	None	None
DME/Prosthetics	None	None	None	None	None
Rehabilitation					
In patient	None	None	None	None	None
Out patient	None	None	None	None	None

Additional Benefits

	$500 Deductible Plan	$750 Deductible Plan	$1,000 Deductible Plan	$2,000 Deductible Plan	$5,000 Deductible Plan
Mental/Nervous – Alcohol/Drug Dependency					
In patient (maximum)	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Outpatient (maximum)	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Serious Mental Illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
In Vitro Fertilization	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

RX Plans (HealthSmartRX)

	Rx 10/20/50	Rx 15/25/60	Rx 20/35/75
Retail Co-pays (30-day supply)			
Generic	$10	$15	$20
Preferred Brand Name (formulary)	$20	$25	$35
Non-Preferred Brand Name (non-formulary)	$50	$60	$75
Mail Order Co-pays (90 Day Supply)			
Generic	$15	$20	$25
Preferred Brand Name (formulary)	$30	$35	$45
Non-Preferred Brand Name (non-formulary)	$75	$90	$110
Diabetic Supply Program			
Testing meter and all program supplies	$0.00 100% paid by plan (no copay)	$0.00 100% paid by plan (no copay)	$0.00 100% paid by plan (no copay)

Vision Plan

Included with Medical Plan, in-network benefits listed below; see Vision Benefits Program for details and for out-of-network benefits.		
Exams	$10 co-pay per exam	One exam every 12 months
Materials	$25 co-pay per set of materials	One set (lenses and frames or contacts) every 12 months
Frame Allowance	$50 wholesale allowance at private practice providers OR $130 allowance at retail chain providers	
Contact Lens Allowance	If covered in full contact lenses NOT elected, $150 reimbursement allowance (including fitting fee) (Materials co-pay does NOT apply)	

Dental Plan (optional)

Every year beginning January 1st, you and your covered dependents each have $2,000 coverage for dental care. The plan reimburses you:
• 0% of the first $50 of eligible dental expenses, then
• 100% of the next $100 of eligible expenses, then
• 80% of the next $500 of eligible expenses, then
• 50% of the next $3,000 of eligible expenses
to a maximum benefit of $2,000 per year.

IMPORTANT NOTE: *This "Benefit Summary" is intended as a reference only and should not be relied upon to fully determine coverage. If this summary conflicts with the Plan Document (or Certificate of Coverage, for fully insured benefits), the Plan Document (or Certificate of Coverage) will prevail. Please refer to the full benefit materials for an exact description of the benefits that are provided and for other terms and conditions of coverage.*