



**Agri-Business Benefit Group, Inc.  
Comprehensive Major Medical - HRA  
Non-Grandfathered**



AGRI005

**Effective July 1, 2026 – June 30, 2027**

Maximum benefits are available when services are received from Blue Choice providers. Your financial responsibility is based on the provider network you select. **Non-Blue Choice & Non-CAP:** Difference between the payment allowance and provider charge, additional 20% coinsurance amount, deductible, coinsurance or copay amount **CAP (Non-Blue Choice):** Additional 20% coinsurance amount,\* deductible, coinsurance or copay amount **Blue Choice:** Deductible, coinsurance or copay amount

\*Limited to a combined \$2,000 per person, \$4,000 two-or-more persons each benefit period.

| Member Pays                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| <b>Deductible</b> (Per group anniversary benefit period)                                                                                                                                                                                                         | \$3,400/\$6,800<br>individual/two-or-more persons                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coinsurance</b> (Member portion for most services)                                                                                                                                                                                                            | 20% of allowed amounts after deductible has been met up to<br>\$2,000/\$4,000 individual/two-or-more persons maximum                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Maximum Out-of-Pocket</b> (includes copays, deductible and coinsurance where applicable)                                                                                                                                                                      | \$6,350/\$12,700 individual/two-or-more persons after the maximum out-of-pocket amount has been reached, eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period..                                                                                                                                                                                                                                                                                                                                                   |
| Doctor's office visits                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Home and office visits<br>Telemedicine visits<br><br>Preventive care as defined by the<br><i>Affordable Care Act</i>                                                                                                                                             | Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br><br>Paid at 100% of the allowable charge. Some of the services include:<br><ul style="list-style-type: none"> <li>• Routine screenings</li> <li>• Preventive immunizations</li> <li>• Well-woman visits/screenings</li> <li>• Contraceptive methods</li> </ul>                                                                                                                                                                                                                          |
| Drug coverage                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Prescription Drugs & Mail order                                                                                                                                                                                                                                  | BlueRx Card \$15/\$40/\$60/\$40/\$60 with Mail order is 2 ½ x copay with ResultsRx formulary. A 90-day supply is available through the Extended Supply Network. The quantity per prescription is a 30-day pharmacy supply or 90-day mail order supply. Designated Specialty Pharmacy.<br><br>Requires a generic equivalent of a brand drug to be purchased if available unless doctor requires the brand name drug to be dispensed. The member will be responsible for the difference of the allowable charge between the generic equivalent and brand name drug. |
| Medical services                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Emergency medical transportation<br>Inpatient surgery physician/surgical<br>Inpatient facility fee<br>Outpatient surgery physician/surgical<br>Outpatient lab and radiology ( <i>Includes Advanced imaging</i> )<br>Emergency room<br>Accidental Injury Services | Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br><br>\$150 copay then subject to deductible/coinsurance.<br>Subject to deductible/coinsurance                                                                                                                                                                                                                                                                             |

| Recovery/Special needs                                                                                                                                             |                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient rehabilitation<br>Hospice<br>Home social work visits                                                                                                    | Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance                                                                                                   |
| Mental health                                                                                                                                                      |                                                                                                                                                                                                               |
| <b>Mental/behavioral health</b><br><b>Inpatient Services</b><br>Requires pre-admission certification<br>from New Directions Behavioral Health<br>at 1-800-952-5906 | Subject to deductible/coinsurance                                                                                                                                                                             |
| <b>Outpatient Services</b>                                                                                                                                         | Subject to deductible/coinsurance                                                                                                                                                                             |
| Other                                                                                                                                                              |                                                                                                                                                                                                               |
| Maximum lifetime benefit                                                                                                                                           | Unlimited                                                                                                                                                                                                     |
| Eligible dependents                                                                                                                                                | Covered to age 26                                                                                                                                                                                             |
| Hearing Aids                                                                                                                                                       | Subject to deductible/coinsurance, \$2,500 max per ear, per member, every three (3) benefit periods. Four (4) add'l ear molds per benefit period up to age three (3). Batteries and fittings are not covered. |

**Exclusions:**

Duplicate benefits provided under federal, state or local laws, regulations or programs except Medicaid; services involving cosmetic or reconstructive surgery except as stated in the certificate; charges for personal items; convalescent or custodial care or rest cure; all keratotomy procedures; services related to temporomandibular joint dysfunction syndrome; blood or payments to donors of blood; any service or supply related to the medical management of obesity; services related to the reversal of sterilization procedures; any medically-aided insemination procedure; charges for services by immediate relatives or by members of the household; acupuncture and admission for acupuncture; medically unnecessary services and admissions; services covered and payable under any medical expense payment provision of any automobile insurance policy; mental illness or substance use disorder services provided by a non-eligible provider; services, supplies or treatments not specifically listed as covered in the member's certificate.

This is a brief summary of the coverage available under this program. It is not a legal document. The exact provisions of the benefits and exclusions are contained in the certificate.

**Customer Service: 1-800-432-3990**

**Website: [www.bcbsks.com](http://www.bcbsks.com)**

**ABBG: 620-513-6135**