AGC Health Benefit Trust – Washington Chapter
Product Grid
Effective August 1, 2020 – July 31, 2021

MEDICAL PLANS – UNITED HEALTHCARE
Choice Plus Network

Plan Name	Plan Code	Rx Code	Network Individual [1]			Virtual Visit	PCP Visit	Specialist Visit	Urgent Care	Routine Lab & X-ray
			Deductible	Coinsurance	OOPM					
Premier 250	CEGT	F75	$250	20%	$4,000	$0	$20	$20	$50	20%
Premier 500	CEGU	F75	$500	20%	$4,000	$0	$20	$20	$50	20%
Premier 1000	CEGV	F75	$1,000	20%	$5,000	$0	$25	$25	$50	20%
Premier 1500	CEGX	F75	$1,500	20%	$6,500	$0	$25	$25	$50	20%
Premier 2000	CEGZ	F76	$2,000	20%	$6,500	$0	$35	$35	$50	20%
Preferred 1000	CEGW	F75	$1,000	30%	$6,850	$0	$25	$55	$50	Ded+30%
Preferred 2000	CEGY	F75	$2,000	30%	$6,850	$0	$25	$55	$50	Ded+30%
Preferred 2500	CEG3	F76	$2,500	20%	$6,500	$0	$30	$60	$50	Ded+20%
Preferred 3000	CEG4	F75	$3,000	30%	$8,150	$0	$25	$55	$50	Ded+30%
Preferred 5000	CEG5	F75	$5,000	30%	$8,150	$0	$35	$65	$50	Ded+30%
Primary Advantage 2000	CEG2	F76	$2,000	20%	$6,500	$0	$0	$100	$50	Ded+20%
HSA 1500 with Motion	CEGJ	F75	$1,500 [2]	20%	$6,900 [3] Family $8,150	Ded+20%	Ded+20%	Ded+20%	Ded+20%	Ded+20%
HSA 2000 with Motion	CEGM	F76	$2,000 [2]	30%	$6,900	Ded+30%	Ded+30%	Ded+30%	Ded+30%	Ded+30%
HSA 3500 with Motion	CEGQ	F75	$3,500	30%	$6,900	Ded+30%	Ded+30%	Ded+30%	Ded+30%	Ded+30%
HSA 5000 with Motion	CEGS	F76	$5,000	30%	$6,900	Ded+30%	Ded+30%	Ded+30%	Ded+30%	Ded+30%

[1] Unless otherwise noted, family deductibles and out-of-pocket maximums are two (2) times the individual deductible and out-of-pocket maximum.
[2] If more than one person in a family is covered under the Policy, no one in the family is eligible for benefits until the family deductible is met.
[3] If more than one person in a family is covered under the Policy, no one in the family is eligible for benefits until the family out-of-pocket maximum is met.

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MEDICAL PLANS – UNITED HEALTHCARE

Navigate Network

Navigate medical plans require an in-network Primary Care Physician (PCP) for all enrolled members, referrals to specialists are coordinated by PCP, and do not include out-of-network benefits.

Plan Name	Plan Code	Rx Code	Network Individual [1]			Virtual Visit	PCP Visit	Specialist Visit	Urgent Care	Routine Lab & X-ray
			Deductible	Coinsurance	OOPM					
Navigate 500	AM5K	F75	$500	20%	$4,500	$10	$35	$65	$50	20%
Navigate 1750	AM5M	F75	$1,750	20%	$6,850	$10	$35	$65	$50	20%
Navigate 2500	AM5N	F75	$2,500	30%	$6,850	$10	$35	$65	$50	30%
Navigate 3500	AM5O	F75	$3,500	30%	$6,850	$10	$45	$70	$50	30%

[1] Unless otherwise noted, family deductibles and out-of-pocket maximums are two (2) times the individual deductible and out-of-pocket maximum.

Select Plus Network

Select Plus medical plans are only available to employers located in King, Pierce and Snohomish counties.
Tiering applies to PCP visits only for SelectPlus network.

Plan Name	Plan Code	Rx Code	Network Individual [1]			Virtual Visit	PCP Visit Tier 1 / Tier 2	Specialist Visit	Urgent Care	Routine Lab & X-ray
			Deductible	Coinsurance	OOPM					
Select Plus 500	CEG6	F75	$500	10%	$2,250	$0	$0 / $40	$60	$50	Ded+10%
Select Plus 1000	CEG7	F75	$1,000	20%	$3,500	$0	$0 / $40	$60	$50	Ded+20%
Select Plus 1500	CEG8	F75	$1,500	20%	$4,000	$0	$0 / $40	$60	$50	Ded+20%
Select Plus 2000	CEG9	F75	$2,000	20%	$4,500	$0	$0 / $40	$60	$50	Ded+20%
Select Plus 2500	CEHA	F75	$2,500	20%	$5,000	$0	$0 / $40	$60	$50	Ded+20%

Medical deductibles, copays, coinsurance and out-of-pocket maximum illustrated reflect the member's responsibility. Medical deductible, copays, and coinsurance apply toward out-of-pocket maximum. All medical plans are administered on a calendar year basis.

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PRESCRIPTION PLANS – UNITED HEALTHCARE
Advantage Prescription Drug List

Rx Code	Individual Rx Deductible	Family Rx Deductible	Medical Deductible Applies	Tier 1	Tier 2	Tier 3	Tier 4	Mail Service Ratio
F75	N/A	N/A	N/A	$15	$50	$125	50%	2.5x
F76	N/A	N/A	N/A	$15	$50	20%	50%	2.5x
F75 HSA	N/A	N/A	Tiers 1-4	$15	$50	$125	50%	2.5x
F76 HSA	N/A	N/A	Tiers 1-4	$15	$50	20%	50%	2.5x

Prescription copays and coinsurance illustrated reflect the member's responsibility. Prescription copays and coinsurance apply toward medical out-of-pocket maximum. All prescription plans are administered on a calendar year basis.

GROUP LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) – UNITED HEALTHCARE

Total Benefit	Trust Rules
$10,000	Required Coverage for all Members; Included in all medical plans
$20,000	Employer Buy-Up Option
$30,000	Employer Buy-Up Option
$40,000	Employer Buy-Up Option
$50,000*	Employer Buy-Up Option

*$50,000 total benefit available for employers with 6 or more employees.
Life Insurance and AD&D benefits both reduce to 65% at age 65, 50% at age 70, 30% at age 75 and 20% at age 80.

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DENTAL PLANS – DELTA DENTAL OF WASHINGTON
Delta Dental PPO Network

Plan Name	Annual Maximum	Deductible Individual / Family	Class I Diagnostic & Preventative	Class II Restorative	Class III Major	Class IV Orthodontia
Plan 1000	$1,000	$50 / $150	Covered in full	Ded+20%	Ded+50%	Not Covered
Plan 1500	$1,500	$50 / $150	Covered in full	Ded+20%	Ded+50%	Not Covered
Plan 2000	$2,000	$50 / $150	Covered in full	Ded+20%	Ded+50%	Not Covered
Plan 1000 w/Ortho	$1,000	$50 / $150	Covered in full	Ded+20%	Ded+50%	50% up to $1,500 lifetime maximum
Plan 1500 w/Ortho	$1,500	$50 / $150	Covered in full	Ded+20%	Ded+50%	50% up to $1,500 lifetime maximum
Plan 2000 w/Ortho	$2,000	$50 / $150	Covered in full	Ded+20%	Ded+50%	50% up to $1,500 lifetime maximum

Deductible and coinsurance illustrated above reflect the member's responsibility. All dental plans are administered on a calendar year basis. Adults and children are eligible for orthodontia services.

VISION PLANS – THE STANDARD

Plan Name	Network	Exam Deductible	Hardware Deductible	Annual Eye Exam	Lenses (per pair) Single Vision, Bifocal, Trifocal or Lenticular	Frame Allowance	Elective Contacts (in lieu of glasses)	Benefit Frequency (months) Exam/Lens/Frame
Plan 150-0	VSP Choice	$10	$0	Covered in full	Covered in full	$150	Up to $150	12/12/24*
Plan 150-10	VSP Choice	$10	$25	Covered in full	Covered in full	$150	Up to $150	12/12/24*
Plan 150-0V (Voluntary)	VSP Choice	$10	$0	Covered in full	Covered in full	$150	Up to $150	12/12/24*
Plan 150-10V (Voluntary)	VSP Choice	$10	$25	Covered in full	Covered in full	$150	Up to $150	12/12/24*

* Benefit frequency based on date of service.

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