AGC Health Benefit Trust – Oregon Columbia Chapter
Product Grid
Effective January 1 – December 31, 2021

MEDICAL PLANS – Regence Blue Cross Blue Shield of Oregon
Preferred Network

Plan Name	Individual Deductible	Individual OOPM	In-Network Coinsurance	Out-of-Network Coinsurance	MDLive Virtual Visit	PCP Visit	Specialist Visit	Urgent Care Visit	Diagnostic Lab/X-Ray
PPO 500	$500	$4,000	20%	40%	$0	$20	$20	Same as PCP or Specialist	20%
PPO 1000	$1,000	$5,500	20%	40%	$0	$30	$30	Same as PCP or Specialist	20%
PPO 1500	$1,500	$5,500	20%	40%	$0	$30	$30	Same as PCP or Specialist	20%
PPO 2000	$2,000	$6,500	20%	40%	$0	$30	$30	Same as PCP or Specialist	20%
PPO 3000	$3,000	$6,500	20%	40%	$0	$30	$30	Same as PCP or Specialist	20%
Value 500	$500	$6,500	30%	50%	$0	$35	$55	Same as PCP or Specialist	30%
Value 1000	$1,000	$7,500	30%	50%	$0	$35	$55	Same as PCP or Specialist	30%
Value 2500	$2,500	$7,500	30%	50%	$0	$35	$55	Same as PCP or Specialist	30%
Value 3500	$3,500	$7,500	30%	50%	$0	$35	$55	Same as PCP or Specialist	30%
Value 5000	$5,000	$7,500	30%	50%	$0	$35	$55	Same as PCP or Specialist	30%
Value 6000	$6,000	$8,150	40%	50%	$0	$35	$55	Same as PCP or Specialist	40%
HSA 2500	$2,500	$6,350	30%	50%	Ded+30%	Ded+30%	Ded+30%	Same as PCP or Specialist	Ded+30%
HSA 4500	$4,500	$7,000	30%	50%	Ded+30%	Ded+30%	Ded+30%	Same as PCP or Specialist	Ded+30%

Deductibles, out-of-pocket maximums, copays, and coinsurance illustrated above reflect member's responsibility.
Copays and coinsurance accumulate to annual out-of-pocket maximum. All medical plans are administered on a calendar year basis.
Family deductibles and out-of-pocket maximums are two (2) times the individual deductible and out-of-pocket maximum.
All plans have an embedded deductible except HSA plans, which have a non-embedded deductible.

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PRESCRIPTION PLANS – Regence Blue Cross Blue Shield of Oregon
Prescription Drug List

Rx Code	Rx Deductible	Generic		Brand		Specialty		Mail Service Ratio (90 day supply)
		Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	
Rx 1	N/A	$10	$15	$30	$50	$150	$200	2x
Rx 2	N/A	$15	25%	$40	40%	40%	50%	2x
Rx 3	N/A	$25	30%	60%	50%	40%	50%	2x

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

GROUP LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) – LifeMap Assurance Company

Total Benefit	Trust Rules
$10,000	Required Coverage for all Members
$20,000	Employer Buy-Up Option
$25,000	Employer Buy-Up Option
$30,000	Employer Buy-Up Option
$50,000	Employer Buy-Up Option

Life Insurance and AD&D benefits both reduce to 65% at age 65, to 45% at age 70, to 30% at age 75, to 20% at age 80, to 15% at age 85, and to 10% at age 90.

NOTE: The information in this grid is provided for informational purposes only and is not intended for use as a contract. For a complete listing of coverage and exclusions, refer to the Certificate of Coverage or benefit contract.

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DENTAL PLANS – STANDARD INSURANCE COMPANY
Ameritas PPO Network

Plan Name	Annual Maximum	Deductible Individual / Family	Out-Of-Network Allowance	Class I Diagnostic & Preventative	Class II Restorative	Class III Major	Class IV Orthodontia (Child Only)
Plan 1000	$1,000	$50 / $150	90th U&C	Covered in full	Ded+20%	Ded+50%	Not Covered
Plan 1500	$1,500	$50 / $150	90th U&C	Covered in full	Ded+20%	Ded+50%	Not Covered
Plan 2000	$2,000	$50 / $150	90th U&C	Covered in full	Ded+20%	Ded+50%	Not Covered
Plan 1000 w/ Ortho	$1,000	$50 / $150	90th U&C	Covered in full	Ded+20%	Ded+50%	50% up to $1,000 lifetime maximum
Plan 1500 w/ Ortho	$1,500	$50 / $150	90th U&C	Covered in full	Ded+20%	Ded+50%	50% up to $1,000 lifetime maximum
Plan 2000 w/ Ortho	$2,000	$50 / $150	90th U&C	Covered in full	Ded+20%	Ded+50%	50% up to $1,000 lifetime maximum

Deductible and coinsurance illustrated above reflect member's responsibility. Dental plans are administered on a calendar year basis.

VISION PLANS – THE STANDARD
VSP Choice Network

Plan Name	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 100	$10	$25	Covered in full	Covered in full	$100	Up to $120	12/12/24*
Plan 150	$10	$25	Covered in full	Covered in full	$150	Up to $120	12/12/24*
Plan 150V (Voluntary)	$10	$25	Covered in full	Covered in full	$100	Up to $120	12/12/24*
Plan 150-10V (Voluntary)	$10	$25	Covered in full	Covered in full	$150	Up to $120	12/12/24*

* Benefit frequency based on date of service.

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