AGC Health Benefit Trust – Oregon Columbia Chapter
Product Grid
Effective October 1, 2021 – September 30, 2021

MEDICAL PLANS – UnitedHealthcare
Choice Plus Network
Available to employers domiciled in Oregon and Southwest Washington

Medical deductibles, out-of-pocket maximums, copays, and coinsurance illustrated below and on the following page reflect a member's responsibility.
Copays and coinsurance accumulate to annual out-of-pocket maximum.
All benefits, accumulations, frequencies, and limitations 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 medical plans have an embedded deductible except the HSA 2500 with Motion, which has a non-embedded deductible.

Plan Name	Individual Deductible	Individual OOPM	In-Network Coinsurance	Out-of-Network Coinsurance	Virtual Visit	PCP Visit	Specialist Visit	Urgent Care Visit	Minor Lab/X-Ray
Premier 500	$500	$4,000	20%	40%	$0	$20	$20	$20	$0
Premier 1000	$1,000	$5,500	20%	40%	$0	$30	$30	$30	$0
Premier 1500	$1,500	$5,500	20%	40%	$0	$30	$30	$30	$25/$75
Premier 2000	$2,000	$6,500	20%	40%	$0	$30	$30	$30	$0
Premier 3000	$3,000	$6,500	20%	40%	$0	$30	$30	$30	$0
Preferred 500	$500	$6,500	30%	50%	$0	$35	$55	$35	$25/$75
Preferred 1000	$1,000	$7,500	30%	50%	$0	$35	$55	$35	$25/$75
Preferred 2500	$2,500	$7,500	30%	50%	$0	$35	$55	$35	30%
Preferred 3500	$3,500	$7,500	30%	50%	$0	$35	$55	$35	$25/$75
Preferred 5000	$5,000	$7,500	30%	50%	$0	$35	$55	$35	$0
Preferred 6000	$6,000	$8,150	40%	50%	$0	$35	$55	$35	40%
HSA 2500 with Motion	$2,500	$6,350	30%	50%	Ded + $0	Ded+30%	Ded+30%	Ded+30%	Ded+30%
HSA 4500 with Motion	$4,500	$7,000	30%	50%	Ded + $0	Ded+30%	Ded+30%	Ded+30%	Ded+30%

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MEDICAL PLANS – UnitedHealthcare
Choice Plus Network
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Plan Name	Individual Deductible	Individual OOPM	In-Network Coinsurance	Out-of-Network Coinsurance	Virtual Visit	Designated Network Copay		Network Copay		Urgent Care Visit	Minor Lab/X-Ray	
						PCP	Specialist	PCP	Specialist		Freestanding	Hospital
Advanced 500	$500	$4,000	20%	50%	$0	$20	$40	$35	$60	$50	$25/$75	$50/$100
Advanced 1000	$1,000	$4,500	20%	50%	$0	$20	$40	$35	$60	$50	$25/$75	$50/$100
Advanced 2000	$2,000	$5,000	20%	50%	$0	$20	$40	$35	$60	$50	$25/$75	$50/$100
Advanced 3000	$3,000	$6,500	20%	50%	$0	$30	$40	$45	$60	$50	$25/$75	$50/$100
Advanced 5000	$5,000	$8,550	20%	50%	$0	$30	$40	$45	$60	$50	$25/$75	$50/$100

PRESCRIPTION PLANS – UnitedHealthcare

Rx Code	Prescription Drug List	Subject to Medical Deductible	Tier 1	Tier 2	Tier 3	Tier 4	Mail Service Ratio (90 day supply)
Rx 1	Advantage	N/A	$10	$30	$50	$150	2x
Rx 2	Advantage	N/A	$15	$40	40%	40%	2x
Rx 3	Advantage	N/A	$25	30%	40%	50%	2x
RX 4	Advantage	N/A	$10	Non-specialty: $35 Specialty: $150	Non-specialty: $70 Specialty: $500	N/A	2.5x
RX 5 (HSA)	Advantage	All Rx Tiers	30%	30%	30%	30%	2x
RX 6 (HSA)	Advantage	All Rx Tiers	$10	Non-specialty: $35 Specialty: $150	Non-specialty: $70 Specialty: $500	N/A	2.5x

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.

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Effective October 1, 2021 – September 30, 2021

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

Total Benefit	Trust Rules
$10,000	Required Coverage for all Members; Included in all medical plans
$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.

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