Idaho AGC HEALTH PLAN

2020 DELUXE HEALTH PLAN OPTIONS

Preferred Blue PPO Benefit Highlights

Medical Benefits	Option 1 $1,000 Deductible Plan		Option 2 $1,750 Deductible Plan		Option 3 $2,750 Deductible Plan		Option 4 $3,250 Deductible Plan		Option 5 $5,000 Deductible Plan		Option 6 $3,000 Deductible HDHP Plan
Deductible	$1,000 Ind / $2,000 Family		$1,750 Ind / $3,500 Family		$2,750 Ind / $5,500 Family		$3,250 Ind / $6,500 Family		$5,000 Ind / $10,000 Family		$3,000 Ind / $6,000 Family
Coinsurance	30% / 50% (In/Out)		30% / 50% (In/Out)		30% / 50% (In/Out)		30% / 50% (In/Out)		30% / 50% (In/Out)		30% / 50% (In/Out)
In-Network Out-of-Pocket Max[1]	$7,350 Ind / $14,700 Family		$7,350 Ind / $14,700 Family		$7,350 Ind / $14,700 Family		$7,350 Ind / $14,700 Family		$7,350 Ind / $14,700 Family		$6,750 Ind / $13,500 Family
Out-of-Network Out-of-Pocket Max[1]	$14,700 Ind / $29,400 Family		$14,700 Ind / $29,400 Family		$14,700 Ind / $29,400 Family		$14,700 Ind / $29,400 Family		$14,700 Ind / $29,400 Family		Combined in and Out of Network
Office Visit Copayment	$30 PCP / $50 Specialist		$30 PCP / $50 Specialist		$30 PCP / $50 Specialist		$30 PCP / $50 Specialist		$30 PCP / $50 Specialist		Subject to ded/coinsurance
Prescription Drugs (Two Options)	**Option 1**	**Option 2**	**Option 1**	**Option 2**	**Option 1**	**Option 2**	**Option 1**	**Option 2**	**Option 1**	**Option 2**	
Prescription Drug Deductible	None	$500 [2]	None	$500 [2]	None	$500 [2]	None	$500 [2]	None	$500 [2]	
Preferred Generic Drugs	$7	$10	$7	$10	$7	$10	$7	$10	$7	$10	
Non-Preferred Generic Drugs	$7	$10	$7	$10	$7	$10	$7	$10	$7	$10	
Preferred Brand Name Drugs	30%	30% up to $50 [2]	30%	30% up to $50 [2]	30%	30% up to $50 [2]	30%	30% up to $50 [2]	30%	30% up to $50 [2]	Prescription drugs as subject to the medical deductible, coinsurance and out-of pocket
Non-Preferred Brand Name Drugs	50%	50% up to $100 [2]	50%	50% up to $100 [2]	50%	50% up to $100 [2]	50%	50% up to $100 [2]	50%	50% up to $100 [2]	
Preferred Specialty Drugs	30%	30% [2]	30%	30% [2]	30%	30% [2]	30%	30% [2]	30%	30% [2]	
Non-Preferred Specialty Drugs	50%	50% [2]	50%	50% [2]	50%	50% [2]	50%	50% [2]	50%	50% [2]	
Dental Benefits											
Deductible Individual	$50		$50		$50		$50		$50		$50
Deductible Family	$150		$150		$150		$150		$150		$150
Preventive & Diagnostic Services	100% Coinsurance (PPO)		100% Coinsurance (PPO)		100% Coinsurance (PPO)		100% Coinsurance (PPO)		100% Coinsurance (PPO)		100% Coinsurance (PPO)
Preventive & Diagnostic Services	80% Coinsurance (Premier)[3]		80% Coinsurance (Premier)[3]		80% Coinsurance (Premier)[3]		80% Coinsurance (Premier)[3]		80% Coinsurance (Premier)[3]		80% Coinsurance (Premier)[3]
Basic Services	80% Coinsurance		80% Coinsurance		80% Coinsurance		80% Coinsurance		80% Coinsurance		80% Coinsurance
Major Services	50% Coinsurance		50% Coinsurance		50% Coinsurance		50% Coinsurance		50% Coinsurance		50% Coinsurance
Implants	50% Coinsurance		50% Coinsurance		50% Coinsurance		50% Coinsurance		50% Coinsurance		50% Coinsurance
Maximum Benefit	$1,000		$1,000		$1,000		$1,000		$1,000		$1,000
Vision Benefits											
Well Vision Exam Copay	$10 - Every 12 months		$10 - Every 12 months		$10 - Every 12 months		$10 - Every 12 months		$10 - Every 12 months		$10 - Every 12 months
Glasses Copay	$20		$20		$20		$20		$20		$20
Frames	Up to $150 allowance - every 24 mo		Up to $150 allowance - every 24 mo		Up to $150 allowance - every 24 mo		Up to $150 allowance - every 24 mo		Up to $150 allowance - every 24 mo		Up to $150 allowance - every 24 mo
Lenses	Included in prescription glasses		Included in prescription glasses		Included in prescription glasses		Included in prescription glasses		Included in prescription glasses		Included in prescription glasses
Lense Options	Varying Copays		Varying Copays		Varying Copays		Varying Copays		Varying Copays		Varying Copays
Contacts (in lieu of glasses)	Up to $150 allowance - every 12 mo.		Up to $150 allowance - every 12 mo.		Up to $150 allowance - every 12 mo.		Up to $150 allowance - every 12 mo.		Up to $150 allowance - every 12 mo.		Up to $150 allowance - every 12 mo.
Non-VSP Providers	Varying Additional Cost		Varying Additional Cost		Varying Additional Cost		Varying Additional Cost		Varying Additional Cost		Varying Additional Cost
Life Insurance and EAP Benefits											
Life Insurance and AD&D	$25,000 emp / $5,000 dependent		$25,000 emp / $5,000 dependent		$25,000 emp / $5,000 dependent		$25,000 emp / $5,000 dependent		$25,000 emp / $5,000 dependent		$25,000 emp / $5,000 dependent
Short-term disability	$125 / week benefit		$125 / week benefit		$125 / week benefit		$125 / week benefit		$125 / week benefit		$125 / week benefit
COBRA Administration (groups of 20+)	Included		Included		Included		Included		Included		Included

[1] The Out-of-Pocket includes medical and prescription drug deductibles, coinsurance, and copayments.

[2] The $500 Drug Individual Deductible applies to Preferred Brand Name, Non-Preferred Brand Name, Preferred Specialty and Non-Preferred Specialty Drugs only

[3] Dental Serivces may be received from a participating PPO Provider or a participating Premier Provider. Members are responsible for additional coinsurance amount when services are received from a Premier Provider.

[4] There is no coinsurance or copayments for specificially listed preventive prescriptions.

Note: this is a brief overview of the features of the plans; it is not a contract. All provisions of the Master Group Plan and Participating Employee Certificate apply to the plans.

This coverage is not insurance and the Idaho AGC Self-Funded Benefit Trust does not participate in the State Guaranty Association

Partners of the Idaho AGC Health Plan

IDAGC - DCOMP2020

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

DELTA DENTAL

VSP Vision care for life

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