AGC Health Benefit Trust - Alaska Chapters
Product Grid

Medical Plans									Pharmacy				
AGC Plan Name	Plan Type	Description	Office Visit	Specialist Office Visit	Individual Deductible (Combined In & Out-of-Network)	Coinsurance (In / Out-of-Network)	Individual Out-of-Pocket Maximum (In / Out-of-Network)	Routine Lab and X-ray	Tier 1	Tier 2	Tier 3	Tier 4	Mail Order
Premier 500	FLAT COPAY	20/500/80%	$25	$25	$500	80% / 50%	$4,500 / Unlimited	80% after deductible	$8	$25	$60	$250	2.5x
Premier 750	FLAT COPAY	25/750/80%	$30	$30	$750	80% / 50%	$5,000 / Unlimited	80% after deductible	$8	$25	$60	$250	2.5x
Premier 1500	FLAT COPAY	25/1500/80%	$30	$30	$1,500	80% / 50%	$5,750 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
Premier 2500	FLAT COPAY	25/2500/80%	$30	$30	$2,500	80% / 50%	$6,500 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
Premier 3000	FLAT COPAY	30/3000/70%	$35	$35	$3,000	70% / 50%	$6,500 / Unlimited	70% after deductible	$15	$35	$65	$250	2.5x
Preferred 750	SPLIT COPAY	15/750/80%	$20	$65	$750	80% / 50%	$5,000 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
Preferred 1250	SPLIT COPAY	20/1250/80%	$25	$70	$1,250	80% / 50%	$5,500 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
Preferred 1500	SPLIT COPAY	25/1500/80%	$30	$75	$1,500	80% / 50%	$5,750 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
Preferred 2000	SPLIT COPAY	25/2000/80%	$30	$75	$2,000	80% / 50%	$5,500 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
Preferred 3000	SPLIT COPAY	30/3000/80%	$35	$70	$3,000	80% / 50%	$6,850 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
CONSUMER 1000	CONSUMER	1000/80%	20% after deductible	20% after deductible	$1,000	80% / 50%	$5,500 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
CONSUMER 2000	CONSUMER	2000/80%	20% after deductible	20% after deductible	$2,000	80% / 50%	$6,500 / Unlimited	80% after deductible	$15	$35	$65	$250	2.5x
HSA 1750	HSA	1750/80%	20% after deductible	20% after deductible	$1,750	80% / 50% after deductible	$4,500 / Unlimited	80% after deductible	$15 after deductible	$35 after deductible	$65 after deductible	$250 after deductible	2.5x
HSA 2500	HSA	2500/70%	30% after deductible	30% after deductible	$2,500	70% / 50% after deductible	$5,500 / Unlimited	70% after deductible	$15 after deductible	$35 after deductible	$65 after deductible	$250 after deductible	2.5x
HSA 3000	HSA	3000/80%	20% after deductible	20% after deductible	$3,000	80% / 50% after deductible	$6,000 / Unlimited	80% after deductible	$15 after deductible	$35 after deductible	$65 after deductible	$250 after deductible	2.5x

All plans have an embedded deductible except HSA plans, which have a non-embedded deductible.
All plans deductible applies toward out-of-pocket maximum.
All benefit plans are administered on a calendar year basis.

Dental Plans									
AGC Plan Name	Individual Calendar Year Benefit Maximum	Individual Deductible	Family Deductible	Type 1*: Preventative and Diagnostic Services	Type 2: Basic Services	Type 3: Major Services	Payment Basis	Orthodontia Services	Orthodontia Lifetime Maximum
Plan 1000	$1,000	$50	$150	80%	80%	50%	95% UCR	N/A	N/A
Plan 1500	$1,500	$50	$150	100%	80%	50%	95% UCR	N/A	N/A
Plan 2000	$2,000	$50	$150	100%	80%	50%	95% UCR	N/A	N/A
Plan 1000 w/ Ortho	$1,000	$50	$150	80%	80%	50%	95% UCR	50%	$1,500
Plan 1500 w/ Ortho	$1,500	$50	$150	100%	80%	50%	95% UCR	50%	$1,500
Plan 2000 w/ Ortho	$2,000	$50	$150	100%	80%	50%	95% UCR	50%	$1,500

* Deductible waived for Type 1 Preventative and Diagnostic Services.

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Vision Plan	VSP Plan $10/$0		VSP Plan $10/$25		EyeMed		Balanced Care Vision III
	Signature Network	Out-of-Network	Signature Network	Out-of-Network	EyeMed Access Network	Out-of-Network	Vision Reimbursement Plan
Deductibles	$10 Exam	$10 Exam	$10 Exam	$10 Exam	$10 Exam	No deductible	$20 Calendar Year Exam, Eye Glass Lenses or Frames
	$0 Eye Glass Lenses or Frames	$0 Eye Glass Lenses or Frames	$25 Eye Glass Lenses or Frames	$25 Eye Glass Lenses or Frames	$25 Eye Glass Lenses		
Annual Eye Exam	Covered in full	Up to $52	Covered in full	Up to $52	Covered in full	Up to $35	Up to $50
Lenses (per pair)							
Single Vision	Covered in full	Up to $55	Covered in full	Up to $55	Covered in full	Up to $25	Up to $40
Bifocal	Covered in full	Up to $75	Covered in full	Up to $75	Covered in full	Up to $40	Up to $60
Trifocal	Covered in full	Up to $95	Covered in full	Up to $95	Covered in full	Up to $55	Up to $75
Lenticular	Covered in full	Up to $125	Covered in full	Up to $125	20% Discount	No Benefit	Up to $80
Contacts	Up to $120	Up to $105	Up to $120	Up to $105	Up to $115	Up to $100	Up to $100
Frame Allowance	$120	Up to $45	$120	Up to $45	$110	Up to $45	$80
Frequency (months)	12/12/2024	12/12/2024	#	12/12/2024	#	12/12/2024	12/12/2024
Exam/Lens/Frame	Based on date of service	Based on date of service	Based on date of service	Based on date of service	Based on date of service	Based on date of service	Based on date of service

Group Life and Accidental Death & Dismemberment (AD&D)		
AGC Plan Name	**Total Benefit**	**Trust Rules**
$10,000	$10,000	Required Coverage for all Members
Additional $10,000	$20,000	Buy-Up Option at Employer Level
Additional $20,000	$30,000	Buy-Up Option at Employer Level
Additional $30,000	$40,000	Buy-Up Option at Employer Level
Additional $40,000	$50,000*	Buy-Up Option at Employer Level

*$50,000 total benefit available for employers with 6 or more employees.

Life insurance and AD&D benefits both reduce 65 percent at age 65; to 50 percent at age 70; to 30 percent at age 75; and to 20 percent at age 80.

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