2017 DELUXE HEALTH PLAN OPTIONS

Preferred Blue PPO Benefit Highlights

Medical Benefits	Option 1 $1,000 Deductible Plan		Option 2 $1,500 Deductible Plan		Option 3 $2,500 Deductible Plan		Option 4 $3,000 Deductible Plan		Option 5 $4,500 Deductible Plan		Option 6 $3,000 Deductible HDHP Plan
Deductible	$1,000 Ind / $2,000 Family		$1,500 Ind / $3,000 Family		$2,500 Ind / $5,000 Family		$3,000 Ind / $6,000 Family		$4,500 Ind / $9,000 Family		$3,000 Ind / $6,000 Family
Coinsurance	25% / 45% (In/Out)		25% / 45% (In/Out)		25% / 45% (In/Out)		25% / 45% (In/Out)		25% / 45% (In/Out)		25% / 45% (In/Out)
In-Network Out-of-Pocket Max*	$6,500 Ind / $13,000 Family		$6,500 Ind / $13,000 Family		$6,500 Ind / $13,000 Family		$6,500 Ind / $13,000 Family		$6,500 Ind / $13,000 Family		$6,450 Ind / $12,900 Family
Out-of-Network Out-of-Pocket Max*	$13,000 Ind / $26,000 Family		$13,000 Ind / $26,000 Family		$13,000 Ind / $26,000 Family		$13,000 Ind / $26,000 Family		$13,000 Ind / $26,000 Family		Combined in and Out of Network
Office Visit Copayment	$30 PCP / $45 Specialist		$30 PCP / $45 Specialist		$30 PCP / $45 Specialist		$30 PCP / $45 Specialist		$30 PCP / $45 Specialist		Subject to ded/coinsurance
Preventive Services	Paid 100% / 45% (In/Out)		Paid at 100% / 45% coin (in/out)		Paid at 100% / 45% coin (in/out)		Paid at 100% / 45% coin (in/out)		Paid at 100% / 45% coin (in/out)		Paid at 100% / 45% coin (in/out)
Annual Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited
Prescription Drug Choices	**Choice 1**	**Choice 2**	**Choice 1**	**Choice 2**	**Choice 1**	**Choice 2**	**Choice 1**	**Choice 2**	**Choice 1**	**Choice 2**	
Prescription Drug Deductible	None	$250 Brand Ded	None	$250 Brand Ded	None	$250 Brand Ded	None	$250 Brand Ded	None	$250 Brand Ded	Prescription drugs as subject to the medical deductible, coinsurance and out-of-pocket
Coinsurance/Copayment	$7/30%/50%	$10/$30/$50/$200***	$7/30%/50%	$10/$30/$50/$200***	$7/30%/50%	$10/$30/$50/$200***	$7/30%/50%	$10/$30/$50/$200***	$7/30%/50%	$10/$30/$50/$200***	
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)**		80% Coinsurance (Premier)**		80% Coinsurance (Premier)**		80% Coinsurance (Premier)**		80% Coinsurance (Premier)**		80% Coinsurance (Premier)**
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											
Employee Assitance Program (EAP)	3 visits per incident		3 visits per incident		3 visits per incident		3 visits per incident		3 visits per incident		3 visits per incident
Life Insurance	$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 weekly benefit		$125 weekly benefit		$125 weekly benefit		$125 weekly benefit		$125 weekly benefit		$125 weekly benefit
COBRA Administration (groups of 20+)	Included		Included		Included		Included		Included		Included

*The Out-of-Pocket includes medical and prescription drug deductibles, coinsurance, and copayments.

**Dental Services 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.

***Members pays: $250 Deductible for preferred, non-preferred and speciality drugs, $10 generic drugs (no deductible), $30 for preferred drugs, $50 for non-preferred drugs and $200 for specialty drugs.

The highlights provide 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 - DCOMP2017

Connect. Improve. Achieve.