2023 Benefit Grid

Region 14 *– Employer Copy*

US Employee Benefits Services Group.

General Details

	Basic Plan - RBP		Basic Plan- UHC		High Deductible - RBP		Select Plan - RBP		Select Plan - UHC	
General Features										
Network	PHCS/Multiplan Primary and Ancillary Network w/Claim Doc		United Health Care Choice Plus Network		PHCS/Multiplan Primary and Ancillary Network w/Claim Doc		PHCS/Multiplan Primary and Ancillary Network w/Claim Doc		United Health Care Choice Plus Network	
Deductible & Coinsurance										
	In Network	Non-Network	In-Network	Non-Network	In Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible-Individual	$5,000	$10,000	$5,000	$10,000	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Deductible-Family	$10,000	$20,000	$10,000	$20,000	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Coinsurance	80% after deductible	60% after deductible	70% after deductible	50% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Out-of-Pocket Maximum (includes deductible, coinsurance and copays)										
	In Network	Non-Network	In-Network	Non-Network	In Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Individual	$7,500	$15,000	$9,100	$18,200	$7,050	$14,100	$7,500	$15,000	$9,100	$18,200
Family	$15,000	$30,000	$18,200	$36,400	$14,100	$28,200	$15,000	$30,000	$18,200	$36,400

Medical Plan

	Prior Auth Required?	Basic Plan - RBP		Basic Plan- UHC		High Deductible - RBP		Select Plan - RBP		Select Plan - UHC	
		Member Pays		Member Pays		Member Pays		Member Pays		Member Pays	
Physician Services		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Primary Care Office Visit	No	$30 Copay	40% after deductible	$30 copay	50% after deductible	20% after deductible	40% after deductible	$30 Copay	40% after deductible	$30 copay	40% after deductible
Specialist Office Visit	No	$70 Copay	40% after deductible	$70 copay	50% after deductible	20% after deductible	40% after deductible	$70 Copay	40% after deductible	$70 copay	40% after deductible
Services provided in a Physicians Office *(other than the office visit)*	No	Included in OV Copay	40% after deductible	Included in OV Copay	50% after deductible	20% after deductible	40% after deductible	Included in OV Copay	40% after deductible	Included in OV Copay	40% after deductible
Urgent Care	No	$50 Copay	40% after deductible	$50 copay	50% after deductible	20% after deductible	40% after deductible	$50 Copay	40% after deductible	$50 Copay	40% after deductible
Telemedicine Services (1 800 MD)	No	$0	no coverage	$0	no coverage	$0	no coverage	$0	no coverage	$0	no coverage
Preventive & Wellness Services *(ACA required preventive services only)*		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Services at Physician Office	No	$0 Copay	40% after deductible	$0 copay	50% after deductible	$0 Copay	40% after deductible	$0 Copay	40% after deductible	$0 copay	20% after deductible
Outpatient Hospital Free Standing Facility Services	Yes	$0 copay		$0 copay		$0 copay		$0 copay		$0 copay	
Hospital/Facility Services		Open Access*		In-Network	Non-Network	Open Access*		Open Access*		In-Network	Non-Network
Inpatient Hospitalization	Yes	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
Inpatient Surgery *(Second surgical opinion may be required)*	Yes	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
Outpatient Hospital Free Standing Facility Services and Surgery	Yes	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
Anesthesia	No	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
Emergency Room Services *(Life threatening Services)*	No	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
Emergency Room Services *(Non-Emergent Care)*	No	Not Covered/100% Paid by Member		Not Covered/100% Paid by Member		Not Covered/100% Paid by Member		Not Covered/100% Paid by Member		Not Covered/100% Paid by Member	
Diagnostic Services (Outpatient)		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Laboratory Services	No	$50 copay		$50 copay		20% after deductible	40% after deductible	$30 copay		$30 copay	
Radiology (x-ray, ultrasound)	No	$50 copay		$50 copay		20% after deductible	40% after deductible	$30 copay		$30 copay	
CT / MRI / MRA / PET Scan	Yes	20% after deductible	40% after deductible	30% after deductible		20% after deductible	40% after deductible	20% coinsurance / no deductible		$20% coinsurance / no deductible	

Medical Plan, Cont.

		Basic Plan - RBP		Basic Plan- UHC		High Deductible - RBP		Select Plan - RBP		Select Plan - UHC	
	Prior Auth Required?	Member Pays		Member Pays		Member Pays		Member Pays		Member Pays	
Pregnancy Benefits		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Physician Visits	No	$30 Copay	40% after deductible	$30 Copay	50% after deductible	20% after deductible	40% after deductible	$30 Copay	40% after deductible	$30 Copay	40% after deductible
Testing/Childbirth/Delivery	No	20% after deductible		30% after deductible		20% after deductible		20% after deductible		20% after deductible	
Mental & Nervous; Chemical Dependency		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Office Visits (outpatient)	No	$30 Copay	40% after deductible	$30 Copay	50% after deductible	20% after deductible	40% after deductible	$30 Copay	40% after deductible	$30 Copay	40% after deductible
Inpatient (Facility)	Yes	20% after deductible		30% after deductible		20% after deductible		20% after deductible		20% after deductible	
Outpatient (Facility)	Yes	$30 Copay		$30 Copay		20% after deductible		$30 Copay		$30 Copay	
Other Services; Network Requirements		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Allergy Office visits *(The copay applies for the office visit only)*	No	$100 Copay	40% after deductible	$100 Copay	50% after deductible	20% after deductible	40% after deductible	$100 Copay	40% after deductible	$100 Copay	40% after deductible
Allergy Services Testing / injections	Yes	20% after deductible	40% after deductible	30% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Rehabilitation/Habilitation Services *(limited to 30 visits per plan year)*	No	20% after deductible	40% after deductible	30% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Other Services		Open Access*		In-Network	Non-Network	Open Access*		Open Access*		In-Network	Non-Network
Emergency Medical Transportation	No	20% after deductible		30% after deductible		20% after deductible		20% after deductible		40% after deductible	
Air Ambulance Transportation - Emergency *(Pre-cert as soon as reasonably possible)*	Yes	20% after deductible		30% after deductible		20% after deductible		20% after deductible		40% after deductible	

Pharmacy Benefits

	Basic Plan - RBP	Basic Plan- UHC	High Deductible - RBP	Select Plan - RBP	Select Plan - UHC
	Participating Pharmacies	Participating Pharmacies	Participating Pharmacies	Participating Pharmacies	Participating Pharmacies
PREVENTIVE Prescriptions ONLY *(Subject to Formulary & ACA requirements)*	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Pharmacy Retail – up to a 30 day supply	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered
Pharmacy Mail Order – up to a 90 day supply	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered	**Generic ONLY:** $0 Copay **Brand Drugs:** Not Covered
NON-PREVENTIVE Prescriptions - *(Subject to Formulary)*	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Retail Pharmacy– (up to a 30 day supply)	**Generic:** $10 Copay **Preferred Brand:** $35 Copay **Non-Preferred Brand:** Not Covered; Member pays 100%	**Generic:** $10 Copay **Preferred Brand:** $35 Copay **Non Preferred Brand:** Not Covered; Member pays 100%	**Generic:** 30% after deductible **Preferred Brand:** 30% after deductible **Non-Preferred Brand:** 30% after deductible	**Generic:** $10 Copay **Preferred Brand:** $35 Copay **Non-Preferred Brand:** 30% to $125 Max	**Generic:** $10 Copay **Preferred Brand:** $35 Copay **Non-Preferred Brand:** 30% to $125 Max
Mail Order Pharmacy (90 day supply)	**Generic:** $25 Copay **Preferred Brand:** $87.50 Copay **Non-Preferred Brand:** Not Covered; Member pays 100%	**Generic:** $25 Copay **Preferred Brand:** $87.50 Copay **Non-Preferred Brand:** Not Covered; Member pays 100%	**Generic:** 30% after deductible **Preferred Brand:** 30% after deductible **Non-Preferred Brand:** 30% after deductible	**Generic:** $25 Copay **Preferred Brand:** $87.50 Copay **Non-Preferred Brand:** 30% to $125 Max	**Generic:** $25 Copay **Preferred Brand:** $87.50 Copay **Non-Preferred Brand:** 30% to $125 Max
SPECIALTY MEDICATIONS	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Rx Contain Program	$0 Copay*	$0 Copay*	50% after deductible; $500 Maximum	$0 Copay*	$0 Copay*
Retail Pharmacy– (up to a 30 day supply)	50% Copay; $500 Maximum	50% Copay; $500 Maximum	50% after deductible; $500 Maximum	50% after deductible; $500 Maximum	50% after deductible; $500 Maximum
Mail Order Pharmacy (90 day supply)	50% Copay; $500 Maximum	50% Copay; $500 Maximum	50% after deductible; $500 Maximum	50% Copay; $500 Maximum	50% Copay; $500 Maximum

**RXContain Program provides certain specialty medications at a $0 copay if the participants family income is below $100,000 annually.*

**Reach out to ABA to schedule hospital services.*

US Employee Benefits Services Group

Premium Totals

	Basic Plan - RBP	Basic Plan- UHC	High Deductible - RBP	Select Plan - RBP	Select Plan - UHC
Total Premiums					
Single	$478.48	$538.62	$516.24	$513.60	$578.84
Employee + Spouse	$1,333.72	$1,512.32	$1,389.86	$1,386.28	$1,572.52
Employee + Child(ren)	$829.55	$937.61	$866.82	$875.59	$990.35
Family	$1,642.89	$1,863.23	$1,709.45	$1,716.84	$1,947.92

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