



# 2023 Benefit Grid

Region 14 – Employer Copy



Employee Benefits  
Services Group.



## General Details

	Basic Plan - RBP	Basic Plan- UHC	High Deductible - RBP	Select Plan - RBP	Select Plan - UHC
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### General Features

Network	Basic Plan - RBP	Basic Plan- UHC	High Deductible - RBP	Select Plan - RBP	Select Plan - UHC
	PHCS/Multiplan Primary and Ancillary Network w/HST	United Health Care Choice Plus Network	PHCS/Multiplan Primary and Ancillary Network w/HST	PHCS/Multiplan Primary and Ancillary Network w/HST	United Health Care Choice Plus Network

### Deductible & Coinsurance

	Basic Plan - RBP		Basic Plan- UHC		High Deductible - RBP		Select Plan - RBP		Select Plan - UHC	
	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)

	Basic Plan - RBP		Basic Plan- UHC		High Deductible - RBP		Select Plan - RBP		Select Plan - UHC	
	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

		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	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
<b>Physician Services</b>	<b>Prior Auth Required?</b>										
<b>Primary Care Office Visit</b>	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
<b>Specialist Office Visit</b>	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
<b>Services provided in a Physicians Office (other than the office visit)</b>	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
<b>Urgent Care</b>	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
<b>Telemedicine Services (1 800 MD)</b>	No	\$0	no coverage	\$0	no coverage	\$0	no coverage	\$0	no coverage	\$0	no coverage
<b>Preventive &amp; Wellness Services (ACA required preventive services only)</b>		<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>
<b>Services at Physician Office</b>	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
<b>Outpatient Hospital Free Standing Facility Services</b>	Yes	\$0 copay		\$0 copay		\$0 copay		\$0 copay		\$0 copay	
<b>Hospital/Facility Services</b>		<b>Open Access*</b>		<b>In-Network</b>	<b>Non-Network</b>	<b>Open Access*</b>		<b>Open Access*</b>		<b>In-Network</b>	<b>Non-Network</b>
<b>Inpatient Hospitalization</b>	Yes	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
<b>Inpatient Surgery (Second surgical opinion may be required)</b>	Yes	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
<b>Outpatient Hospital Free Standing Facility Services and Surgery</b>	Yes	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
<b>Anesthesia</b>	No	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
<b>Emergency Room Services (Life threatening Services)</b>	No	20% after deductible		30% after deductible	50% after deductible	20% after deductible		20% after deductible		20% after deductible	40% after deductible
<b>Emergency Room Services (Non-Emergent Care)</b>	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	
<b>Diagnostic Services (Outpatient)</b>		<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>	<b>In-Network</b>	<b>Non-Network</b>
<b>Laboratory Services</b>	No	\$50 copay		\$50 copay		20% after deductible	40% after deductible	\$30 copay		\$30 copay	
<b>Radiology (x-ray, ultrasound)</b>	No	\$50 copay		\$50 copay		20% after deductible	40% after deductible	\$30 copay		\$30 copay	
<b>CT / MRI / MRA / PET Scan</b>	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	
		Member Pays		Member Pays		Member Pays		Member Pays		Member Pays	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
<b>Pregnancy Benefits</b>											
<b>Physician Visits</b>	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
<b>Testing/Childbirth/Delivery</b>	No	20% after deductible		30% after deductible		20% after deductible		20% after deductible		20% after deductible	
<b>Mental &amp; Nervous; Chemical Dependency</b>		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
<b>Office Visits (outpatient)</b>	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
<b>Inpatient (Facility)</b>	Yes	20% after deductible		30% after deductible		20% after deductible		20% after deductible		20% after deductible	
<b>Outpatient (Facility)</b>	Yes	\$30 Copay		\$30 Copay		20% after deductible		\$30 Copay		\$30 Copay	
<b>Other Services; Network Requirements</b>		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
<b>Allergy Office visits</b> <i>(The copay applies for the office visit only)</i>	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
<b>Allergy Services Testing / injections</b>	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
<b>Rehabilitation/Habilitation Services</b> <i>(limited to 30 visits per plan year)</i>	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
<b>Other Services</b>		Open Access*		In-Network	Non-Network	Open Access*		Open Access*		In-Network	Non-Network
<b>Emergency Medical Transportation</b>	No	20% after deductible		30% after deductible		20% after deductible		20% after deductible		40% after deductible	
<b>Air Ambulance Transportation - Emergency</b> <i>(Pre-cert as soon as reasonably possible)</i>	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
<b>PREVENTIVE Prescriptions ONLY</b> <i>(Subject to Formulary &amp; ACA requirements)</i>	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Pharmacy Retail – up to a 30 day supply	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered
Pharmacy Mail Order – up to a 90 day supply	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered	<b>Generic ONLY:</b> \$0 Copay <b>Brand Drugs:</b> Not Covered
<b>NON-PREVENTIVE Prescriptions -</b> <i>(Subject to Formulary)</i>	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Retail Pharmacy– (up to a 30 day supply)	<b>Generic:</b> \$10 Copay <b>Preferred Brand:</b> \$35 Copay <b>Non-Preferred Brand:</b> Not Covered; Member pays 100%	<b>Generic:</b> \$10 Copay <b>Preferred Brand:</b> \$35 Copay <b>Non-Preferred Brand:</b> Not Covered; Member pays 100%	<b>Generic:</b> 30% after deductible <b>Preferred Brand:</b> 30% after deductible <b>Non-Preferred Brand:</b> 30% after deductible	<b>Generic:</b> \$10 Copay <b>Preferred Brand:</b> \$35 Copay <b>Non-Preferred Brand:</b> 30% to \$125 Max	<b>Generic:</b> \$10 Copay <b>Preferred Brand:</b> \$35 Copay <b>Non-Preferred Brand:</b> 30% to \$125 Max
Mail Order Pharmacy (90 day supply)	<b>Generic:</b> \$25 Copay <b>Preferred Brand:</b> \$87.50 Copay <b>Non-Preferred Brand:</b> Not Covered; Member pays 100%	<b>Generic:</b> \$25 Copay <b>Preferred Brand:</b> \$87.50 Copay <b>Non-Preferred Brand:</b> Not Covered; Member pays 100%	<b>Generic:</b> 30% after deductible <b>Preferred Brand:</b> 30% after deductible <b>Non-Preferred Brand:</b> 30% after deductible	<b>Generic:</b> \$25 Copay <b>Preferred Brand:</b> \$87.50 Copay <b>Non-Preferred Brand:</b> 30% to \$125 Max	<b>Generic:</b> \$25 Copay <b>Preferred Brand:</b> \$87.50 Copay <b>Non-Preferred Brand:</b> 30% to \$125 Max
<b>SPECIALTY MEDICATIONS</b>	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.



## Premium Totals

	Basic Plan - RBP	Basic Plan- UHC	High Deductible - RBP	Select Plan - RBP	Select Plan - UHC
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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