

The Dermatology Group

Effective Date: **12/1/2023**

NEW - ADVENT

RENEWING

NEW

**FOR ILLUSTRATIVE PURPOSES
REFER TO BENEFIT SUMMARY**

Carrier	United Healthcare	United HealthCare	United Healthcare
Plan Name	DBY9/ Rx NH46	BWQ7/ DO1 Rx	DB6V/ 124S Rx (H.S.A)
Network	NHP HMO	Choice (INS)	Choice Plus (INS)
IN-NETWORK BENEFITS			
FINANCIALS			
Deductible - (Individual / Family)	\$5,000 / \$10,000	\$2,000/ \$4,000	\$3,000/ \$6,000
Deductible - (Embedded / Non-Embedded)	Embedded	Embedded	Embedded
Coinsurance	30%	0%	0%
Out of Pocket Maximum - (Individual / Family)	\$6,500/ \$13,000	\$4,000/ \$8,000	\$5,000/ \$10,000
PREVENTATIVE CARE			
Routine Exams (Physical, Well Woman, Well Child)	\$0	\$0	\$0
Routine Mammograms, Colonoscopies, etc.	\$0	\$0	\$0
PHYSICIAN OFFICE VISITS			
PCP Office Visit (Convenient Care Clinics)	\$30	\$25	DEDUCTIBLE
Tele-Medicine	\$0	\$0	DEDUCTIBLE
Specialist Office Visit	\$55	\$50	DEDUCTIBLE
PRESCRIPTION BENEFITS			
Rx Deductible	\$0/ Broad Network	\$0/ Broad Network	Integ. w/ Med. / Broad network
Prescription Drugs	\$10/ 45/ 80/ 125	\$10/ 45/ 85	DED, then \$10/ 35/ 70
Specialty Drugs	\$10/ 45/ 80/ 125	\$10/ 150/ 500	DED, then \$10/ 150/ 500
Mail Order Drugs (Up to 90 Day Supply)	2.5 X Retail	2.5 X Retail	DED, then 2.5 X Retail
DIAGNOSTIC / LAB			
Independent Clinical Lab	DED + 30%	\$0 (DDP)/ DED + 50% (Non-DDP)	DED (DDP)/ D+ 50% (Non-DDP)
Independent Diagnostic Services (other than AIS)	DED + 30%	\$0	DEDUCTIBLE
Independent Advanced Imaging Services (MRI, CAT Scan, etc.)	D + 30% (DDP)/ D + 50% (Non-DDP)	DED (DDP)/ DED + 50% (Non-DDP)	DED (DDP)/ DED + 50% (Non-DDP)
HOSPITALIZATION & OUTPATIENT SERVICES			
Ambulatory Surgical Center	DED + 30%	DEDUCTIBLE	DEDUCTIBLE
Outpatient Hospital Facility Services	DED + 30%	DEDUCTIBLE	DEDUCTIBLE
Inpatient Hospital Facility Services	DED + 30%	DEDUCTIBLE	DEDUCTIBLE
Physician Services (ER / Hospital or ASC)	DED + 30%	DEDUCTIBLE	DEDUCTIBLE
Emergency Room- Facility	\$300	\$250	DEDUCTIBLE
Urgent Care (Value Choice Providers/ Other Network Providers)	\$75	\$75	DEDUCTIBLE
OUT-OF-NETWORK BENEFITS			
FINANCIALS			
Deductible - (Individual / Family)	N/A	N/A	\$5,000/ \$10,000
Coinsurance	N/A	N/A	50%
Out of Pocket Maximum - (Individual / Family)	N/A	N/A	\$10,000/ \$20,000
COVERAGE TIER			
	DBY9 NHP HMO	BWQ7 Choice (INS)	DB6V Choice Plus (INS)

PER PAYCHECK DEDUCTIONS

Employee Only	\$69.85	\$202.20	\$149.34
Employee + Spouse	\$365.65	\$648.87	\$535.75
Employee + Child(ren)	\$339.69	\$609.68	\$501.84
Family	\$604.36	\$1,009.33	\$847.58