





Major Medical Plans	Ultra 8000 HSA	Ultra 6000	Ultra 3000	Ultra 1000
Network	 Cigna	 Cigna	 Cigna	 Cigna
Type of Plan	Qualified HSA Health Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan
Plan Availability	All 50 States	All 50 States	All 50 States	All 50 States
Member:	\$782.00	\$855.00	\$979.00	\$1,318.00
Member + Spouse	\$1,423.00	\$1,559.00	\$1,787.00	\$2,416.00
Member + Child(ren)	\$1,265.00	\$1,385.00	\$1,588.00	\$2,145.00
Family	\$1,876.00	\$2,056.00	\$2,358.00	\$3,190.00
<b>Benefits</b>				
Individual Deductible	\$8,000	\$6,000	\$3,000	\$1,000
Family Deductible	\$16,000	\$12,000	\$6,000	\$2,000
Individual Max Out of Pocket	\$8,000	\$9,200	\$9,200	\$5,000
Family Max Out of Pocket	\$16,000	\$18,900	\$18,900	\$10,000
Coinsurance	None	70%	70%	80%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Primary Care Copay	0% after deductible	\$30	\$30	\$20
Specialist Care Copay	0% after deductible	\$60	\$60	\$40
Urgent Care	0% after deductible	\$60	\$60	\$40
<b>Laboratory</b>				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
<b>Radiology Services</b>				
Facility (CT, PET, MRI's) up to plan allowance	Facility: 0% after deductible Professional Fees: 0% after deductible	Facility: 30% of plan allowable, deductible does not apply. Professional Fees: 30% after deductible	Facility: 30% of plan allowable, deductible does not apply. Professional Fees: 30% after deductible	Deductible then 20%
<b>Facility &amp; Professional Services</b>				
Emergency Room - Professional Fee	0% after deductible	30% after deductible. Out of network is subject to plan allowable fee.	30% after deductible. Out of network is subject to plan allowable fee.	Deductible then 20%
Emergency Room - Facility	0% after deductible	30% of plan allowable, deductible does not apply.	30% of plan allowable, deductible does not apply.	Deductible then 20%
Inpatient Hospital - Physician Fees	0% after deductible	Deductible then 30%	Deductible then 30%	Deductible then 20%
Inpatient - Facility	0% after deductible	Deductible then 30%	Deductible then 30%	Deductible then 20%
Outpatient - Physician	0% after deductible	30% after deductible, subject to plan allowable	30% after deductible, subject to plan allowable	Deductible then 20%
Outpatient Hospital - Facility	0% after deductible	30% of plan allowable, deductible does not apply	30% of plan allowable, deductible does not apply	Deductible then 20%
<b>Out of Network</b>				
Deductible	\$16,000/\$32,000	\$12,000/\$24,000	\$6,000/\$12,000	\$2,000/\$4,000
MOOP	\$18,900/ \$37,900	\$18,900/ \$37,900	\$18,950/ \$37,900	\$10,000/ \$20,000
Coinsurance	40%	40%	40%	60%
Reimbursement	Plans Allowable Fee	Plans Allowable Fee	Plans Allowable Fee	Plans Allowable Fee
<b>Prescription Drug Benefit</b>				
Generic	0% after deductible	\$15	\$15	\$15
Preferred Brand	0% after deductible	\$65	\$65	\$45
Non-Preferred Brand	0% after deductible	\$100	\$100	\$85



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- 12-month rate guarantee from effective date. Renewal June 1, 2026
- All benefits are on a calendar year basis. (Deductible and MOOP reset on January 1st.)
- All plans will have a One-time Processing fee of \$125
- Does not include \$10 association fee.
- Disclaimer: This spreadsheet is only a snapshot of benefits. Please refer to the SBC as this is for illustration purposes only. Online rates and benefits supersede this sheet.

Major Medical Plans	Ultra 8000 HSA	Ultra 6000	Ultra 3000	Ultra 1000
Network				
Type of Plan	Qualified HSA/ Reference-based	Reference-based pricing	Reference-based pricing	Reference-based pricing
Plan Availability	49 States (Not available in New Jersey)	49 States (Not available in New Jersey)	49 States (Not available in New Jersey)	49 States (Not available in New Jersey)
Member:	\$656.00	\$718.00	\$820.00	\$1,103.00
Member + Spouse	\$1,190.00	\$1,304.00	\$1,494.00	\$2,018.00
Member + Child(ren)	\$1,058.00	\$1,159.00	\$1,328.00	\$1,792.00
Family	\$1,568.00	\$1,718.00	\$1,970.00	\$2,663.00
<b>Benefits</b>				
Individual Deductible	\$8,000	\$6,000	\$3,000	\$1,000
Family Deductible	\$16,000	\$12,000	\$6,000	\$2,000
Individual Max Out of Pocket	\$8,000	\$9,200	\$9,200	\$5,000
Family Max Out of Pocket	\$16,000	\$18,900	\$18,900	\$10,000
Coinsurance	none	70%	70%	80%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Primary Care Copay	0% after deductible	\$30	\$30	\$20
Specialist Care Copay	0% after deductible	\$60	\$60	\$40
Urgent Care	0% after deductible	\$60	\$60	\$40
<b>Laboratory</b>				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
<b>Radiology Services</b>				
Facility (CT, PET, MRI's) up to plan allowance	Facility: 0% after deductible Professional Fees: 0% after deductible	Facility: 30% of plan allowable, deductible does not apply. Professional Fees: 30% after deductible	Facility: 30% of plan allowable, deductible does not apply. Professional Fees: 30% after deductible	Deductible then 20%
<b>Facility &amp; Professional Services</b>				
Emergency Room - Professional Fee	0% after deductible	30% after deductible	30% after deductible	Deductible then 20%
Emergency Room - Facility	0% after deductible	30% of plan allowable, deductible does not apply.	30% of plan allowable, deductible does not apply	Deductible then 20%
Inpatient Hospital - Physician Fees	0% after deductible	30% after deductible	30% after deductible	Deductible then 20%
Inpatient - Facility	0% after deductible	30% of plan allowable, deductible does not apply	30% of plan allowable, deductible does not apply	Deductible then 20%
Outpatient - Physician	0% after deductible	30% of plan allowable, deductible does not apply	30% after deductible	Deductible then 20%
Outpatient Hospital - Facility	0% after deductible	30% of plan allowable, deductible does not apply	30% of plan allowable, deductible does not apply	Deductible then 20%
<b>MOOP</b>				
	\$8,000/\$16,000	\$9,450/ \$18,900	\$9,450/ \$18,900	\$5,000/ \$10,000
<b>Prescription Drug Benefit</b>				
Generic	0% after deductible	\$15	\$15	\$15
Preferred Brand	0% after deductible	\$65	\$65	\$45
Non-Preferred Brand	0% after deductible	\$100	\$100	\$85

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- All plans will have a One-time Processing fee of \$125
- Does not include \$10 association fee.
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Major Medical Plans	Ultra 8000 HSA	Ultra 6000	Ultra 3000	Ultra 1000
Network	 QUALCARE	 QUALCARE	 QUALCARE	 QUALCARE
Type of Plan	Qualified HSA Health Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan
Plan Availability	New Jersey Residents Only	New Jersey Residents Only	New Jersey Residents Only	New Jersey Residents Only
Member:	\$656.00	\$718.00	\$820.00	\$1,103.00
Member + Spouse	\$1,190.00	\$1,304.00	\$1,494.00	\$2,018.00
Member + Child(ren)	\$1,058.00	\$1,159.00	\$1,328.00	\$1,792.00
Family	\$1,568.00	\$1,718.00	\$1,970.00	\$2,663.00
<b>Benefits</b>				
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Family Deductible	\$16,000	\$12,000	\$6,000	\$2,000
Individual Max Out of Pocket	\$8,000	\$9,200	\$9,200	\$5,000
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Coinsurance	None	70%	70%	80%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Primary Care Copay	0% after deductible	\$30	\$30	\$20
Specialist Care Copay	0% after deductible	\$60	\$60	\$40
Urgent Care	0% after deductible	\$60	\$60	\$90
<b>Laboratory</b>				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
<b>Radiology Services</b>				
Facility (CT, PET, MRI's) up to plan allowance	Facility: 0% after deductible Professional Fees: 0% after deductible	Facility: 30% of plan allowable, deductible does not apply. Professional Fees: 30% after deductible	Facility: 30% of plan allowable, deductible does not apply. Professional Fees: 30% after deductible	Deductible then 20%
<b>Facility &amp; Professional Services</b>				
Emergency Room - Professional Fee	0% after deductible	30% after deductible	30% after deductible	Deductible then 20%
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Inpatient Hospital - Physician Fees	0% after deductible	Deductible then 30%	Deductible then 30%	Deductible then 20%
Inpatient - Facility	0% after deductible	30% of plan allowable, deductible does not apply	30% of plan allowable, deductible does not apply	Deductible then 20%
Outpatient - Physician	0% after deductible	30% of plan allowable, deductible does not apply	Deductible then 30%	Deductible then 20%
Outpatient Hospital - Facility	0% after deductible	30% of plan allowable, deductible does not apply	30% of plan allowable, deductible does not apply	Deductible then 20%
<b>Out of State</b>				
Deductible	\$16,000/\$32,000	\$12,000/\$24,000	\$6,000/\$12,000	\$2,000/\$4,000
MOOP	\$16,000/\$32,000	\$18,900/ \$37,900	\$18,950/ \$37,900	\$10,000/ \$20,000
Coinsurance	none	40%	40%	60%
Reimbursement	Subject to plan allowable	Subject to plan allowable	Subject to plan allowable	Subject to plan allowable
<b>Prescription Drug Benefit</b>				
Generic	0% after deductible	\$15	\$15	\$15
Preferred Brand	0% after deductible	\$65	\$65	\$45
Non-Preferred Brand	0% after deductible	\$100	\$100	\$85

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