



Major Medical Plans	Ultra 8000 HSA	Ultra 7350	Ultra 6000	Ultra 3000	Ultra 1000
Network	Anthem	Anthem	Anthem	Anthem	Anthem
Type of Plan	Qualified HSA Health Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan
Plan Availability	14 States	14 States	14 States	14 States	14 States
Member:	\$763.00	\$800.00	\$829.00	\$940.00	\$1,244.00
Member + Spouse	\$1,338.00	\$1,407.00	\$1,460.00	\$1,665.00	\$2,228.00
Member + Child(ren)	\$1,196.00	\$1,257.00	\$1,304.00	\$1,485.00	\$1,985.00
Family	\$1,744.00	\$1,835.00	\$1,905.00	\$2,176.00	\$2,922.00
Benefits					
Individual Deductible	\$8,000	\$7,350	\$6,000	\$3,000	\$1,000
Family Deductible	\$16,000	\$14,700	\$12,000	\$6,000	\$2,000
Individual Max Out of Pocket	\$8,000	\$9,200	\$9,200	\$9,200	\$9,200
Family Max Out of Pocket	\$16,000	\$18,400	\$18,400	\$18,400	\$18,400
Coinsurance	100%	70%	70%	70%	70%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Primary Care Copay	0% after deductible	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit
Specialist Care Copay	0% after deductible	\$60 copay/visit	\$60 copay/visit	\$60 copay/visit	\$60 copay/visit
Urgent Care	0% after deductible	\$60 copay/visit	\$60 copay/visit	\$60 copay/visit	\$60 copay/visit
Mental Health Outpatient	0% after deductible	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit
Rehabilitation & Habilitation services	0% after deductible	\$60 copay/visit	\$60 copay/visit	\$60 copay/visit	\$60 copay/visit
Laboratory					
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit
Radiology Services					
Facility (CT, PET, MRI's) up to plan allowance	Facility: 0% after deductible Professional Fees: 0% after deductible	Facility: 30%, deductible does not apply. Professional Fees: 30% after deductible	Facility: 30%, deductible does not apply. Professional Fees: 30% after deductible	Facility: 30%, deductible does not apply. Professional Fees: 30% after deductible	Facility: 30%, deductible does not apply. Professional Fees: 30% after deductible
Facility & Professional Services					
Emergency Room - Physician Fees	0% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency Room - Facility	0% after deductible	30%, deductible does not apply.	30%, deductible does not apply.	30%, deductible does not apply.	30%, deductible does not apply.
Inpatient Hospital - Physician Fees	0% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Inpatient - Facility	0% after deductible	30%, deductible does not apply.	30%, deductible does not apply.	30%, deductible does not apply.	30%, deductible does not apply.
Outpatient - Physician	0% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient Hospital - Facility	0% after deductible	30%, deductible does not apply.	30%, deductible does not apply.	30%, deductible does not apply.	30%, deductible does not apply.
Out of Network					
Deductible	\$16,000/\$32,000	\$14,700/\$29,400	\$12,000/\$24,000	\$6,000/\$12,000	\$2,000/\$4,000
MOOP	\$18,400/\$36,800	\$18,400/\$36,800	\$18,400/\$36,800	\$18,400/\$36,800	\$18,400/\$36,800
Coinsurance	40%	40%	40%	40%	40%
Reimbursement	Plans Allowable Fee	Plans Allowable Fee	Plans Allowable Fee	Plans Allowable Fee	Plans Allowable Fee
Prescription Drug Benefit					
Generic	0% after deductible	\$15	\$15	\$15	\$15
Preferred Brand	0% after deductible	\$65	\$65	\$65	\$65
Non-Preferred Brand	0% after deductible	\$100	\$100	\$100	\$100

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- 12-month rate guarantee from effective date. Renewal Jan 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.
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June 2025

****Available in 14 States:** California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, Wisconsin

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
Benefits				
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
Laboratory				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
Radiology Services				
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%
Facility & Professional Services				
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%
Out of Network				
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
Prescription Drug Benefit				
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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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
Benefits				
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
Laboratory				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
Radiology Services				
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%
Facility & Professional Services				
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%
MOOP				
	\$8,000/\$16,000	\$9,450/ \$18,900	\$9,450/ \$18,900	\$5,000/ \$10,000
Prescription Drug Benefit				
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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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
Benefits				
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	\$90
Laboratory				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
Radiology Services				
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%
Facility & Professional Services				
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	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%
Out of State				
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
Prescription Drug Benefit				
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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