

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:	\$808.00	\$847.00	\$877.00	\$996.00	\$1,315.00	
Member + Spouse	\$1,416.00	\$1,489.00	\$1,545.00	\$1,763.00	\$2,355.00	
Member + Child(ren)	\$1,266.00	\$1,330.00	\$1,380.00	\$1,573.00	\$2,098.00	
Family	\$1,846.00	\$1,942.00	\$2,016.00	\$2,304.00	\$3,088.00	
	•	Benef	fits	<u></u>		
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	
		Labora	tory	^		
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit	\$30 copay/visit	
	•	Radiology	Services	<u> </u>		
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.				
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.				
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.				
Out of Network						
Deductible	\$16,000/\$32,000	\$14,700/\$29,400	\$12,000/\$24,000	\$6,000/\$12,000	\$2,000/\$4,000	
МООР	\$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	

- 12-month rate guarantee from effective date. Renewal Jan 1 2027
- 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: \(\sigma \) his 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

June 2025

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



Plan Availability	Major Medical Plans	Ultra 8000 HSA	Ultra 6000	Ultra 3000	Ultra 1000
Plan Availability	Network	Cigna	Cigna	Cigna	Cigna
Plan Availability	Type of Plan	Qualified HSA Health Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan	Traditional Co-Pay Plan
Member + Spouse	Plan Availability	All 50 States		All 50 States	-
Member + Child(ren)	Member:	\$782.00	\$855.00	\$979.00	\$1,318.00
Family	Member + Spouse	\$1,423.00	\$1,559.00	\$1,787.00	\$2,416.00
Benefits	Member + Child(ren)	\$1,265.00	\$1,385.00	\$1,588.00	\$2,145.00
Individual Deductible	Family	\$1,876.00	\$2,056.00	\$2,358.00	\$3,190.00
Family beductible			Benefits		
Individual Max Out of Pocket	Individual Deductible	\$8,000	\$6,000	\$3,000	\$1,000
Family Max Out of Pocket	Family Deductible	\$16,000	\$12,000	\$6,000	\$2,000
None 70% 80%	Individual Max Out of Pocket	\$8,000	\$9,200	\$9,200	\$5,000
None 70% 80%	Family Max Out of Pocket	·	<u> </u>	 	· · · · · · · · · · · · · · · · · · ·
No Maximum No		None	70%	70%	80%
Primary Care Copay 0% after deductible \$30 \$30 \$20	Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Specialist Care Copay 0% after deductible \$60 \$60 \$40 Urgent Care 0% after deductible \$60 \$60 \$60 \$40 Urgent Care 0% after deductible \$30 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 200 copay 200 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 copay/wisit \$30 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 copay/wisit \$30 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 copay/wisit \$30 copay/wisit \$30 copay/wisit \$30 copay/wisit Deductible then 200 copay/wisit \$30 copa	Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Specialist Care Copay 0% after deductible \$60 \$60 \$40 Urgent Care 0% after deductible \$60 \$60 \$60 \$40 Urgent Care 0% after deductible \$60 \$60 \$60 \$40 Urgent Care 0% after deductible \$60 \$60 \$60 \$40 Urgent Care 0% after deductible \$60 \$60 \$60 \$40 Urgent Care 0% after deductible \$60 \$60 \$60 \$60 \$60 Urgent Care 0% after deductible \$60 \$60 \$60 \$60 \$60 Urgent Care 0% after deductible Professional Fees: 30% after deductible Professional Fees: 30% after deductible Professional Fees: 30% after deductible Out of network is subject to plan allowable, deduc	Primary Care Copay	0% after deductible	\$30	\$30	\$20
Diagnostic Test O% after deductible S30 copay/visit S30 copay/visit Deductible then 20		0% after deductible	\$60	\$60	\$40
Diagnostic Test 0% after deductible \$30 copay/visit \$30 copay/visit Deductible then 20 company Professional Fees: 0% after deductible Count of network is subject to plan allowable, deductible Deductible then 20 count apply. Deductible then 20 count app	Urgent Care	0% after deductible	\$60	\$60	\$40
Diagnostic Test 0% after deductible \$30 copay/visit \$30 copay/visit Deductible then 20 company			Laboratory		
Radiology Services Facility: 0% after deductible Professional Fees: 30% after deductible Out of network is subject to plan allowable fee. Out of network i	Diagnostic Test	0% after deductible		\$30 copay/visit	Deductible then 20%
Facility (CT, PET, MRI's) up to plan allowance Professional Fees: 0% after deductible up to plan allowance Professional Fees: 0% after deductible does not apply. Professional Fees: 30% after deductible does not apply. Professional Fees: 30% after deductible Deductible then 20	- J		1		
up to plan allowance Professional Fees: 0% after deductible does not apply. Professional Fees: 30% after deductible does not apply. Professional Fees: 30% after deductible Deductible then 20% Professional Fees: 30% after deductible Emergency Room - Professional Fee 0% after deductible 30% after deductible. Out of network is subject to plan allowable fee. 0ut of network is subject to plan allowable fee. Deductible then 20% Deductible then 20% deductible does not apply. Deductible then 20% deductible does not apply. Deductible then 20% Deductible then 30% Deductible then 3	Facility (CT. PET. MRI's)	Facility: 0% after deductible		Facility: 30% of plan, allowable, deductible	
Facility & Professional Services		-	does not apply.		Deductible then 20%
Emergency Room - Professional Fee Ow after deductible Out of network is subject to plan allowable fee. Out of network is subject to plan allowable fee. Out of network is subject to plan allowable fee. Deductible then 20			Professional Fees: 30% after deductible	Professional Fees: 30% after deductible	
Pee Out of network is subject to plan allowable fee. Deductible then 20			Facility & Professional Services		
Emergency Room - Facility Owafter deductible Owafter deductible Deductible then 30% Deductible then 20% Subject to plan allowable Subject to plan	~ -	0% after deductible			Dodustible then 200/
Inpatient Hospital - Physician Fees 0% after deductible Deductible then 30% Deductible then 20% Deductible then 30% Deductible then 30% Deductible then 20% Dedu		00/	· · ·		
Inpatient Hospital - Physician Fees 0% after deductible Deductible then 30% Deductible then 30% Deductible then 30% Inpatient - Facility 0% after deductible Deductible then 30% Deductible then 30% Deductible then 30% Outpatient - Physician 0% after deductible 30% after deductible, subject to plan allowable 30% after deductible, subject to plan allowable 30% of plan allowable Deductible then 20% deductible does not apply Deductible and allowable Deductible then 20% deductible does not apply	Emergency Room - Facility	0% after deductible			Deductible then 20%
Deductible then 30% Deductible then 20%	Inpatient Hospital - Physician Fees	0% after deductible			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 subject to plan allowable 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 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply Deductible then 20 subject to plan allowable, deductible does not apply De			 	+	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 deductible does not apply 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 \$45	· · · · · · · · · · · · · · · · · · ·		30% after deductible,	30% after deductible,	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 \$15 \$15 \$15 Generic 0% after deductible \$65 \$45 \$45	Outpatient Hospital - Facility	0% after deductible	30% of plan allowable,	30% of plan allowable,	Deductible then 20%
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 \$45					
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 \$45	Deductible	\$16,000/\$32,000		\$6,000/\$12,000	\$2,000/\$4,000
Coinsurance 40% 40% 40% 60% Reimbursement Plans Allowable Fee Plans Allo					
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				 	
Prescription Drug Benefit Generic 0% after deductible \$15 \$15 Preferred Brand 0% after deductible \$65 \$65 \$45				-	Plans Allowable Fee
Generic 0% after deductible \$15 \$15 \$15 Preferred Brand 0% after deductible \$65 \$65 \$45			<u>!</u>		
Preferred Brand 0% after deductible \$65 \$45	Generic	0% after deductible	, 	\$15	\$15
			<u> </u>	+	<u> </u>
NOD-Preference Reador I III ATTENDACIONE I COL	Non-Preferred Brand	0% after deductible	\$100	\$100	\$85

- 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.)
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June 2025



Major Medical Plans	Ultra 8000 HSA	Ultra 6000	Ultra 3000	Ultra 1000
Network	N PHCS	. ₩PHCS	. ≱PHCS	. ₩PHCS
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	100 00 00 000	
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
	40,000,410,000	Prescription Drug Benefit	Ψ2/T30/ Ψ10/300	#3,000/ #10,000
Generic	0% after deductible	\$15	\$15	 \$15
Preferred Brand		· ·		
	0% after deductible	\$65	\$65	\$45

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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		
ndividual Deductible	\$8,000	\$6,000	\$3,000	\$1,000
amily Deductible	\$16,000	\$12,000	\$6,000	\$2,000
ndividual Max Out of Pocket	\$8,000	\$9,200	\$9,200	\$5,000
amily 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%
ifetime 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
Jrgent Care	0% after deductible	\$60	\$60	\$90
		Laboratory		
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
- C		Radiology Services		
Facility (CT, PET, MRI's)	Facility: 0% after deductible	Facility: 30% of plan	Facility: 30% of plan	
up to plan allowance	Professional Fees: 0% after deductible	allowable, deductible does not apply. Professional Fees: 30% after deductible	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,	30% of plan allowable,	Deductible then 20%
		deductible does not apply.	deductible does not apply	
npatient Hospital - Physician Fees	0% after deductible	Deductible then 30%	Deductible then 30%	Deductible then 20%
Inpatient - Facility	0% after deductible	30% of plan allowable,	30% of plan allowable,	Deductible then 20%
	00/ 5: 1 1 11/1	deductible does not apply	deductible does not apply	D 1 (111 11 000)
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,	30% of plan allowable,	Deductible then 20%
outputione respiral ruently	ow arter deddetable	deductible does not apply	deductible does not apply	beddelible 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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- 12-month rate guarantee from effective date. Renewal Jan 1 2026
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	Ultra Advantage	Ultra MEC	Ultra MVP				
Network	. ≱PHCS	Cigna	Cigna .				
Underwriting	Guaranteed Issue	Guaranteed Issue	Simplified Issue				
Plan Availability	All 50 States	All 50 States	All 50 States				
Member:	\$481.00	\$527.00	\$682.00				
Member + Spouse	\$780.00	\$850.00	\$1,161.00				
Member + Child(ren)	\$686.00	\$765.00	\$992.00				
Family	\$1032.00	\$1,027.00	\$1,448.00				
		Benefits					
Individual Deductible	\$0	\$0	\$0				
Family Deductible	\$0	\$0	\$0				
Individual Max Out of Pocket	\$7,350	\$7,350	\$5,000				
Family Max Out of Pocket	\$14,700	\$14,700	\$10,000				
Preventive Care	Covered 100%	Covered 100%	Covered 100%				
Yearly Maximum	\$40,000	No Maximum	No Maximum				
Primary Care Copay	\$20	\$25 - Limited to 6 visits per plan year.	\$15 - Limited to 12 visits per plan year.				
Specialist Care Copay	\$40	\$50 - Limited to 6 visits per plan year.	\$25 - Limited to 12 visits per plan year.				
Urgent Care	\$60 copay/visit	\$50 copay/visit - Limited to 2 visits per plan year.	\$35 copay/visit - Limited to 3 visits per plan year.				
	Laboratory & Diagnostic						
Diagnostic Test	Deductible then 20%	Independent Lab and X-Ray: \$50 copay/visit Limited to 3 visits per year.	Independent Lab and X-Ray: \$50 copay/visit Limited to 4 visits per year.				
	Ra	adiology Services					
Facility (CT, PET, MRI's)	\$150 copay 2 per year	\$350 copay - Limited to 1 per plan year. Preauthorization is required.	\$350 copay - Limited to 3 per plan year. Preauthorization is required.				
	Facility 8	& Professional Services					
Emergency Room	\$350 copay - Limited to 2 visits per benefit period per Member	\$350 copay - Limited to 1 visit per plan year.	\$350 copay - Limited to 2 visits per plan year.				
Inpatient Hospital - Physician Fees	\$150 copay per day up to \$750 per stay Limited to 6 days per benefit period per Member	Included in Inpatient Hospitalization copay Limited to visits up to 3 days per plan year.	Included in Inpatient Hospitalization copay Limited to visits up to 10 days per plan year				
Inpatient - Facility	Paid at the facility's semi-private room rate Limited to 6 days per benefit period per Member	\$350 copay - Limited to visits up to 3 days per plan year.	\$350 copay - Limited to visits up to 10 days per plan year				
Outpatient - Physician	100% after \$500 copayment per surgery, subject to plan allowable	\$350 copay - Limited to 1 visit per plan year. Preauthorization is required.	\$350 copay - Limited to 2 visit per plan year. Preauthorization is required.				
Outpatient Hospital - Facility	Limited to 1 surgery per benefit period per Employee/2 surgeries per benefit period per Family Limited to \$2,500 maximum per surgery	\$350 copay - Limited to 1 visit per plan year. Preauthorization is required.	\$350 copay - Limited to 2 visit per plan year. Preauthorization is required.				
	Presc	ription Drug Benefit					
Generic	\$0 Generic	\$10 copay/prescription for retail \$30 copay/prescription for mail order	20% copay /prescription for retail				
Preferred Brand	Not Covered	Not Covered	20% copay/prescription for retail				
Non-Preferred Brand	Not Covered	Not Covered	Not Covered				

- 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
- All plans will have a One-time Processing fee of \$125
- Disclaintein Thikes \$100 and showing this country as an appear of benefits. Please refer to the SBC as this is for illustration purposes only. Online rates and benefits supersede this sheet.

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