PATRIOT MEDICAL

	Ultra Advantage	Ultra MEC	Ultra Gold
Network	PHCS	First Health Network	First Health Network
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.
Radiology 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 & 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.
Prescription 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**

For Internal Use ONLY

- 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
- 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.

June 2025