PATRIOT MEDICAL

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
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

For Internal Use ONLY

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

PATRIOT MEDICAL

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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June 2025

PATRIOT MEDICAL

Major Medical Plans	Ultra 8000 HSA	Ultra 6000	Ultra 3000	Ultra 1000
Network	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				
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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June 2025

PATRIOT MEDICAL

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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June 2025

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**

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