

	Ultra Advantage	Ultra MEC	Ultra Gold
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 is not a solicitation or 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