




	Ultra Advantage	Ultra MEC	Ultra MVP
<b>Network</b>			
<b>Underwriting</b>	Guaranteed Issue	Guaranteed Issue	Simplified Issue
<b>Plan Availability</b>	All 50 States	All 50 States	All 50 States
<b>Member:</b>	\$456.50	\$500.00	\$647.75
<b>Member + Spouse</b>	\$741.00	\$807.00	\$1,102.50
<b>Member + Child(ren)</b>	\$651.50	\$725.25	\$942.25
<b>Family</b>	\$979.75	\$975.00	\$1,375.00
<b>Benefits</b>			
<b>Individual Deductible</b>	\$0	\$0	\$0
<b>Family Deductible</b>	\$0	\$0	\$0
<b>Individual Max Out of Pocket</b>	\$7,350	\$7,350	\$5,000
<b>Family Max Out of Pocket</b>	\$14,700	\$14,700	\$10,000
<b>Preventive Care</b>	Covered 100%	Covered 100%	Covered 100%
<b>Yearly Maximum</b>	\$40,000	No Maximum	No Maximum
<b>Primary Care Copay</b>	\$20	\$25 - Limited to 6 visits per plan year.	\$15 - Limited to 12 visits per plan year.
<b>Specialist Care Copay</b>	\$40	\$50 - Limited to 6 visits per plan year.	\$25 - Limited to 12 visits per plan year.
<b>Urgent Care</b>	\$60 copay/visit	\$50 copay/visit - Limited to 2 visits per plan year.	\$35 copay/visit - Limited to 3 visits per plan year.
<b>Laboratory &amp; Diagnostic</b>			
<b>Diagnostic Test</b>	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.
<b>Radiology Services</b>			
<b>Facility (CT, PET, MRI's)</b>	\$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.
<b>Facility &amp; Professional Services</b>			
<b>Emergency Room</b>	\$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.
<b>Inpatient Hospital - Physician Fees</b>	\$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
<b>Inpatient - Facility</b>	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
<b>Outpatient - Physician</b>	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.
<b>Outpatient Hospital - Facility</b>	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.
<b>Prescription Drug Benefit</b>			
<b>Generic</b>	\$15 Generic	\$10 copay/prescription for retail \$30 copay/prescription for mail order	20% copay /prescription for retail
<b>Preferred Brand</b>	\$45 Brand	<b>Not Covered</b>	20% copay/prescription for retail
<b>Non-Preferred Brand</b>	\$85 Non-Preferred - Specialty Through MyRX	<b>Not Covered</b>	<b>Not Covered</b>

For Internal Use ONLY

- 12-month rate guarantee from effective date.
- 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.