


| 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: | \$763.00 | \$800.00 | \$829.00 | \$940.00 | \$1,244.00 |
| Member + Spouse | \$1,338.00 | \$1,407.00 | \$1,460.00 | \$1,665.00 | \$2,228.00 |
| Member + Child(ren) | \$1,196.00 | \$1,257.00 | \$1,304.00 | \$1,485.00 | \$1,985.00 |
| Family | \$1,744.00 | \$1,835.00 | \$1,905.00 | \$2,176.00 | \$2,922.00 |
| 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

- 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
- Does not include \$10 association fee.
- 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.


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

| 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: | \$723.00 | \$844.50 | \$948.00 | \$1,232.00 |
| Member + Spouse | \$1,312.00 | \$1,482.00 | \$1,674.00 | \$2,247.00 |
| Member + Child(ren) | \$1,167.00 | \$1,335.50 | \$1,506.00 | \$2,008.00 |
| Family | \$1,729.00 | \$1,899.50 | \$2,154.00 | \$2,932.00 |
| 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 | \$9,450 | \$9,450 | \$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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- All plans will have a One-time Processing fee of \$125
- Does not include \$10 association fee.
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NOV 2024

| Major Medical Plans | Ultra 8000 HSA | Ultra 6000 | Ultra 3000 | Ultra 1000 |
|---|---|--|--|---|
| Network |  |  |  |  |
| 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: | \$607.00 | \$753.50 | \$844.00 | \$1,035.50 |
| Member + Spouse | \$1,098.00 | \$1,314.00 | \$1,481.00 | \$1,883.00 |
| Member + Child(ren) | \$977.00 | \$1,186.50 | \$1,334.50 | \$1,685.50 |
| Family | \$1,445.00 | \$1,677.00 | \$1,898.50 | \$2,450.00 |
| 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 | \$9,450 | \$9,450 | \$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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- All plans will have a One-time Processing fee of \$125
- Does not include \$10 association fee.
- 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.

| 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: | \$607.00 | \$753.50 | \$844.00 | \$1,035.50 |
| Member + Spouse | \$1,098.00 | \$1,314.00 | \$1,481.00 | \$1,883.00 |
| Member + Child(ren) | \$977.00 | \$1,186.50 | \$1,334.50 | \$1,685.50 |
| Family | \$1,445.00 | \$1,677.00 | \$1,898.50 | \$2,450.00 |
| 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 | \$9,450 | \$9,450 | \$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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