





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:	\$857.00	\$938.00	\$1,074.00	\$1,448.00
Member + Spouse	\$1,563.00	\$1,712.00	\$1,963.00	\$2,654.00
Member + Child(ren)	\$1,388.00	\$1,521.00	\$1,744.00	\$2,356.00
Family	\$2,060.00	\$2,259.00	\$2,591.00	\$3,506.00
<b>Benefits</b>				
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
<b>Laboratory</b>				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
<b>Radiology Services</b>				
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%
<b>Facility &amp; Professional Services</b>				
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%
<b>Out of Network</b>				
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
<b>Prescription Drug Benefit</b>				
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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- 12-month rate guarantee from effective date. Renewal June 1, 2027
- 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.
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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:	\$719.00	\$786.00	\$900.00	\$1,211.00
Member + Spouse	\$1,307.00	\$1,432.00	\$1,641.00	\$2,217.00
Member + Child(ren)	\$1,162.00	\$1,272.00	\$1,458.00	\$1,968.00
Family	\$1,722.00	\$1,887.00	\$2,164.00	\$2,927.00
<b>Benefits</b>				
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
<b>Laboratory</b>				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
<b>Radiology Services</b>				
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%
<b>Facility &amp; Professional Services</b>				
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%
<b>MOOP</b>				
	\$8,000/\$16,000	\$9,450/ \$18,900	\$9,450/ \$18,900	\$5,000/ \$10,000
<b>Prescription Drug Benefit</b>				
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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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:	\$719.00	\$786.00	\$900.00	\$1,211.00
Member + Spouse	\$1,307.00	\$1,432.00	\$1,641.00	\$2,217.00
Member + Child(ren)	\$1,162.00	\$1,272.00	\$1,458.00	\$1,968.00
Family	\$1,722.00	\$1,887.00	\$2,164.00	\$2,927.00
<b>Benefits</b>				
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
<b>Laboratory</b>				
Diagnostic Test	0% after deductible	\$30 copay/visit	\$30 copay/visit	Deductible then 20%
<b>Radiology Services</b>				
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%
<b>Facility &amp; Professional Services</b>				
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%
<b>Out of State</b>				
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
<b>Prescription Drug Benefit</b>				
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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	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>	\$529.00	\$579.00	\$750.00
<b>Member + Spouse</b>	\$858.00	\$935.00	\$1,277.00
<b>Member + Child(ren)</b>	\$754.00	\$841.00	\$1,091.00
<b>Family</b>	\$1,135.00	\$1,129.00	\$1,592.00
<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>

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