Benefits Proposal Prepared for:

Paragroup, LLC

Effective Date: 11/1/2025 | Subscriber Count: 1

Quote Id: 926886

Prepared by Chuck Hackel of Chuck Hackel
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10 Madison Ave Ste 301
Morristown, NJ 07960

10/17/25
Group SIC Code: 2711
Number of Subscribers: 1
Number of Employees: 2
Group Zip Code: 08873

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Per The Consolidated Appropriations Act (CAA) 2021, beginning Dec 27, 2021, brokers and consultants will be required to disclose their compensation to group health plans if they expect to receive $1,000 or more in direct or indirect compensation for the services they provide. The CAA defines compensation as anything of monetary value except non-monetary compensation valued at $250 or less. Under the CAA, the broadened definition of an ERISA "covered plan" includes group health plans (including dental and vision), HRAs, ICHRAs, FSAs, etc. except QSEHRAs.

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Medical Coverage Options	AmeriHealth New Jersey SEH Select Gold EPO Local Value $30/$60 *Fully Insured* View PDF	AmeriHealth New Jersey SEH Select Silver EPO AmeriHealth Advantage RP with NY $30/$60 *Fully Insured* View PDF	Horizon OMNIA Gold *Fully Insured* View PDF	Horizon OMNIA Silver *Fully Insured* View PDF	Horizon Advantage EPO Silver 100/50 *Fully Insured* View PDF	Horizon OMNIA Silver Value *Fully Insured* View PDF	UnitedHealthcare Oxford NJ S MTRO NG 50/75/2500/50 EPO 25 *Fully Insured* View PDF
Benefits Summary	**Alternate Option 1**	**Alternate Option 2**	**Alternate Option 3**	**Alternate Option 4**	**Alternate Option 5**	**Alternate Option 6**	**Alternate Option 7**
Network	AmeriHealth - Local Value EPO	AmeriHealth - Advantage RP EPO	Horizon - OMNIA EPO	Horizon - OMNIA EPO	Horizon - Advantage EPO	Horizon - OMNIA EPO	Oxford - Metro EPO
Health Account Compatibility	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Covered Employees	2 / 2	2 / 2	2 / 2	2 / 2	2 / 2	2 / 2	2 / 2
Deductible Individual (IN / OON)	$1,500 / N/A	$2,500 / N/A	Tier 1: $1,350, Tier 2: $2,500 / N/A	Tier 1: $1,500, Tier 2: $2,500 / N/A	$2,500 / N/A	Tier 1: $2,500, Tier 2: $3,000 / N/A	$2,500 / N/A
Deductible Family (IN / OON)	$3,000 / N/A	$5,000 / N/A	Tier 1: $2,700, Tier 2: $5,000 / N/A	Tier 1: $3,000, Tier 2: $5,000 / N/A	$5,000 / N/A	Tier 1: $5,000, Tier 2: $6,000 / N/A	$5,000 / N/A
OOP Max Individual (IN / OON)	$7,000 / N/A	$9,200 / N/A	Tier 1: $8,550, Tier 2: $9,000 / N/A	$9,200 / N/A	$9,200 / N/A	$9,200 / N/A	$9,200 / N/A
OOP Max Family (IN / OON)	$14,000 / N/A	$18,400 / N/A	Tier 1: $17,100, Tier 2: $18,000 / N/A	$18,400 / N/A	$18,400 / N/A	$18,400 / N/A	$18,400 / N/A
Coinsurance (IN / OON)	20% / N/A	Tier 1: 20%, Tier 2: 50% / N/A	Tier 1: 0%, Tier 2: 30% / N/A	Tier 1: 0%, Tier 2: 50% / N/A	50% / N/A	50% / N/A	50% / N/A
PCP Visit Copay	$30	Tier 1: $30, Tier 2: $50 after deductible	Tier 1: $20, Tier 2: $30 after deductible	Tier 1: $25, Tier 2: 50% after deductible	$50	Tier 1: $40, Tier 2: 50% after deductible	$50
Specialist Visit Copay	$60	Tier 1: $60, Tier 2: $75 after deductible	Tier 1: $40, Tier 2: $50 after deductible	Tier 1: $50, Tier 2: 50% after deductible	$75	Tier 1: $75, Tier 2: 50% after deductible	$75
Urgent Care Copay	$75	$75 after deductible	Tier 1: $75, Tier 2: $75 after deductible	Tier 1: $75, Tier 2: 50% after deductible	$75	Tier 1: $75, Tier 2: 50% after deductible	$75
ER Copay	20% after deductible	Tier 1: 20% after deductible, Tier 2: 50% after deductible	$100 waived if admitted, then 10% after deductible	$100 waived if admitted, then 20% after deductible	$100 waived if admitted, then 50% after deductible	$100 waived if admitted, then 50% after deductible	$100 per occurrence deductible, then 50% after medical deductible
Outpatient Diagnostic Labs / X-Ray	$0 / 20% after deductible	$0 / 50% after deductible	Tier 1: Freestanding: $0 / Hospital: $50 after deductible, Tier 2: Freestanding: $0 / Hospital: 30% after deductible	Tier 1: Freestanding: $0 / Hospital: $100 after deductible, Tier 2: Freestanding: $0 / Hospital: 50% after deductible	Freestanding: $0 / Hospital: $100 after deductible	Freestanding: $0 / Hospital: 50% after deductible	Designated Network: $0, Network: 50% after deductible / 50% after deductible
Outpatient Complex Imaging	20% after deductible (pre-approval required)	50% after deductible (pre-approval required)	Tier 1: $75 after deductible (pre-approval required), Tier 2: 30% after deductible (pre-approval required)	Tier 1: $100 after deductible (pre-approval required), Tier 2: 50% after deductible (pre-approval required)	50% after deductible (pre-approval required)	50% after deductible (pre-approval required)	Hospital: 50% after deductible / Freestanding: $100 after deductible
Physical / Occupational Therapy	$60, 30 visits max	$60, 30 visits max	Tier 1: Inpatient Hospital: $500/day - $2,500 max/admission after deductible (pre-approval required), Office: $20, Outpatient Facility: $20 after deductible, 30 visits max, Tier 2: Inpatient Hospital: 30% after deductible (pre-approval required), Office: $30 after deductible, Outpatient Facility: 30% after deductible, 30 visits max	Tier 1: Inpatient Hospital: $500/day - $2,500 max/admission after deductible (pre-approval required), Office: $25, Outpatient Facility: $50 after deductible, 30 visits max, Tier 2: Inpatient Hospital: 50% after deductible (pre-approval required), Office: 50% after deductible, Outpatient Facility: 50% after deductible, 30 visits max	Inpatient Hospital: 50% after deductible (pre-approval required), Office: $50, Outpatient Facility: 50% after deductible, 30 visits max	Tier 1: Inpatient Hospital: 50% after deductible (pre-approval required), Office: $40, Outpatient Facility: 50% after deductible, 30 visits max, Tier 2: Inpatient Hospital: 50% after deductible (pre-approval required), Office: 50% after deductible, Outpatient Facility: 50% after deductible, 30 visits max	$50, 30 visits max
Inpatient Hospital	20% after deductible (pre-approval required)	Tier 1: 20% after deductible (pre-approval required), Tier 2: 50% after deductible (pre-approval required)	Tier 1: Facility: $500/day - $2,500 max/admission after deductible (pre-approval required) / Physician: $0 after deductible, Tier 2: Facility: 30% after deductible (pre-approval required) / Physician: 30% after deductible	Tier 1: Facility: $500/day - $2,500 max/admission after deductible (pre-approval required) / Physician: $0 after deductible, Tier 2: Facility: 50% after deductible (pre-approval required) / Physician: 50% after deductible	Facility: 50% after deductible (pre-approval required) / Physician: 50% after deductible	Facility: 50% after deductible (pre-approval required) / Physician: 50% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	Tier 1: 20% after deductible, Tier 2: 50% after deductible	Tier 1: Freestanding: $200 after deductible / Hospital: $250 after deductible / Physician: $0 after deductible, Tier 2: 30% after deductible	Tier 1: Freestanding: $200 after deductible / Hospital: $250 after deductible / Physician: $0 after deductible, Tier 2: 50% after deductible	Freestanding: 40% after deductible, Hospital: 50% after deductible	Tier 1: Freestanding: 40% after deductible, Hospital: 50% after deductible, Tier 2: 50% after deductible	Facility: Freestanding: $500 after deductible, Hospital: 50% after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible	50% after deductible (pre-approval required)	50% after deductible (pre-approval required)	50% (pre-approval required)	50% after deductible (pre-approval required)	$0
Pediatric Dental	N/A	N/A	N/A	N/A	N/A	N/A	Preventive services: $0 after deductible, 2 visits max
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0	1 exam/12 months: $0, 1 pair/12 months: $0	1 exam/12 months: $0, 1 pair/12 months: $150 Allowance	1 exam/12 months: $0, 1 pair/12 months: $150 Allowance	1 exam/12 months: $0, 1 pair/12 months: $150 Allowance	1 exam/12 months: $0, 1 pair/12 months: $150 Allowance	1 exam/12 months: $30, 1 pair/12 months: 50%
Rx Deductible	In Network: None	In Network: $250 individual	In Network: $250 individual/$500 family	In Network: $250 individual/$500 family	In Network: None	In Network: Integrated	In Network: $250 individual/$250 family
Rx Retail	$10/50% - $125 max/50% - $125 max	$20/50% - $125 max/50% - $125 max after Rx deductible, does not apply to Generic	$10/$40/$75 after Rx deductible	$25/50%/50% after Rx deductible, does not apply to Generic	$20/$50/$75	$20/25%/50% after deductible	$15/$50/50% after Rx deductible, does not apply to Tier 1
Rx Specialty	50% - $125 max/50% - $250 max	50% - $125 max/50% - $250 max after Rx deductible	Covered at retail benefit in applicable categories.	Covered at retail benefit in applicable categories.	Covered at retail benefit in applicable categories.	Covered at retail benefit in applicable categories.	$15/20% - $150 max/50% - $500 max after Rx deductible, does not apply to Specialty Tier 1
Rx Mail Order	$20/50% - $250 max/50% - $250 max	$40/50% - $250 max/50% - $250 max after Rx deductible, does not apply to Generic	$20/$80/$150 after Rx deductible	$50/50%/50% after Rx deductible, does not apply to Generic	$40/$100/$150	$40/25%/50% after deductible	$30/$100/50% after Rx deductible, does not apply to Tier 1
Cost Summary	**Alternate Option 1**	**Alternate Option 2**	**Alternate Option 3**	**Alternate Option 4**	**Alternate Option 5**	**Alternate Option 6**	**Alternate Option 7**
Monthly Premium	$2,484.23	$2,053.33	$2,837.89	$2,453.96	$2,797.02	$2,213.10	$2,198.44
Annual Premium	$29,810.76	$24,639.96	$34,054.68	$29,447.52	$33,564.24	$26,557.20	$26,381.28

Rates are subject to change based on final enrollment.

Programs are subject to change. This is a brief description of benefits provided for demonstration purposes only.

Actual benefits, limitations and exclusions are set forth in the certificate of insurance issued to members.

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Census Details					AmeriHealth New Jersey SEH Select Gold EPO Local Value $30/$60 *Fully Insured* View PDF					AmeriHealth New Jersey SEH Select Silver EPO AmeriHealth Advantage RP with NY $30/$60 *Fully Insured* View PDF					Horizon OMNIA Gold *Fully Insured* View PDF					Horizon OMNIA Silver *Fully Insured* View PDF				
Name	Type	Coverage Tier	DOB	ZIP Code	Alternate Option 1 Rate	Family Rate	ER	EE	Payroll Deduction	Alternate Option 2 Rate	Family Rate	ER	EE	Payroll Deduction	Alternate Option 3 Rate	Family Rate	ER	EE	Payroll Deduction	Alternate Option 4 Rate	Family Rate	ER	EE	Payroll Deduction
Rajesh Gupta	EE	F	6/21/1981	08873	847.77	2,484.23	847.77	-	-	700.72	2,053.33	700.72	-	-	968.46	2,837.89	968.46	-	-	837.44	2,453.96	837.44	-	-
Sonali Kiran	SP		11/11/1992	08873	758.86		758.86	-		627.23		627.23	-		866.89		866.89	-		749.62		749.62	-	
child 1	D		4/16/2016	08873	438.80		438.80	-		362.69		362.69	-		501.27		501.27	-		433.45		433.45	-	
child 2	D		7/3/2024	08873	438.80		438.80	-		362.69		362.69	-		501.27		501.27	-		433.45		433.45	-	
Vinod Yellagonda	EE	W	1/1/1980	08873	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cost Summary					**Alternate Option 1**					**Alternate Option 2**					**Alternate Option 3**					**Alternate Option 4**				
				Monthly Premium	$2,484.23					$2,053.33					$2,837.89					$2,453.96				
				Annual Premium	$29,810.76					$24,639.96					$34,054.68					$29,447.52				

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Census Details					Horizon Advantage EPO Silver 100/50 *Fully Insured* View PDF					Horizon OMNIA Silver Value *Fully Insured* View PDF					UnitedHealthcare Oxford NJ S MTRO NG 50/75/2500/50 EPO 25 *Fully Insured* View PDF				
					Alternate Option 5					Alternate Option 6					Alternate Option 7				
Name	Type	Coverage Tier	DOB	ZIP Code	Rate	Family Rate	ER	EE	Payroll Deduction	Rate	Family Rate	ER	EE	Payroll Deduction	Rate	Family Rate	ER	EE	Payroll Deduction
Rajesh Gupta	EE	F	6/21/1981	08873	954.51	2,797.02	954.51	-	-	755.24	2,213.10	755.24	-	-	750.24	2,198.44	750.24	-	-
Sonali Kiran	SP		11/11/1992	08873	854.41		854.41	-		676.04		676.04	-		671.56		671.56	-	
child 1	D		4/16/2016	08873	494.05		494.05	-		390.91		390.91	-		388.32		388.32	-	
child 2	D		7/3/2024	08873	494.05		494.05	-		390.91		390.91	-		388.32		388.32	-	
Vinod Yellagonda	EE	W	1/1/1980	08873	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cost Summary					**Alternate Option 5**					**Alternate Option 6**					**Alternate Option 7**				
				Monthly Premium	$2,797.02					$2,213.10					$2,198.44				
				Annual Premium	$33,564.24					$26,557.20					$26,381.28				

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Age Band	**1**	**2**	**3**	**4**	**5**	**6**	**7**
0 - 14	$438.80	$362.69	$501.27	$433.45	$494.05	$390.91	$388.32
15	$477.80	$394.93	$545.82	$471.98	$537.96	$425.65	$422.83
16	$492.71	$407.25	$562.86	$486.71	$554.75	$438.94	$436.03
17	$507.63	$419.58	$579.90	$501.45	$571.54	$452.23	$449.23
18	$523.69	$432.85	$598.24	$517.31	$589.63	$466.53	$463.44
19	$539.75	$446.13	$616.59	$533.18	$607.71	$480.84	$477.66
20	$556.38	$459.88	$635.59	$549.61	$626.44	$495.66	$492.38
21	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
22	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
23	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
24	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
25	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
26	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
27	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
28	$716.99	$592.63	$819.06	$708.26	$807.26	$638.74	$634.51
29	$731.33	$604.48	$835.44	$722.42	$823.41	$651.51	$647.20
30	$738.21	$610.17	$843.31	$729.22	$831.16	$657.64	$653.29
31	$748.53	$618.70	$855.10	$739.42	$842.78	$666.84	$662.42
32	$758.86	$627.23	$866.89	$749.62	$854.41	$676.04	$671.56
33	$765.17	$632.45	$874.10	$755.85	$861.51	$681.66	$677.14
34	$772.05	$638.14	$881.96	$762.65	$869.26	$687.79	$683.24
35	$775.49	$640.98	$885.90	$766.05	$873.14	$690.86	$686.28
36	$778.94	$643.83	$889.83	$769.45	$877.01	$693.92	$689.33
37	$781.80	$646.20	$893.10	$772.28	$880.24	$696.48	$691.86
38	$785.24	$649.04	$897.04	$775.68	$884.11	$699.54	$694.91
39	$792.13	$654.73	$904.90	$782.48	$891.86	$705.68	$701.00
40	$799.01	$660.42	$912.76	$789.28	$899.61	$711.81	$707.09
41	$808.76	$668.48	$923.90	$798.91	$910.59	$720.50	$715.72
42	$818.51	$676.54	$935.04	$808.55	$921.57	$729.18	$724.35
43	$831.71	$687.45	$950.11	$821.58	$936.43	$740.93	$736.03
44	$847.77	$700.72	$968.46	$837.44	$954.51	$755.24	$750.24
45	$866.69	$716.37	$990.08	$856.14	$975.82	$772.11	$766.99
46	$889.06	$734.86	$1,015.64	$878.24	$1,001.01	$792.03	$786.79
47	$913.73	$755.24	$1,043.81	$902.60	$1,028.78	$814.01	$808.61
48	$941.26	$778.00	$1,075.26	$929.80	$1,059.78	$838.53	$832.98
49	$968.22	$800.28	$1,106.06	$956.43	$1,090.13	$862.55	$856.84
50	$998.62	$825.41	$1,140.79	$986.46	$1,124.36	$889.63	$883.74
51	$1,027.87	$849.59	$1,174.21	$1,015.36	$1,157.29	$915.69	$909.63
52	$1,059.42	$875.66	$1,210.24	$1,046.52	$1,192.81	$943.80	$937.55
53	$1,090.97	$901.74	$1,246.28	$1,077.68	$1,228.33	$971.90	$965.46
54	$1,124.81	$929.71	$1,284.94	$1,111.11	$1,266.43	$1,002.05	$995.41
55	$1,158.08	$957.21	$1,322.95	$1,143.98	$1,303.89	$1,031.69	$1,024.85
56	$1,193.07	$986.13	$1,362.92	$1,178.54	$1,343.29	$1,062.86	$1,055.82
57	$1,228.63	$1,015.52	$1,403.54	$1,213.67	$1,383.33	$1,094.54	$1,087.29
58	$1,265.34	$1,045.86	$1,445.48	$1,249.93	$1,424.66	$1,127.24	$1,119.78
59	$1,307.79	$1,080.95	$1,493.97	$1,291.86	$1,472.45	$1,165.06	$1,157.34
60	$1,307.79	$1,080.95	$1,493.97	$1,291.86	$1,472.45	$1,165.06	$1,157.34
61	$1,307.79	$1,080.95	$1,493.97	$1,291.86	$1,472.45	$1,165.06	$1,157.34
62	$1,307.79	$1,080.95	$1,493.97	$1,291.86	$1,472.45	$1,165.06	$1,157.34
63	$1,307.79	$1,080.95	$1,493.97	$1,291.86	$1,472.45	$1,165.06	$1,157.34
64+	$1,307.79	$1,080.95	$1,493.97	$1,291.86	$1,472.45	$1,165.06	$1,157.34

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Carrier and Plan Disclaimers

Horizon

OMNIA Gold: OMNIA & Advantage medical plans without BlueCard are best suited for members who live in New Jersey & contiguous counties due to limited out-of-network benefits

Advantage EPO Silver 100/50: OMNIA & Advantage medical plans without BlueCard are best suited for members who live in New Jersey & contiguous counties due to limited out-of-network benefits

OMNIA Silver: OMNIA & Advantage medical plans without BlueCard are best suited for members who live in New Jersey & contiguous counties due to limited out-of-network benefits

OMNIA Silver Value: OMNIA & Advantage medical plans without BlueCard are best suited for members who live in New Jersey & contiguous counties due to limited out-of-network benefits

UnitedHealthcare Oxford

Medical: The Fully Funded rates and benefits included within this proposal are for general information and discussion purposes only and not valid unless approved by UnitedHealthcare. This rate quote is not an offer or a guarantee of coverage. The rates quoted are applicable to the plan design selected. UnitedHealthcare reserves the right to modify your rates in the event your plan design must be modified as a result of any change, modification or clarification in law, including the Patient Protection and Affordable Care Act. This group should not, under any circumstances, cancel its existing coverage unless and until coverage is offered by UnitedHealthcare and final rates have been accepted by and initial premium paid by the group. Final rates are determined by UnitedHealthcare's underwriting guidelines and final enrollment. The insurance policy, not general rates and descriptions in this Web site or printed output, will form the contract between the insured and UnitedHealthcare, and the Certificate of Coverage issued to the subscriber will provide the legal description of coverage.

NJ S MTRO NG 50/75/2500/50 EPO 25: Please verify member eligibility with your carrier representative.