Renewal Date: **June 1, 2023**

	ULTRA	GOLD	MEC 5
Member-only:	$779.00	$637.00	$447.00
Member + Spouse:	$1,299.00	$1,036.00	$667.00
Member + Child(ren):	$1,162.00	$926.00	$599.00
Member + Family:	$1,697.00	$1,299.00	$818.00

* There are no minimum hours required for employment

HOW DOES REFERENCE-BASED PRICING WORK?

A reference-based pricing healthcare model that significantly lowers hospital and outpatient facility costs claims are the ones that set fair and reasonable rates for hospital and outpatient facility services, based on the average price primarily paid by Medicare. The plan will typically pay providers between 102% - 150% of Medicare reimbursement and is considerably less than private insurance for the same services you receive. Therefore, reducing the claims costs and helping control renewal rates.

Ours pays 150% of Medicare, with the ability to pay up to 200% of Medicare.
The rates are configured with a 200% payout, and our plan guarantees no balance billing.

	ULTRA	GOLD	MEC 5
PPO Network (New York & New Jersey)	MagnaCare	MagnaCare	MagnaCare
PPO Network (All other states)	PHCS	PHCS	PHCS
Type of plan	Referenced Based	Referenced Based	Referenced Based
Plan availability	All 50 states	All 50 states	All 50 states
NETWORK BASED			
Referrals	Not required	Not required	Not required
Preventative Care	No Charge	No Charge	No Charge
Deductible	In-Net: $0 Single / $0 Family	In-Net: $0 Single / $0 Family	In-Net: $0 Single / $0 Family
Coinsurance	In-Net: None	In-Net: None	In-Net: None
Out-of-Pocket Max	In-Net: $2,000 Single /$13,200 Family	In-Net: $5,000 Single /$10,000 Family	In-Net: $7,350 Single /$14,700 Family
Physician Office Visit	In-Net: $20 /$40 copay (No Limit) Out-Net: Subject to Deductible and 40% Coinsurance	In-Net:$15 /$25 copay (Limited to 12 visits per plan year) Out-Net: $15 /$25 copay (Limited to 12 visits per plan year)	In-Net: $25 /$50 copay (Limited to 6 visits per plan year) Out-Net: $25 /$50 copay (Limited to 6 visits per plan year)
Other Physician Services Performed in the Office Limited to Primary Care/Specialist visits per plan year)	In-Net: $50 Out-Net: Subject to Deductible and 40% Coinsurance	In-Net: $25 Out-Net: $25	In-Net: $50 Out-Net: $50
Urgent Care	In-Net: $50 Out-Net: Subject to Deductible and 40% Coinsurance (No Visit limit)	In-Net: $35 Out-Net: $35 (Limited to 3 visits per plan year)	In-Net: $50 Out-Net: $50 (Limited to 2 visits per plan year)
Telemedicine Vendor Services	In-Net: $0 Out-Net: Not covered	In-Net: $0 Out-Net: Not covered	In-Net: $0 Out-Net: Not covered
Laboratory & Minor Diagnostic Services* (Laboratory Services, Ultrasounds, Bone Density, Echography, etc.)	In-Net: $50 Out-Net: Subject to Deductible and 40% Coinsurance (No Visit limit)	In-Net: $50 Out-Net: $50 (Combined limit of 4 visits per plan year with Radiology)	In-Net: $50 Out-Net: Not covered (Combined limit of 3 visits per plan year with Radiology)
	*Lab & Radiology - Out patient not covered at a hospital unless the test cannot be preformed at a diagnostic center or participating labs		
Radiology*	In-Net: $50 Out-Net: Subject to Deductible and 40% Coinsurance (No Visit limit)	In-Net: $50 Out-Net: $50 (Combined limit of 4 visits per plan year with Radiology)	In-Net: $50 Out-Net: Not covered (Combined limit of 3 visits per plan year with Radiology)
	*Lab & Radiology - Out patient not covered at a hospital unless the test cannot be preformed at a diagnostic center or participating labs		
Pregnancy Professional Services	In-Net: $50 Out-Net: Subject to Deductible and 40% Coinsurance (No Visit limit)	In-Net: $350 Copay Out-Net: $350 Copay	Not Covered 100% paid by Member
Chiropractic Care	In-Net: $40 Copay Out-Net: $40 Copay (Limited to 10 visits per plan year)	In-Net: $40 Copay Out-Net: $40 Copay (Limited to 10 visits per plan year)	Not Covered 100% paid by Member
Home Health Care	In-Net: $25 Copay Out-Net: $25 Copay (Limited to 20 visits per plan year)	In-Net: $25 Copay Out-Net: $25 Copay (Limited to 20 visits per plan year)	In-Net: $25 Copay Out-Net: $25 Copay (Limited to 5 visits per plan year)

Rehabilitation/Habilitation Services	In-Net: $75 Copay Out-Net: $75 Copay (Physical, Speech, and Occupational; Limited to 20 visits per plan year. Pre-certification is required after 6 visits.)	In-Net: $50 Copay Out-Net: $50 Copay (Combined limit of 12 visits per plan year with physical, speech, and occupational therapies. Pre-authorization is required after 6 visits.)	In-Net: $50 Copay Out-Net: $50 Copay (Combined limit of 6 visits per plan year with physical, speech, and occupational therapies)
Child Eye Exam & Dental Check-up	In-Net: 1 vision Screening 3-5 yrs Flouride application Infant to 5 yrs. Out-Net: Not Covered	In-Net: 1 vision Screening 3-5 yrs Flouride application Infant to 5 yrs. Out-Net: Not Covered	In-Net: 1 vision Screening 3-5 yrs Flouride application Infant to 5 yrs. Out-Net: Not Covered
REFERENCED BASED (Plan guarantees no balance billing)			
Hospital In-Patient (Applies to any Hospital)	$400 Copay per admission (Subject to Reference Based Pricing)	$350 Copay per admission (Subject to Reference Based Pricing)	$350Copay per admission (Subject to Reference Based Pricing) (Limited to 3 days per plan year)
Outpatient Hospital or Free-Standing Facility Services and Surgery	$400 Copay per admission (Subject to Reference Based Pricing)	$350 Copay per admission (Subject to Reference Based Pricing) (Limited to 2 visits per plan year)	$350 Copay per admission (Subject to Reference Based Pricing) (Limited to 1 visits per plan year)
Inpatient Visits - Physician	Included in Inpatient Hospitalization Copay (Subject to Referenced Based Pricing)	$350 Copay per admission (Subject to Reference Based Pricing) (Limited to visits up to 10 days per plan year)	$350 Copay per admission (Subject to Reference Based Pricing) (Limited to visits up to 3 days per plan year)
Inpatient Surgery - Physician and Anesthesiologist Charges (Second surgical opinion may be required)	Included in Inpatient Hospitalization Copay (No Surgery Limit)	Included in Inpatient Hospitalization Copay (Limited to 4 inpatient and 2 outpatient procedures per plan year)	Included in Inpatient Hospitalization Copay (Limited to 2 inpatient and 1 outpatient procedures per plan year)
Anesthesia	Included in Inpatient Hospitalization or Outpatient Hospital or FreeStanding Facility Services and Surgery Copay	Included in Inpatient Hospitalization or Outpatient Hospital or FreeStanding Facility Services and Surgery Copay (Limited to 4 inpatient and 2 outpatient anesthetic procedure per plan year)	Included in Inpatient Hospitalization or Outpatient Hospital or FreeStanding Facility Services and Surgery Copay (Limited to 2 inpatient and 1 outpatient anesthetic procedure per plan year)
Emergency Room Services	$400 Copay per admission (Subject to Reference Based Pricing)	$350Copay per admission (Subject to Reference Based Pricing) (Limited to 2 visits per plan year)	$350Copay per admission (Subject to Reference Based Pricing) (Limited to 1 visit per plan year)
CT/MRI/MRA/PET Scan	$400 Copay per admission (Subject to Reference Based Pricing) (No limit)	Non-Hospital $350 Copay per admission (Subject to Reference Based Pricing) (Limited to 3 per plan year) Hospital *Not Covered 100% paid by Member	Non-Hospital $350 Copay per admission (Subject to Reference Based Pricing) (Limited to 1 per plan year) Hospital *Not Covered 100% paid by Member
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)	$400 Copay per admission (Subject to Reference Based Pricing)	$350 Copay per admission (Subject to Reference Based Pricing)	Not Covered 100% paid by Member
Emergency Medical Transportation (Ground Service Only)	$400 Copay per admission (Subject to Reference Based Pricing)	$250 Copay per admission (Subject to Reference Based Pricing) (Limited to 2 transports per plan year)	$350 Copay per admission (Subject to Reference Based Pricing)
Durable Medical	$400 Copay per admission (Subject to Reference Based Pricing)	Not Covered	Not Covered
OUT-OF-NETWORK			
Deductible	$500 Single / $1,000 Family	$0 Single / $0 Family	$0 Single / $0 Family
Co-Insurance	40% After Deductible	None	None
Out Of Pocket Max (MOOP)	Unlimited Single / Unlimited Family	$5,000 Single / $ 10,000 Family	$7,350 Single / $ 14,700 Family
Reimbursement	Paid at 85th percentile UCR	Paid at 85th percentile UCR	Paid at 85th percentile UCR
RX PRESCRIPTIONS (*Out-of-Network Not Covered)			
Type A - Rx Prescriptions* (Subject to Formulary) (up to a 30-day supply)	In-Net: Generic - $0 Copay	In-Net: Generic - $0 Copay	In-Net: Generic - $0 Copay
Type B - Rx Prescriptions* (Subject to Formulary) (up to a 30-day supply)	Generic - $10 Copay Preferred: $40 Copay Non-Preferred: $80 Copay Specialty Drugs: 25%	Generic - 20% Limited Brand: 20% Non-limited Brand & Specialty Drugs: 25%	Generic - $10 Copay