Reg.

MEMBERSHIP ACCESS PROGRAMS

(Available to association members only)

2022 Rates

Reference Based Pricing (RBP) Plans

Plan Name:	ULTRA	GOLD	MEC 5
Network:	MagnaCare PPO (NY &NJ) *PHCS available in 48 States	MagnaCare PPO (NY &NJ) *PHCS available in 48 States	MagnaCare PPO (NY &NJ) *PHCS available in 48 States
Network Search:	www.magnacare.com www.multiplan.com	www.magnacare.com www.multiplan.com	www.magnacare.com www.multiplan.com
States Available:	Available in 50 States	Available in 50 States	Available in 50 States
Member Only:	$799.00	$677.00	$467.00
Member + Spouse:	$1,329.00	$1,115.00	$697.00
Member + Child(ren):	$1,192.00	$1,004.00	$629.00
Member + Family:	$1,727.00	$1,395.00	$848.00
Referrals:	No Referrals Required	No Referrals Required	No Referrals Required
Preventative Care:	No Charge	No Charge	No Charge
Deductible:	In-Net: $0 Single / $0 Family Out-Net: $500 Single / $1,000 Family	In-Net: $0 Single / $0 Family Out-Net: $0 Single / $0 Family	In-Net: $0 Single / $0 Family Out-Net: $0 Single / $0 Family
Co-Insurance:	In-Net: None Out-Net: 40% After Deductible	In-Net: None Out-Net: None	In-Net: None Out-Net: None
Out of Pocket Max:	In-Net: $2,000 Single / $13.200 Family Out-Net: Unlimited Single / Unlimited Family	$5,000 Single / $10.000 Family	$7,350 Single / $14,700 Family
Office Co-payments:	In-Net: $20/$40 Copay Out-Net: 40% After Deductible	In & Out Net: $15/$25 Copay Limited to 12 visits per plan year.	In & Out Net: $25/$50 Copay Limited to 6 visits per plan year.
NON REFERENCE BASED			
Urgent Care:	In-Net: $50 Copay Out-Net: 40% After Deductible	In & Out Net: $35 Not subject to deductible Limited to 3 visits per plan year.	In & Out Net: $50 Not subject to deductible Limited to 2 visits per plan year.
Laboratory & Minor Diagnostic Services	In-Net: $50 Copay Out-Net: 40% After Deductible Hospital Based - Not Covered - 100% Paid by Member	In & Out Net: $50 Copay Combined limit of 4 visits per plan year for Laboratory Services and Radiology. Hospital Based - Not Covered - 100% Paid by Member	In & Out Net: $50 Copay Combined limit of 3 visits per plan year for Laboratory Services and Radiology. Hospital Based - Not Covered - 100% Paid by Member
Mental Health: (Out-Patient)	In-Net: $40 Copay Out-Net: Deductible & Co-Insurance	In & Out Net: $25 Copay Limited to 12 specialists visits and 10 non-specialist visits per plan year.	In & Out Net: Not Covered
Chiropractor: (10 Visits Per/Yr.)	In-Net: $40 Copay Out-Net: 40% After Deductible	In & Out Net: $40 Copay	In & Out Net: Not Covered
Telemedicine:	Included	Included	Included
Radiology	In-Net: $50 Copay Out-Net: 40% After Deductible Hospital Based - Not Covered - 100% Paid by Member	In & Out Net: $50 Copay Combined limit of 4 visits per plan year for Laboratory Services and Radiology. Hospital Based - Not Covered - 100% Paid by Member	In & Out Net: $50 Copay Combined limit of 3 visits per plan year for Laboratory Services and Radiology. Hospital Based - Not Covered - 100% Paid by Member
Home Health Care:	In-Net: $50 Copay Out-Net: Not Covered	In-Net: $35 Copay Out-Net: $35 Copay Limited to 20 visits per plan year.	In-Net: $25 Copay Out-Net: $25 Copay Limited to 5 visits per plan year.
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
REFERENCE BASED (No network) - Plan Guarantees No Balance Billing			
CT/MRI/MRA/PET Scan	$400 Copay Subject to Reference Based Pricing	$350 Copay Limited to 3 per plan year. Subject to Reference Based Pricing	$350 Copay Limited to 1 per plan year. Subject to Reference Based Pricing
Emergency Medical Transportation: (Ground Service Only)	$400 Copay Subject to Reference Based Pricing	$250 Copay Limited to 2 ground transports per plan year. Subject to Reference Based Pricing	$250 Copay Limited to 1 ground transports per plan year. Subject to Reference Based Pricing
Emergency Room:	$400 Copay Subject to Reference Based Pricing	$350 Copay Limited to 3 per plan year. Subject to Reference Based Pricing	$350 Copay Limited to 1 per plan year. Subject to Reference Based Pricing
Hospital Stay: (In-Patient)	$400 Copay Subject to Reference Based Pricing	$350 Copay Limited to 10 days per plan year. Subject to Reference Based Pricing	$350 Copay Limited to 3 days per plan year. Subject to Reference Based Pricing
Inpatient Physician and Surgeon & Anesthesiologist Charges:	Included in Inpatient Hospitalization copay Subject to Reference Based Pricing	Included in Inpatient Hospitalization copay Subject to Reference Based Pricing	Included in Inpatient Hospitalization copay Subject to Reference Based Pricing
Outpatient Surgery:	$400 Copay Subject to Reference Based Pricing	In & Out Subject to Reference Based Pricing $350 Copay Limited to 2 visits per plan year. Subject to Reference Based Pricing	In & Out Subject to Reference Based Pricing $350 Copay Limited to 1 visits per plan year. Subject to Reference Based Pricing
RX Prescriptions (Out-Net RX Not Covered)			
Type A - Rx Prescription (Subject to Formulary)	Generic: $0 Copay	Generic: $0 Copay	Generic: $0 Copay
Type B - Rx Prescription (Subject to Formulary)	Generic: $10 Copay Brand Preferred: $40 Copay Non-Preferred: $80 Copay	Generic: 20% Copay Brand Preferred: 20% Copay Non-Preferred: Not Covered	Generic: $10 Copay Brand Preferred & Non-Preferred: Not Covered
MagnaCare PPO (NY &NJ) / PHCS available in 48 States			
Notes:	One-Time Processing Fee: $250 June 1, 2023 Renewal Deductible and MOOP Reset every January 1st X-Ray, Bloodwork: Not covered at Hospital, the test must be performed at non hospital based lab or facility. Advanced Imaging: Not covered at Hospital unless the test cannot be performed at a non hospital based diagnostic center or lab. Out-Net Claims Paid At the 85th Percentile (UCR)		

***FOR INTERNAL USE ONLY**

This is for illustration purposes only must meet certain requirements.