Reg.

MEMBERSHIP ACCESS PROGRAMS

(Available to association members only)

2023 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:	$852.00	$722.00	$487.00
Member + Spouse:	$1,458.00	$1,194.00	$728.00
Member + Child(ren):	$1,260.00	$1,060.00	$653.00
Member + Family:	$1,892.00	$1,518.00	$898.00
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 - Plan Guarentees No Balance Billing			
CT/MRI/MRA/PET Scan	In-Net: $400 Copay Out-Net: $400 Copay In & Out Subject to Reference Based Pricing	In-Net: $350 Copay Out-Net: $350 Copay Limited to 3 per plan year. In & Out Subject to Reference Based Pricing	In-Net: $350 Copay Out-Net: $350 Copay Limited to 1 per plan year. In & Out Subject to Reference Based Pricing
Emergency Medical Transportation: (Ground Service Only)	In-Net: $400 Copay Out-Net: $400 Copay In & Out Subject to Reference Based Pricing	In-Net: $250 Copay Out-Net: $250 Copay Limited to 2 ground transports per plan year. In & Out Subject to Reference Based Pricing	In-Net: $250 Copay Out-Net: $250 Copay Limited to 1 ground transports per plan year. In & Out Subject to Reference Based Pricing
Emergency Room:	In-Net: $400 Copay Out-Net: $400 Copay In & Out Subject to Reference Based Pricing	In-Net: $350 Copay Out-Net: $350 Copay Limited to 3 per plan year. In & Out Subject to Reference Based Pricing	In-Net: $350 Copay Out-Net: $350 Copay Limited to 1 per plan year. In & Out Subject to Reference Based Pricing
Hospital Stay: (In-Patient)	In-Net: $400 Copay Out-Net: $400 Copay In & Out Subject to Reference Based Pricing	In-Net: $350 Copay Out-Net: $350 Copay Limited to 10 days per plan year.	In-Net: $350 Copay Out-Net: $350 Copay Limited to 3 days per plan year.
Inpatient Physician and Surgeon & Anesthesiologist Charges:	Included in Inpatient Hospitalization copay	Included in Inpatient Hospitalization copay	Included in Inpatient Hospitalization copay
Outpatient Surgery:	In-Net: $400 Copay Out-Net: $400 Copay In & Out Subject to Reference Based Pricing	In & Out Subject to Reference Based Pricing In-Net: $350 Copay Out-Net: $350 Copay Limited to 2 visits per plan year. In & Out Subject to Reference Based Pricing	In & Out Subject to Reference Based Pricing In-Net: $350 Copay Out-Net: $350 Copay Limited to 1 visits per plan year. In & Out 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: $125 June 1, 2024 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.