Current monthly premiums (3+ Employee Groups) –

Ultra:	**Gold:**	**MEC 5:**
$ 799 – Single	$ 677 – Single	$467 – Single
$1,329 – Member & Spouse	$1,115 – Member & Spouse	$697 – Member & Spouse
$1,192 – Member & Child(ren)	$1,004 – Member & Child(ren)	$629 – Member & Child(ren)
$1,727 – Family	$1,395 – Family	$848 - Family

(Note that the Plans Annual Anniversary is June)

Be aware that there are employee/dependent health questions to qualify for enrollment in these plans

HOW DOES REFERENCE-BASED PRICING WORK?

A reference-based pricing healthcare model that significantly lowers hospital and outpatient facility costs claims are 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 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 Provider Search (New York & New Jersey)		MAGNACARE	
PPO Provider Search (All other States)	PHCS	PHCS	PHCS
RX - FORMULARY (Click to View)	Capital Rx	Capital Rx	Capital Rx
SBC (Click to View)	SBC	SBC	SBC
Type of Plan	Referenced Based	Referenced Based	Referenced Based
Plan Availability	All 50 States	All 50 States	All 50 States
Enrollment Deadline	18th of month Prior to Effective date	18th of month Prior to Effective date	18th of month Prior to Effective date
Out of Network Claims	Paid at 85th percentile UCR	Paid at 85th percentile UCR	Paid at 85th percentile UCR
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	In-Net: $0 Single / $0 Family	In-Net: $0 Single / $0 Family

Co-Insurance	In-Net: None	In-Net: None	In-Net: None
Out Of Pocket Max (MOOP)	In-Net: $2,000 Single / $ 13,200 Family	In-Net: $5,000 Single / $ 10,000 Family	In-Net: $7,350 Single / $ 14,700 Family
	If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.		
REFERENCED BASED (Plan guarantees no balance billing)			
Hospital (In Patient) (Any Hospital)	$400 Copay per admission (Subject to Reference Based Pricing)	$350 Copay per admission (Subject to Reference Based Pricing)	$350 Copay per admission Limited to 3 days per plan year (Subject to Reference Based Pricing)
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 (Subject to Reference Based Pricing) (Limited to 1 visit per plan year)
Inpatient Visits - Physician	Included in Inpatient Hospitalization Copay (Subject to Referenced Based Pricing)	$350 Copay per admission (Limited to visits up to 10 days per plan year) (Subject to Referenced Based Pricing)	Included in Inpatient Hospitalization Copay (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 procedures 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 procedures per plan year)
Emergency Room Services (Any Hospital)	$400 Copay (Subject to Reference Based Pricing)	$350 Copay per admission (Limited to 2 visits per plan year) (Subject to Referenced Based Pricing)	$350 Copay Limited to 1 visit per plan year (Subject to Reference Based Pricing)
CT/MRI/MRA/PET Scan	$400 Copay (Subject to Reference Based Pricing) (No Limit)	Non-Hospital: $350 Copay (Subject to ReferencedBasedPricing) (Limited to 3 per plan year) Hospital: *Not Covered 100% paid by Member	Non-Hospital: $350 Copay (Subject to Referenced Based Pricing) (Limited to 1 per plan year) Hospital: *Not Covered 100% paid by Member
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)	$400 Copay (Subject to Reference Based Pricing)	$350 Copay per admission (Subject to ReferencedBased Pricing)	Not Covered 100% paid by Member
Emergency Medical Transportation (Ground Service Only)	$400 Copay (Subject to Reference Based Pricing)	$250 Copay (Limited to 2 transports per plan year) (Subject to Referenced Based Pricing)	$350 Copay (Subject to Referenced Based Pricing)

Durable Medical	In-Net: $400 Copay Out-Net: $400 Copay Subject to Reference Based Pricing	Not Covered	Not Covered
NETWORK BASED			
Physician Office Visit	In-Net: $20/$40 copay (No Limit)	In-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: Subject to Deductible and 40% Coinsurance	Out-Net: $15/$25 copay (Limited to 12 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 (No Limit)	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 Copay Out-Net: $50 Copay (Limited to 2 visits per plan year)
Telemedicine Vendor Services	In-Net: $0 Copay Out-Net: N/A	In-Net: $0 Copay Out-Net: N/A	In-Net: $0 Copay Out-Net: N/A
Laboratory & Minor Diagnostic Services* (Laboratory Services, Ultrasounds, Bone Density, Echography, etc.)	In-Net: $50 Copay Out-Net:	In-Net: $50 Copay Out-Net: $50 Copay	In-Net: $50 Copay Out-Net: Not Covered 100% paid by Member

	Subject to Deductible and 40% Coinsurance (No Visit Limit)	(Combined limit of 4 visits per plan year with Radiology)	(Combined limit of 3 visits per plan year with Radiology)
Radiology*	In-Net: $50 Copay Out-Net: Subject to Deductible and40% Coinsurance (No Visit Limit)	In-Net: $50 Copay Out-Net: $50 Copay (Combined limit of 4 visits per plan year with Radiology)	In-Net: $50 Copay Hospital:$50 Copay 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	In-Net: $350 copay Out-Net:$350 copay	Not Covered 100% paid by Member
Allergy Services	In-Net: $40 Out-Net: Subject to Deductible and 40% Coinsurance (The copay applies to the administration of the allergy service and is separate from the copay for the office visit)	In-Net: $25 Out-Net: $25 (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)	In-Net: $25 Out-Net: $25 (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)

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
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			
Type A - Rx Prescriptions* (Subject to Formulary)	**Pharmacy Retail up to a 30-day supply** In-Net: Generic - $0 Copay	**Pharmacy Retail up to a 30-day supply** In-Net: Generic - $0 Copay	**Pharmacy Retail up to a 30-day supply** In-Net: Generic - $0 Copay
Type B - Rx Prescriptions* (Subject to Formulary)	**Pharmacy Retail up to a 30-day supply** (Compounds are not covered) Generic: $10 Copay Preferred: $40 Copay Non-Preferred: $80 Copay **Pharmacy Mail Order 90-day supply** Generic: $30 Copay Preferred: $120 Copay Non-Preferred: $240 Copay **Specialty Drugs** In-Net: 25% Coinsurance	**Pharmacy Retail up to a 30-day supply** In-Net: Generic & Limited Brand 20% Copay **Pharmacy Mail Order 90-day supply** In-Net: Generic & Limited Brand 20% Copay **Non-Limited Brand & Specialty Drugs** In-Net: 25% Coinsurance	**Pharmacy Retail up to a 30-day supply** Generic: $10 Copay **Pharmacy Mail Order 90-day supply** Generic: $30 Copay **Preferred Brand, Non-Preferred Brand & Specialty Drugs** Not Covered

***Out of network Rx prescriptions are not covered**