PLANS AVAILABLE THRU ASSOCIATION MEMBERSHIP

PLAN	**ULTRA**		**GOLD**	
PLAN ANNIVERSARY	**6/1/2022**		**6/1/2022**	
	In-Network	Out of Network	In-Network	Out of Network
Deductible: Per Person	$0	$500	$0	$0
Co-Insurance	0%	0%	0%	0%
Out of Pocket Max: Per Person / Family	$2,000 $13,200	Unlimited	$5,000 $10,000	
PatientCopays/Co-Insurance(until yearly co-insurance maximum is reached)for selected benefits andservices:				
Facility Fees:				
Inpat Hospital Facility	$400	$400	$350 [1]	$350 [1]
O/P Hospital Facility	$400	$400	$350 [2]	$350 [2]
Emergency Room	$400	$400	$350 [2]	$350 [2]
Urgent Care	$50	$0	$35 [3]	$35 [3]
Skilled Nursing	Not Cov'd	Not Cov'd	Not Cov'd	Not Cov'd
Professional Fees:				
Primary Doctor Office	$20	40% after ded	$15 [4]	$15 [4]
Specialist Office	$40	40% after ded	$25 [4]	$25 [4]
Well Care(Adult/Baby)	$0	60% after ded	$0	$0
Inpat Physician	Included in Hospital Copay	Included in Hospital Copay	Included in Hospital Copay ^	Included in Hospital Copay ^
Surgeon	Included in Hospital Copay	Included in Hospital Copay	Included in Hospital Copay ^	Included in Hospital Copay ^
Anesthesia	Included in Hospital Copay	Included in Hospital Copay	Included in Hospital Copay ^	Included in Hospital Copay ^
Outpatient Mental Health	$40	40% after ded	$25 [4]	$25 4
Home Health Care	$25*	$25*	$25*	$25*
Ambulance	$400	$400	$250 [2]	$250 [2]
Air Ambulance	Not Cov'd	Not Cov'd	Not Cov'd	Not Cov'd
Dur Medical Equip	$400	$400	Not Cov'd	Not Cov'd
O/P Laboratory	$50	40% after ded	$50 [5]	$50 [5]
O/P Radiology	$50	40% after ded	$350 [5]	$350 [5]
O/P Therapies	75*	$75*	$50	$50
RX Benefits Mail Order Speciality Drugs	Co-Pay $10/$40/$80 Rx Co-Pay $30/$120/$240 25%		20% (Generic/Limited Brand) 20% (Generic/Limited Brand) 25%	
WEBSITE	www.magnacare.com			
RATES				
SINGLE				
EMPLOYEE/SPOUSE				
EMPLOYEE + CHILD(REN)				
FAMILY				
ENROLLMENT REQUIREMENTS:	MEMBER MUST BE EMPLOYED WITH A EIN NUMBER. A MEMBER MUST RESIDE AND PLAN AREA		MEMBER MUST BE EMPLOYED WITH A EIN NUMBER. A MEMBER MUST RESIDE AND PLAN AREA	

ALL APPLICATIONS MUST BE RECEVIED BY THE 15TH OF THE MONTH FOR THE FOLLOWING MONTH'S ENROLLMENT

Applications may be sent to: 455 Tarrytown Road #1207 White Plains, NY 10607

Fax to : 914-422-1986

The rates and benefits in this report are for discussion and estimation purposed only and are not valid with approval from the carrier. Final rates must be based on carrier confirmation and final enrollment

Note: This is not a fill description of benefit plans: see Summary of Benefits and coverages for a more full description with coverage limits

*20 visits per plan year

^please see full SOB description

1 - 10 hospital days/ year limit

2 - 2 per year

3 - 3 per year

4 - 12 per year

5 - Combined limit of 4 visits/ year (if O/pat, must be non-hosp based)