FreedomCare

COMPASSION • INDEPENDENCE • CHOICE

Your Benefit Plan

totalplan

CONCEPTS

YOUR HEALTH BENEFITS PLAN

This is your health benefits package. The Plan is provided to you by Freedomcare to statisfy the wage parity obligation. This plan is administered by Total Plan Concepts. Please read it carefully and call (800) 507-1433 with any questions.

FINDING YOUR PLAN

There are eight levels for benefit plans. Here's how we determine which benefit level you will be enrolled in, according to the amount of wage-parity hours you accumulate each month:

$440+ monthly wage parity= Plan A, Dental and Vision

$360-$439 monthly wage parity= Plan B, Dental and Vision

$310-$359 monthly wage parity= Plan C, Dental and Vision

$260-$309 monthly wage parity= Plan D, Dental and Vision

$220-$259 monthly wage parity= Plan E, Dental and Vision

$180 -$219 monthly wage parity= MEC, Dental and Vision

$30-$179 monthly wage parity= Dental and Vision

$0-$29 monthly wage parity = Vision

Once you've been enrolled with the program, you will receive an ID card in the mail. The card will appear the same across all benefit tiers. Therefore, please call Total Plan Concepts customer service at (800) 507-1433 to find out which benefit plan you are enrolled with.

There is no option to opt out of this program.

We will reassess your enrollment monthly, based on the non-overtime hours you worked during that month. In order to maintain consistent enrollment within plan tiers, your total monthly wage parity dollars will be averaged across 30.416 days each month. Any wages you receive which are above the prevailing minimum wage will reduce your benefit eligibility.

HOW IT WORKS

Your health benefit plan features a wide array of primary care doctors and specialists to choose from. The Plan will only cover office visits at a Magnacare-contracted doctor. You may visit any doctor in the Magnacare network, show them your card with the Magnacare logo, and they will simply charge you your plan's copay. The plan's deductible will not apply to office visits. **You will not pay a copay for preventive care.** The plan pays for an annual exam in full, as well as screenings and counseling services for members at appropriate age or risk status, in accordance with the Affordable Care Act.

This Plan pays for covered inpatient and outpatient hospital services at hospitals included within the Plan's Hospital List, which may be found within this benefit booklet. The Plan will pay the hospital an amount equal to the Maximum Allowable Charge. Most of the time, this will result in hassle-free services at the provider you chose. In the event the provider bills you for the difference in charges, an Member Advocate will address those for you. Call (800) 507-1433 if you feel you've been charged more than you should pay according to your plan. Only care rendered at the Plan's listed Hospitals will be paid by the Plan, with the exception of emergency room services.

To the extent the Plan provides coverage for medical and surgical benefits with respect to a mastectomy, it will also provide coverage for reconstructive surgery in a manner determined in consultation with the attending doctor and the patient. Coverage includes reconstruction of the breast on which the mastectomy was peformed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stage of the mastectomy, including lymphedemas. The applicable coinsurance, copays, plan maximums and requirements apply to reconstructive surgery in connection with a mastectomy and follow those established for comparable benefits under the plan.

DENTAL PLAN

The dental plan does not include a provider network, so you may visit the dentist of your choice. Your dentist should submit a Dental Claim Form to Total Plan Concepts using Payer ID 80900. Or, you may request reimbursement if you pay up front for your dental visit. Benefits for the dental plan are based off a fee schedule and are limited to the service codes included in the Schedule. The dental plan fee schedule may be found with this brochure. Please bring the Dental Fee Schedule to your dental visit. For reimbursement, email your receipt to claims@freedomcareny.com.

VISION PLAN

The vision program covers one annual eye exam at a Magnacare participating provider. Simply show the provider your ID card, and pay a $10 copay. The plan will also reimburse you for the lenses or frames of your choice. For reimbursement, email your receipt with your name and member ID to claims@freedomcareny.com.

HOSPITAL LIST

New Jersey

Monmouth Medical Center
300 2nd Ave, Long Branch, NJ 07740
600 River Ave, Lakewood, NJ 08701

Robert Wood Johnson Medical Center
Robert Wood Johnson Pl, New Brunswick, NJ 08901
865 Stone St, Rahway, NJ 07065
120 Albany St #360, New Brunswick, NJ 08901
60 Cooke Ave, Carteret, NJ 07008
110 Rehill Ave, Somerville, NJ 08876
1 Hamilton Health Pl, Hamilton Township, NJ .08690

Morristown Medical Center
100 Madison Ave, Morristown, NJ 07960

John F Kennedy
65 James St, Edison, NJ 08820

Newark Beth Israel
201 Lyons Ave, Newark, NJ 07112

Clara Mass Medical Center
1 Clara Maass Dr, Belleville, NJ 07109

Jersey City Medical
355 Grand St, Jersey City, NJ 07302

Bayonne Hospital Center
29 E 29th St, Bayonne, NJ 07002

Christ Hospital
176 Palisade Ave, Jersey City, NJ 07306

East Orange General Hospital
300 Central Ave, East Orange, NJ 07018

Trinitas Regional Medical Center
225 Williamson St, Elizabeth, NJ 07202

Brooklyn

Maimonides Medical Center
4802 10th Avenue Brooklyn, NY 11219

New York Presbyterian
506 Sixth Street Brooklyn, NY 11215

Kings County Hospital
451 Clarkson Ave, Brooklyn, NY 11233

SUNY Downstate
450 Clarkson Ave, Brooklyn, NY 11203

New York Community Hospital of Brooklyn
2525 Kings Hwy, Brooklyn, NY 11229

Mount Sinai Brooklyn
3201 Kings Hwy, Brooklyn, NY 11234

Coney Island Hospital
2601 Ocean Pkwy, Brooklyn, NY 11235

Wyckoff Heights
374 Stockholm St, Brooklyn, NY 11237

Kingsbrook Jewish
585 Schenectady Ave, Brooklyn, NY 11203

Woodhull Medical
760 Broadway, Brooklyn, NY 11206

Lutheran
150 55th St, Brooklyn, NY 11220

Mount Sinai Hospital
3201 Kings Hwy, Brooklyn, NY 11234

Brooklyn Hospital
121 DeKalb Avenue Brooklyn, NY 11204

Staten Island University Hospital
475 Seaview Ave, Staten Island, NY 10305

Richmond Medical Center
355 Bard Ave, Staten Island, NY 10310

Manhattan

New York Eye and Ear Infirmary
310 E 14th St, New York, NY 10003

Bellevue Hospital Center
462 1st Avenue, New York, NY 10016

Lenox Hill
100 E 77th St, New York, NY 10075

Mount Sinai St Luke's
1111 Amsterdam Ave, New York, NY 10025

Metropolitan Hospital Center
1901 1st Avenue, New York, NY 10029

New York Presbyterian Columbia University
622 West 168th Street New York, NY 10032

Harlem Hospital
506 Lenox Ave, New York, NY 10037

New York University Medical Center
550 1st Avenue, New York, NY 10016

Queens

New York Presbyterian Queens
56-45 Main Street
Flushing, NY 11355

Lincoln Hospital
234 E 149th St, Bronx, NY 10451

Flushing Hospital
4500 Parsons Blvd, Flushing, NY 11355

Jamaica Hospital
8900 Van Wyck Expy, Richmond Hill, NY 11418

Elmhurst Hospital
79-01 Broadway, Queens, NY 11373

Queens Hospital
82-68 164th St, Jamaica, NY 11434

Nassau

North Shore Hospital
300 Community Dr, Manhasset, NY 11030
Long Island Jewish Medical Center
270-05 76th Avenue, New Hyde Park, NY 11040
South Nassau Community Hospital
1 Healthy Way, Oceanside, NY 11572
221 Jericho Turnpike, Syosset, NY 11791
Nassau University Medical Center
2201 Hempstead Turnpike, East Meadow, NY 11554
NSUH at Syosset
221 Jericho Turnpike, Syosset, NY 11791
St. Francis Hospital
100 Port Washington Boulevard Roslyn, NY 11576
Mercy Medical Center
1000 N Village Ave, Rockville Centre, NY 11570

Westchester

Montefiore Mount Vernon Hospital
12 N 7th Ave, Mt Vernon, NY 10550
St. Johns Riverside Hospital
967 N Broadway, Yonkers, NY 10701
20 E 1st St, Mt Vernon, NY 10550
Montefiore New Rochelle Hospital
16 Guion Pl, New Rochelle, NY 10802
White Plains Hospital
41 E Post Rd, White Plains, NY 10601
Hudson Valley Hospital Center
1980 Crompond Road, Cortland Manor, NY 10567
Northern Westchester
400 E Main St, Mt Kisco, NY 10549
Lawrence Hospital
55 Palmer Ave, Bronxville, NY 10708

Bronx

Montefiore Medical Center
1575 Blondell Ave, Bronx, NY 10461
3415 Bainbridge Ave, Bronx, NY 10467
60 E 208th St, Bronx, NY 10467
3380 Reservoir Oval E, Bronx, NY 10467
3725 Henry Hudson Pkwy #1D, Bronx, NY 10463
1055 E Tremont Ave, Bronx, NY 10460
3311 Bainbridge Ave, Bronx, NY 10467
3011 Boston Rd, Bronx, NY 10469
1250 Waters Pl, Bronx, NY 10461
North Central Bronx
3424 Kossuth Ave, Bronx, NY 10467
Montefiore Medical Center North Division
111 E 210th St, Bronx, NY 10467
Jacobi Medical Center
1400 Pelham Pkwy S, Bronx, NY 10461

Orange

Nyack Hospital
160 N Midland Ave, Nyack, NY 10960

Rockland

Good Samaritan Regional Medical Center
255 Lafayette Avenue, Suffern, NY 10901

Suffolk

Good Samaritan Hospital
1000 Montauk Hwy, West Islip, NY 11795
St. Catherine of Siena Medical Center
50 Route 25A Smithtown, NY 11787
John T. Mather Memorial Hospital
75 North Country Road Port Jefferson, NY 11777
St. Charles Hospital
200 Belle Terre Road Port Jefferson, NY 11777
St. Joseph Hospital
4295 Hempstead Turnpike Bethpage, NY 11714

Upsate New York

Buffalo General Hospital
100 High Street, Buffalo, NY 14203
Erie County Medical Center
462 Grider Street, Buffalo, NY 14215
Kenmore Mercy
2950 Elmwood Avenue, Kenmore, NY 14217
Millard Fillmore Suburban
1540 Maple Road, Amherst, NY 14226
Sisters of Charity Hospital
2157 Main Street, Buffalo, NY 14214
Mount St. Mary's Hospital
5300 Military Road, Lewston, NY 14092
Glens Falls Hospital
100 Park St, Glens Falls, NY 12801
Ellis Medicine
1101 Nott St, Schenectady, NY 12308
St. Josephs Hospital Syracuse
301 Prospect Avenue, Syracuse, NY 13203
Faxton St. Luke's
1656 Champlin Ave, Utica, NY 13502
University of Rochester Medical Center
601 Elmwood Ave, Rochester, NY 14642

DENTAL FEE SCHEDULE

Procedure Code & Description Allowance

DIAGNOSTIC

D0120	Periodic oral exam-once in 6 months	**80.00**
D0140	Emergency/problem oral exam	**80.00**
D0150	New patient - initial exam-once in 6 months**	**110.00**
D0210	Intraoral - complete-once in 6 months	**120.00**
D0220	Intraoral - first film-once in 6 months	**40.00**
D0230	Intraoral - each additional-once in 6 months	**30.00**
D0272	Bitewing x-rays-once in 6 months	**50.00**
D0274	Bitewing x-rays-once in 12 months	**100.00**

PREVENTIVE

D1110	Prophylaxis (cleaning) adult-once in 6 months	**90.00**
D1120	Prophylaxis (cleaning) child-once in 6 months	**90.00**
D1203	Fluoride, child (excludes prophy)-once in 6 months	**35.00**

SPACE MAINTENANCE (PASSIVE APPLIANCES)

D1510	Fixed - unilateral	**65.00**
D1515	Fixed - bilateral	**85.00**
D1550	Recementation	**15.00**

RESTORATIONS

D2140	Amalgam, 1 surface	**35.00**
D2150	Amalgam, 2 surfaces	**60.00**
D2160	Amalgam,3 surfaces	**100.00**
D2330	Resin, 1 surface, anterior	**35.00**
D2331	Resin, 2 surface, anterior	**60.00**
D2332	Resin, 3 surface, anterior	**100.00**

SINGLE CROWNS

D2750	Porcelain fused to high noble metal	**200.00**
D2790	Full cast high noble metal	**175.00**
02920	Recement crown	**25.00**

ENDODONTICS

D3220	Therapeutic pulpotomy	**50.00**
D3310	Root canal, anterior	**400.00**
D3320	Root canal, bicuspid	**500.00**
D3330	Root canal, molar	**450.00**

PERIODONTICS

D4210	Gingivectomy/plasty, per quad	**150.00**
D4260	Osseous surgery, per quad	**350.00**
D4341	Perio scaling/root planning	**65.00**
D4910	Perio maintenance, after active therapy	**25.00**

DENTURES/REPAIRS

D5640	Replace broken teeth, per tooth	**85.00**
D5650	Add tooth to existing parial	**50.00**
D5660	Add clasp to existing partial	**50.00**
D5750	Reline complete upper denture (lab)	**150.00**

BRIDGE PONTICS/CROWNS

D6240	Porcelain fused to high noble metal	**400.00**
D6250	Resin with high noble metal	**350.00**
D6720	Crown resin with high noble metal	**350.00**
D6750	Crown porcelain fused to high noble	**400.00**
D6930	Recement bridge	**50.00**

EXTRACTIONS/ORAL SURGERY

D7140	Erupted tooth/exposed root	**75.00**
D7220	Impacted tooth - soft tissue	**80.00**
D7230	Impacted tooth, partially bony	**100.00**
D7240	Impacted tooth, completely bony	**110.00**
D7310	Alveoplasty with extractions, per quad	**70.00**

ADJUNCTIVE GENERAL SERVICE

D9110	Emergency treatment, by report	**50.00**

totalplan CONCEPTS

Please submit claim forms to:
Total Plan Concepts
P.O. Box 40328
Brooklyn, NY 11204

**Frequency max is combined with periodic oral exam
Maximum annual benefits $1,500 per person

COVERED BENEFITS	WHAT YOU PAY		
In network providers include all Magnacare-contracted doctors. Claims for hospitals listed on the Preferred Hospital List will be paid at the Maximum Allowable Charge.			
	PLAN A	**PLAN B**	**PLAN C**
Maximum Benefits Lifetime Period	Unlimited	Unlimited	Unlimited
Annual Deductible	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 Family
Coinsurance	20%	20%	20%
Out of Pocket Maximum	$6,000 Individual $12,000 Family	$6,000 Individual $12,000 Family	$7,900 Individual $15,800 Family
Semi-Private Room and Board*	20% Coinsurance After Deductible *60 days maximum inpatient days per year*	20% Coinsurance After Deductible *30 days maximum inpatient days per year*	20% Coinsurance After Deductible *30 days maximum inpatient days per year*
Anesthesia	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Intensive Care & Coronary Units*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Surgeon Fees*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Maternity	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Routine Nursery Care	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Skilled Nursing Facility Care*	20% Coinsurance After Deductible *Maximum of 25 days per year*	20% Coinsurance After Deductible *Maximum of 25 days per year*	20% Coinsurance After Deductible *Maximum of 25 days per year*
Inpatient Rehabilitation*	20% Coinsurance After Deductible *Maximum of 25 days per year*	20% Coinsurance After Deductible *Maximum of 25 days per year*	20% Coinsurance After Deductible *Maximum of 25 days per year*
Hospice Care (Inpatient)*	20% Coinsurance After Deductible *Maximum 45 visits per year*	20% Coinsurance After Deductible *Maximum of 45 days per year*	20% Coinsurance After Deductible *Maximum 45 visits per year*
Organ Transplant	Not Covered	Not Covered	Not Covered
Pre-Admission Testing	No Charge	No Charge	No Charge
Ambulatory Surgery*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Inpatient and Outpatient Dialysis*	20% Coinsurance After Deductible *Maximum 30 visits per year*	20% Coinsurance After Deductible *Maximum of 30 days per year*	20% Coinsurance After Deductible *Maximum 30 visits per year*
Home Health Care Services*	$35 Copay Per Visit *Maximum of 30 visits per year*	$35 Copay Per Visit *Maximum 30 visits per year*	$35 Copay Per Visit *Maximum of 30 visits per year*
PCP Office Visit	$5 Copay Per Visit	$10 Copay Per Visit	$15 Copay Per Visit
Specialist Visit	$10 Copay Per Visit	$20 Copay Per Visit	$30 Copay Per Visit
I/P Hospital Doctor Visits	$5 Copay Per Visit	$10 Copay Per Visit	$15 Copay Per Visit
Allergy Care	$40 Copay Per Visit	$40 Copay Per Visit	$40 Copay Per Visit
Chiropractic Care	$40 Copay Per Visit	$40 Copay Per Visit	$40 Copay Per Visit
Physical & Occupational Therapy	$40 Copay Per Visit	$40 Copay Per Visit	$40 Copay Per Visit
Prenatal and Post-Natal Care	$5 Copay First Visit	$10 Copay First Visit	$15 Copay First Visit

COVERED BENEFITS	WHAT YOU PAY		
	PLAN A	PLAN B	PLAN C
Routine Adult Physical (1 per year)	No Charge	No Charge	No Charge
Preventive Mammography and Pap Smear Screening	No Charge	No Charge	No Charge
Preventive Prostate Screening	No Charge	No Charge	No Charge
Speech Therapy	Not Covered	Not Covered	Not Covered
Ambulance Services	$400 Copay	$400 Copay	$400 Copay
Diagnostic Lab Tests	$10 Copay	$20 Copay	$30 Copay
High Tech Radiology* (e.g., CT Scan, MRI)	$75 Copay	$75 Copay	$75 Copay
X-rays	$10 Copay	$20 Copay	$30 Copay
Emergency Room Visit	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Urgent Care Facility	$40 Copay Per Visit	$40 Copay Per Visit	$40 Copay Per Visit
Durable Medical Equipment	30% Coinsurance After Deductible	30% Coinsurance After Deductible	30% Coinsurance After Deductible
Radiation and Chemotherapy*	$40 Copay *Maximum of 30 visits per year*	$40 Copay *Maximum of 30 visits per year*	$40 Copay *Maximum of 30 visits per year*
Home Infusion Therapy*	$35 Copay *Maximum of 10 visits per year*	$35 Copay *Maximum of 10 visits per year*	$35 Copay *Maximum of 10 visits per year*
Inpatient Mental Health*	15% Coinsurance After Deductible *Maximum of 60 visits per year*	15% Coinsurance After Deductible *Maximum of 30 days per year*	15% Coinsurance After Deductible *Maximum of 30 days per year*
Outpatient Mental Health	$10 Copay Per Visit	$20 Copay Per Visit	$30 Copay Per Visit
Inpatient Detoxification*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Inpatient Substance Abuse Rehab	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Outpatient Chemical Dependency Treatment	$10 Copay Per Visit	$20 Copay Per Visit	$30 Copay Per Visit
Vision	$10 Copay 1 Eye Exam Up to $50 Annually Toward Lenses or Frames	$10 Copay 1 Eye Exam Up to $50 Annually Toward Lenses or Frames	$10 Copay 1 Eye Exam Up to $50 Annually Toward Lenses or Frames
Dental	Included See Schedule Page 5	Included See Schedule Page 5	Included See Schedule Page 5
Pharmacy Benefits Retail	Generic Drugs: $10 Copay Preferred Brand: $35 Copay	Generic Drugs: $10 Copay	Generic Drugs: $10 Copay

COVERED BENEFITS	WHAT YOU PAY		
In network providers include all Magnacare-contracted doctors. Claims for hospitals listed on the Preferred Hospital List will be paid at the Maximum Allowable Charge.			
	PLAN D	**PLAN E**	**MEC**
Maximum Benefits Lifetime Period	Unlimited	Unlimited	Unlimited
Annual Deductible	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family	$0 Individual $0 Family
Coinsurance	20%	20%	0%
Out of Pocket Maximum	$7,900 Individual $15,800 Family	$7,900 Individual $15,800 Family	$7,900 Individual $15,800 Family
Semi-Private Room and Board*	20% Coinsurance After Deductible *30 days maximum inpatient days per year*	20% Coinsurance After Deductible *30 days maximum inpatient days per year*	Not Covered
Anesthesia	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Intensive Care & Coronary Units*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Surgeon Fees*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Maternity	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Routine Nursery Care	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Skilled Nursing Facility Care*	20% Coinsurance After Deductible *Maximum of 25 days per year*	20% Coinsurance After Deductible *Maximum of 25 days per year*	Not Covered
Inpatient Rehabilitation*	20% Coinsurance After Deductible *Maximum of 25 days per year*	20% Coinsurance After Deductible *Maximum of 25 days per year*	Not Covered
Hospice Care (Inpatient)*	20% Coinsurance After Deductible *Maximum 45 visits per year*	20% Coinsurance After Deductible *Maximum 45 visits per year*	Not Covered
Organ Transplant	Not Covered	Not Covered	Not Covered
Pre-Admission Testing	No Charge	No Charge	Not Covered
Ambulatory Surgery*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Outpatient Dialysis*	20% Coinsurance After Deductible *Maximum 10 visits per year*	20% Coinsurance After Deductible *Maximum 10 visits per year*	Not Covered
Home Health Care Services*	$35 Copay Per Visit *Maximum of 10 visits per year*	$35 Copay Per Visit *Maximum of 10 visits per year*	Not Covered
PCP Office Visit	$10 Copay Per Visit	$15 Copay Per Visit	Not Covered
Specialist Visit	$20 Copay Per Visit	$30 Copay Per Visit	Not Covered
I/P Hospital Doctor Visits	$10 Copay Per Visit	$15 Copay Per Visit	Not Covered
Allergy Care	$40 Copay Per Visit	$40 Copay Per Visit	Not Covered
Chiropractic Care	$40 Copay Per Visit	$40 Copay Per Visit	Not Covered
Physical & Occupational Therapy	$40 Copay Per Visit	$40 Copay Per Visit	Not Covered
Prenatal and Post-Natal Care	$10 Copay First Visit	$15 Copay First Visit	Not Covered

COVERED BENEFITS	WHAT YOU PAY		
	PLAN D	PLAN E	MEC
Routine Adult Physical (one per year)	No Charge	No Charge	No Charge
Preventive Mammography and Pap Smear Screening	No Charge	No Charge	No Charge
Preventive Prostate Screening	No Charge	No Charge	No Charge
Speech Therapy	Not Covered	Not Covered	Not Covered
Ambulance Services	$400 Copay	$400 Copay	Not Covered
Diagnostic Lab Tests	$20 Copay	$30 Copay	Not Covered
High Tech Radiology* (e.g., CT Scan, MRI)	$75 Copay	$75 Copay	Not Covered
X-rays	$20 Copay	$30 Copay	Not Covered
Emergency Room Visit	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Urgent Care Facility	$40 Copay Per Visit	$40 Copay Per Visit	Not Covered
Durable Medical Equipment	30% Coinsurance After Deductible	30% Coinsurance After Deductible	Not Covered
Radiation and Chemotherapy*	$40 Copay *Maximum of 10 visits per year*	$40 Copay *Maximum of 10 visits per year*	Not Covered
Home Infusion Therapy*	$35 Copay *Maximum of 10 visits per year*	$35 Copay *Maximum of 10 visits per year*	Not Covered
Inpatient Mental Health*	15% Coinsurance After Deductible *Maximum of 30 days per year*	15% Coinsurance After Deductible *Maximum of 30 days per year*	Not Covered
Outpatient Mental Health	$20 Copay Per Visit	$30 Copay Per Visit	Not Covered
Inpatient Detoxification*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Inpatient Substance Abuse Rehab	20% Coinsurance After Deductible	20% Coinsurance After Deductible	Not Covered
Outpatient Chemical Dependency Treatment	$20 Copay Per Visit	$30 Copay Per Visit	Not Covered
Vision	$10 Copay 1 Eye Exam Up to $50 Annually Toward Lenses or Frames	$10 Copay 1 Eye Exam Up to $50 Annually Toward Lenses or Frames	$10 Copay 1 Eye Exam Up to $50 Annually Toward Lenses or Frames
Dental	Included See Schedule Page 5	Included See Schedule Page 5	Included See Schedule Page 5
Pharmacy Benefits Retail	Generic Drugs: $10 Copay	Generic Drugs: $10 Copay	Not Covered

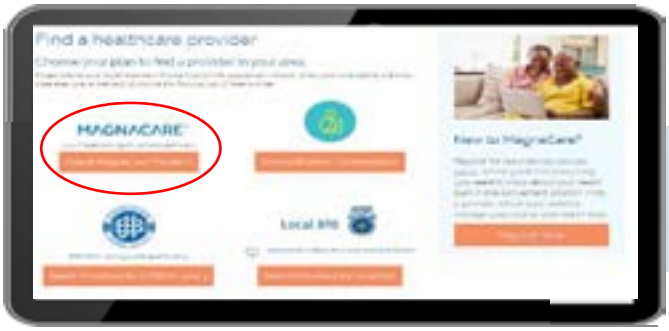
Provider Lookup

MAGNACARE™

Physicians can be identified at

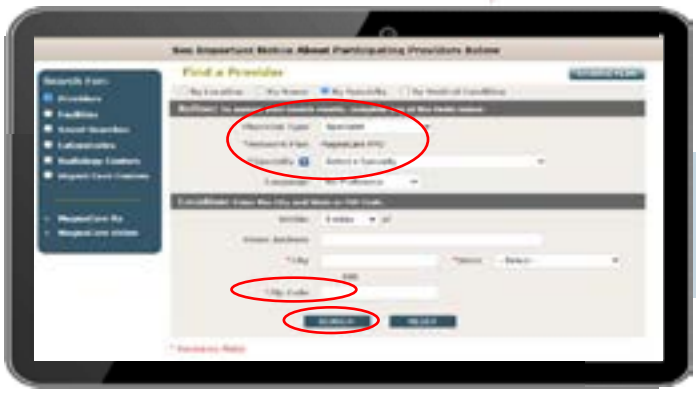
Magnacare.com

1 Click on ***Find a Provider***



2 Select ***Magnacare*** as your healthcare provider

3 Choose a provider type



4 Enter ***Physician Type*** and ***Specialty,*** then enter your ***Zip Code*** and ***Search***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