



Your Benefit Plan



totalplan
CONCEPTS

YOUR HEALTH BENEFITS PLAN

You choose your pay rate: \$20.20 or \$21.10. If you elect to get paid \$21.10 per hour, you will be asked to waive Freedom Care's comprehensive medical plan. This benefit guide will detail all of the perks included within your employment with Freedom Care.

FINDING YOUR PLAN

\$20.20 Pay Rate :

There are seven 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:

- \$210+ monthly wage parity= Plan A, Dental and Vision
- \$181-\$209 monthly wage parity= Plan B, Dental and Vision
- \$151-\$180 monthly wage parity= Plan C, Dental and Vision
- \$120-\$150 monthly wage parity= Plan D, Dental and Vision
- \$90 -\$120 monthly wage parity= MEC, Dental and Vision
- \$30-\$89 monthly wage parity= Dental and Vision
- \$0-\$29 monthly wage parity = Vision

\$21.10 Pay Rate :

There are two 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:

- \$50+ monthly wage parity = MEC
- <\$50 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.

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

YOUR HEALTH BENEFITS PLAN

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, a 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 performed, 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 \$50 per year 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 prophylaxis)-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 partial | 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 |
|-------|--------------------------------|-------|



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 <i>60 days maximum inpatient days per year</i> | 20% Coinsurance After Deductible <i>30 days maximum inpatient days per year</i> | 20% Coinsurance After Deductible <i>30 days maximum inpatient days per year</i> |
| 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 <i>Maximum of 25 days per year</i> | 20% Coinsurance After Deductible <i>Maximum of 25 days per year</i> | 20% Coinsurance After Deductible <i>Maximum of 25 days per year</i> |
| Inpatient Rehabilitation* | 20% Coinsurance After Deductible <i>Maximum of 25 days per year</i> | 20% Coinsurance After Deductible <i>Maximum of 25 days per year</i> | 20% Coinsurance After Deductible <i>Maximum of 25 days per year</i> |
| Hospice Care (Inpatient)* | 20% Coinsurance After Deductible <i>Maximum 45 visits per year</i> | 20% Coinsurance After Deductible <i>Maximum of 45 days per year</i> | 20% Coinsurance After Deductible <i>Maximum 45 visits per year</i> |
| 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 <i>Maximum 30 visits per year</i> | 20% Coinsurance After Deductible <i>Maximum of 30 days per year</i> | 20% Coinsurance After Deductible <i>Maximum 30 visits per year</i> |
| Home Health Care Services* | \$35 Copay Per Visit <i>Maximum of 30 visits per year</i> | \$35 Copay Per Visit <i>Maximum 30 visits per year</i> | \$35 Copay Per Visit <i>Maximum of 30 visits per year</i> |
| 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 <i>Maximum of 30 visits per year</i> | \$40 Copay <i>Maximum of 30 visits per year</i> | \$40 Copay <i>Maximum of 30 visits per year</i> |
| Home Infusion Therapy* | \$35 Copay <i>Maximum of 10 visits per year</i> | \$35 Copay <i>Maximum of 10 visits per year</i> | \$35 Copay <i>Maximum of 10 visits per year</i> |
| Inpatient Mental Health* | 15% Coinsurance After Deductible <i>Maximum of 60 visits per year</i> | 15% Coinsurance After Deductible <i>Maximum of 30 days per year</i> | 15% Coinsurance After Deductible <i>Maximum of 30 days per year</i> |
| 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 Non-Preferred Brand: \$70 Copay | Generic Drugs: \$10 Copay Preferred Brand: \$35 Copay Non-Preferred Brand: \$70 Copay | Generic Drugs: \$10 Copay Preferred Brand: \$35 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 | MEC \$20.20 PAY RATE | MEC \$21.10 PAY RATE |
|----------------------------------|--|---------------------------------------|---------------------------------------|
| Maximum Benefits Lifetime Period | Unlimited | Unlimited | Unlimited |
| Annual Deductible | \$3,000 Individual \$6,000 Family | \$0 Individual \$0 Family | \$0 Individual \$0 Family |
| Coinsurance | 20% | 0% | 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 <i>30 days maximum inpatient days per year</i> | Not Covered | Not Covered |
| Anesthesia | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Intensive Care & Coronary Units* | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Surgeon Fees* | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Maternity | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Routine Nursery Care | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Skilled Nursing Facility Care* | 20% Coinsurance After Deductible <i>Maximum of 25 days per year</i> | Not Covered | Not Covered |
| Inpatient Rehabilitation* | 20% Coinsurance After Deductible <i>Maximum of 25 days per year</i> | Not Covered | Not Covered |
| Hospice Care (Inpatient)* | 20% Coinsurance After Deductible <i>Maximum 45 visits per year</i> | Not Covered | Not Covered |
| Organ Transplant | Not Covered | Not Covered | Not Covered |
| Pre-Admission Testing | No Charge | Not Covered | Not Covered |
| Ambulatory Surgery* | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Outpatient Dialysis* | 20% Coinsurance After Deductible <i>Maximum 10 visits per year</i> | Not Covered | Not Covered |
| Home Health Care Services* | \$35 Copay Per Visit <i>Maximum of 10 visits per year</i> | Not Covered | Not Covered |
| PCP Office Visit | \$10 Copay Per Visit | Not Covered | Not Covered |
| Specialist Visit | \$20 Copay Per Visit | Not Covered | Not Covered |
| I/P Hospital Doctor Visits | \$10 Copay Per Visit | Not Covered | Not Covered |
| Allergy Care | \$40 Copay Per Visit | Not Covered | Not Covered |
| Chiropractic Care | \$40 Copay Per Visit | Not Covered | Not Covered |
| Physical & Occupational Therapy | \$40 Copay Per Visit | Not Covered | Not Covered |

| COVERED BENEFITS | WHAT YOU PAY | | |
|--|---|---|-------------------------------------|
| | PLAN D | MEC \$20.20 PAY RATE | MEC \$21.10 PAY RATE |
| 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 | Not Covered | Not Covered |
| Diagnostic Lab Tests | \$20 Copay | Not Covered | Not Covered |
| High Tech Radiology* (e.g., CT Scan, MRI) | \$75 Copay | Not Covered | Not Covered |
| X-rays | \$20 Copay | Not Covered | Not Covered |
| Emergency Room Visit | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Urgent Care Facility | \$40 Copay Per Visit | Not Covered | Not Covered |
| Durable Medical Equipment | 30% Coinsurance After Deductible | Not Covered | Not Covered |
| Radiation and Chemotherapy* | \$40 Copay <i>Maximum of 10 visits per year</i> | Not Covered | Not Covered |
| Home Infusion Therapy* | \$35 Copay <i>Maximum of 10 visits per year</i> | Not Covered | Not Covered |
| Inpatient Mental Health* | 15% Coinsurance After Deductible <i>Maximum of 30 days per year</i> | Not Covered | Not Covered |
| Outpatient Mental Health | \$20 Copay Per Visit | Not Covered | Not Covered |
| Inpatient Detoxification* | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Inpatient Substance Abuse Rehab | 20% Coinsurance After Deductible | Not Covered | Not Covered |
| Outpatient Chemical Dependency Treatment | \$20 Copay Per Visit | Not Covered | 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 | Not Covered |
| Dental | Included See Schedule Page 5 | Included See Schedule Page 5 | Not Covered |
| Pharmacy Benefits Retail | Generic Drugs: \$10 Copay Preferred Brand: \$35 Copay | Plan covers only ACA required drugs | Plan covers only ACA required drugs |

Provider Lookup

MAGNACARESM

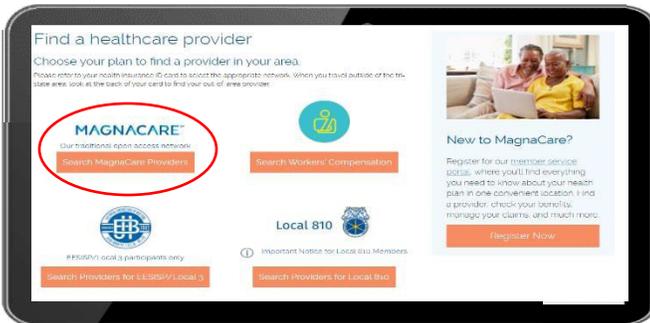
Physicians can be identified at

Magnacare.com

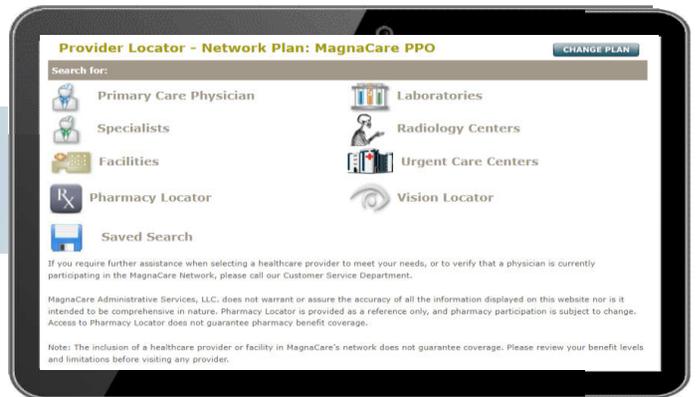
1 Click on *Find a Provider*



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*

