## II. SCHEDULE OF BENEFITS

## HDHP PLAN

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Calendar Year Deductible**<br>Individual<br>Family | <br>$2,500<br>$5,000 | <br>$2,500<br>$5,000 |
| **Coinsurance After Deductible** | 10% | 30% |
| **Lifetime Maximum**<br>(Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits) | Unlimited | |
| **Out-of-Pocket Maximum**<br>(includes deductibles and copays)<br>Individual<br>Family | <br><br>$4,000<br>$8,000 | <br><br>$5,000<br>$10,000 |
| **Physician Office Visits**<br>Primary Care Physician | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrist, etc.) | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Preventative Care Benefits**<br>(One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG & mammography) | No Charge | 30% coinsurance, after deductible |
| **Allergy Injections/Immunotherapy** | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Diagnostic Tests** (X-Rays and blood tests) | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Imaging Services** (CT and MRI scans require prior authorization) | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Ambulance** | 10% coinsurance, after deductible | 10% coinsurance, after deductible |
| **Emergency Room** (waived if admitted) | 10% coinsurance, after deductible | 10% coinsurance, after deductible |

## HDHP PLAN

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Urgent Care Center Services** | 10% coinsurance, after deductible | 10% coinsurance, after deductible |
| **Outpatient Surgery Center**<br>Facility | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| Physician & Surgeon Fees | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Hospital Benefits**<br>Daily Hospital Room and Board, Semi Private and other allowable expenses | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Mental and Substance Use Disorder**<br>Inpatient | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| Outpatient | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Maternity Services**<br>Prenatal and postnatal services | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| All other hospital and physician services | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Hospice Services** (Up to 210 days per lifetime) | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Home Health Care**<br>(Limited up to 100 visits per calendar year) | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Skilled Nursing Facility** (Limited up to 60 days per calendar year) | 10% coinsurance, after deductible | Not Covered |

## HDHP PLAN

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Durable Medical Equipment** (Total rental not to exceed purchase price) | 10% coinsurance, after deductible | Not Covered |
| **External Prosthetic Devices** | 10% coinsurance, after deductible | Not Covered |
| -Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenic alopecia- male pattern baldness) | 10% coinsurance, after deductible, up to a maximum of $350 | Not Covered |
| **Physical, Occupational and Speech Therapy** (Limited to 30 visits each per calendar year) | 10% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Chiropractic Care** | $25 copay | 30% coinsurance, after deductible |
| **Hearing Aids** (Both Ears- Once every 3 years. Includes batteries, supplies, maintenance, and fittings) | 10% coinsurance, after deductible | 30% coinsurance, after deductible |

## HDHP PLAN

| PRESCRIPTION DRUG PLAN | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| ****Copays shown are after the medical <u>deductible</u> has been met** | **In-Network** | **Out-of-Network** |
| **Retail 30-Day Supply** | | |
| Generic Drugs | $10 copay | Not Covered |
| Preferred Brand Name Drugs | $30 copay | Not Covered |
| Non-Preferred Brand Name Drugs | $60 copay | Not Covered |
| Specialty Drugs | 10% coinsurance, up to $150 maximum | Not Covered |

| PRESCRIPTION DRUG PLAN | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| ****Copays shown are after the medical <u>deductible</u> has been met** | **In-Network** | **Out-of-Network** |
| **Mail-Order 90-Day Supply** | | |
| Generic Drugs | $20 copay | Not Covered |
| Preferred Brand Name Drugs | $60 copay | Not Covered |
| Non-Preferred Brand Name Drugs | $120 copay | Not Covered |
| Specialty Drugs | 10% coinsurance, up to $300 maximum | Not Covered |

## IF YOU ELECT THESE BENEFITS:

**Dental Benefits**
Provided by Delta Dental- call 1-800-452-9310 for Customer Service
1-800-335-8265 for Providers in your area
(Delta-Ok)

You may also obtain information on their website at www.deltadentalnj.com

**Vision Benefits**
Provided by VSP- call 1-800-877-7195 for Customer Service

You may also obtain information on their website at www.vsp.com