II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible -Individual -Family	 $200 $400	 $200 $400
Co-insurance After Deductible	10%	30%
Lifetime Maximum (Amount payable per eligible individual includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (Includes deductibles, coinsurance, and copays) -Individual -Family	 $2,000 $4,000	 $2,000 $4,000
Physician's Office Visits -Primary Care Physician	$15 copay	30% co-insurance, after deductible
-Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$15 copay	30% co-insurance, after deductible
Preventative Care (Includes one annual exam per calendar year including blood, cancer, diabetic retinal screenings, urine tests, chest x-ray, EKG & mammography)	No Charge	30% co-insurance, after deductible
Telemedicine	No Charge	30% co-insurance, after deductible
Virtual Care (Use of online technology, telephone and secure messaging initiated care from remote location that is diagnostic and treatment focused.)	No Charge	Not Covered
Diagnostic Testing (X-rays and blood tests)	10% co-insurance, after deductible	30% co-insurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	10% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance -Emergency ground or transport to any facility.	10% co-insurance, after deductible	10% co-insurance, after deductible
-Non- emergency ground or air interfacility transfer.	10% co-insurance, after deductible	10% co-insurance, after deductible
Emergency Room (Copay waived if admitted)	$100 copay, plus 10% coinsurance, after deductible	$100 copay, plus 10% coinsurance, after deductible
Urgent Care Center	$15 copay	30% co-insurance, after deductible
Hospital (Daily hospital room and board, semi-private and other allowable expense)	10% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient Hospital (Includes anesthesia services, ambulatory surgery centers, and endoscopic procedures, etc.)	10% co-insurance, after deductible	30% co-insurance, after deductible
Radiation Therapy and Chemotherapy	$15 copay	30% co-insurance, after deductible
Dialysis -Home and outpatient settings	$15 copay	30% coinsurance, after deductible
-Outpatient injections	$15 copay	30% coinsurance, after deductible
Infusion Therapy	$15 copay	30% co-insurance, after deductible
-Associated infused medication	10% co-insurance, after deductible	30% co-insurance, after deductible
Clinical Trials (Requires pre-authorization) -Inpatient	10% co-insurance, after deductible	30% co-insurance, after deductible
-Outpatient	10% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
-Office Visits	$15 copay	30% co-insurance, after deductible
Transplant Services (Requires prior authorization)	10% co-insurance, after deductible	30% co-insurance, after deductible
-Office Visits	$15 copay	30% co-insurance, after deductible
Maternity Care Services -Pre-natal & Postnatal Care	$15 copay	30% coinsurance, after deductible
-Hospital inpatient and outpatient services (Includes home births and birthing centers)	10% coinsurance, after deductible	30% coinsurance, after deductible
Reproductive Health Services	No Charge	30% co-insurance, after deductible
Infertility Counseling Limited to one consultation visit to diagnose infertility condition -Doctor's office	$15 copay	30% co-insurance, after deductible
Sexual Dysfunction (Limited up to 1 consultation visit)	$15 copay	30% co-insurance, after deductible
Sterilization (Includes FDA- approved female sterilization procedures, services, supplies and vasectomy)	No Charge	30% co-insurance, after deductible
Transgender Services (Requires prior authorization)	10% co-insurance, after deductible	30% co-insurance, after deductible
Reconstructive and Plastic Surgery (Correction of congenital disease or congenital anomaly and/ or following after a mastectomy) -Hospital	10% co-insurance, after deductible	30% co-insurance, after deductible
-Office Visits	$15 copay	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Substance Abuse Treatment -Inpatient Hospital	10% co-insurance, after deductible	30% co-insurance, after deductible
-Outpatient • Hospital	10% co-insurance, after deductible	30% co-insurance, after deductible
• Doctor's office	$15 copay	30% co-insurance, after deductible
Inpatient Hospice Care (Limited up to 5 consecutive days per 3 month period)	10% co-insurance, after deductible	30% co-insurance, after deductible
Home Health Care	10% co-insurance, after deductible	30% co-insurance, after deductible
Skilled Nursing Facility Care	10% co-insurance, after deductible	30% co-insurance, after deductible
Acupuncture (12 visits per calendar year)	$15 copay	30% co-insurance, after deductible
Allergy Injections and Allergy Tests	$15 copay	30% co-insurance, after deductible
Chiropractic Office Visits (Limited up to 15 visits per calendar year)	$15 copay	30% co-insurance, after deductible
Diabetic services -Diabetic education and training	$15 copay	30% coinsurance, after deductible
-Diabetic equipment (Includes blood glucose monitors, insulin pumps, and therapeutic shoes)	10% coinsurance, after deductible	30% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	10% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
External Prosthetic Devices -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, and any amount over $350 maximum	30% coinsurance, after deductible, and any amount over $350 maximum
Hearing Exams and Hearing Aids Hearing exams for hearing loss and evaluation are covered. Services cover for cochlear implants and Bone Anchored Hearing Aids (BAHA). Diagnostic testing, Pre-implant testing, implant surgery, post implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable and batteries) are included. *Hearing aids including hearing aid examinations are not covered.		
-Hospital	10% co-insurance, after deductible	30% co-insurance, after deductible
-Office Visits	$15 copay	30% co-insurance, after deductible
Naturopathic Services	$15 copay	30% coinsurance, after deductible
Nutritional Counseling	$15 copay	Not Covered
Nutritional Therapy -Dietary formula for the treatment of phenylketonuria (PKU)	No Charge	30% coinsurance, after deductible
-Enteral therapy	20% coinsurance, after deductible	30% coinsurance, after deductible
-Parenteral therapy	10% coinsurance, after deductible	30% coinsurance, after deductible
Oral Surgery Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheek; lips, tongue gums, roof and floor of the mouth; and incision of salivary glands and ducts.		
-Hospital	10% co-insurance, after deductible	30% co-insurance, after deductible
-Office Visits	$15 copay	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Podiatry (Medically Necessary foot care. Routine foot care covered when such care is directly related to the treatment of diabetes and other clinical conditions that effect sensation and circulation to the feet.)	$15 copay	30% coinsurance, after deductible
Rehabilitation and Habilitative Care (Includes massage, occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy -Inpatient Hospital	10% coinsurance, after deductible	30% coinsurance, after deductible
-Office Visits	$15 copay	30% coinsurance, after deductible
Temporomandibular Joint Disorder (TMJ) Treatment	10% co-insurance, after deductible	30% co-insurance, after deductible
Tobacco Cessation (Includes education materials and counseling for individual or groups)	10% co-insurance, after deductible	30% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply Generic	$15 copay	Not Covered
Preferred Brand Name	$25 copay	Not Covered
Non-Preferred Brand Name	$45 copay	Not Covered
Specialty Drugs (30-day mail order supply)	10% coinsurance, after deductible	Not Covered
Mail Order 90-Day Supply Generic	$30 copay	Not Covered
Preferred Brand Name	$50 copay	Not Covered
Non-Preferred Brand Name	$90 copay	Not Covered

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