

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	\$250 \$500	\$250 \$500
Coinsurance After Deductible	20%	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 and copays) Individual Family	\$6,850 \$13,700	None None
Physician Office Visits and Other In-office Services Primary Care Physician	20% coinsurance, after deductible	30% coinsurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrist, etc.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG, and mammography)	No Charge	30% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	30% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (waived if admitted)	\$50 copay, then 20% coinsurance	\$50 copay, then 20% coinsurance
Outpatient Surgery Center (Includes ambulatory surgery centers)	No Charge	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient	No Charge	30% coinsurance, after deductible
	Outpatient	20% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of \$5,000	
Mental and Substance Use Disorder Inpatient	No Charge	30% coinsurance, after deductible
	Outpatient	20% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	30% coinsurance, after deductible
Skilled Nursing Facility	20% coinsurance, after deductible	30% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	30% coinsurance, after deductible
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)	20% coinsurance, after deductible	30% coinsurance, after deductible
	20% coinsurance, after deductible, and any amount over \$350 maximum	30% coinsurance, after deductible, and any amount over \$350 maximum
Physical, Occupational and Speech Therapy (Excludes chiropractic services)	20% coinsurance, after deductible	30% coinsurance, after deductible
Chiropractic Services (Maximum of 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Vision Benefit (Payable during any two (2) year period with maximums)		
Eye Exam	No Charge	No Charge
Frames/ Lenses	Covered in full up to \$100 per person per calendar year	Covered in full up to \$100 per person per calendar year

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Specialty Drugs		
• Generic	10% coinsurance, after deductible	Not Covered
• Preferred and Non-Preferred	20% coinsurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	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

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

SHORT TERM DISABILITY

Benefits payable the 1st day of an accident, 7th day of a sickness, for 26 weeks:

Weeks 1 - 26 66.7% of your pre-disability earnings up to a maximum of \$500