

## II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Calendar Year Deductible</b> Individual Family	\$250 \$500	\$250 \$500
<b>Coinsurance After Deductible</b>	20%	30%
<b>Lifetime Maximum</b> (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
<b>Out-of-Pocket Maximum</b> Individual Family	\$6,850 \$13,700	\$13,700 \$41,000
<b>Physician Office Visits and other eligible office expenses</b>  Primary Doctor	20% coinsurance, after deductible	30% coinsurance, after deductible
Specialist (Includes Cardiologist, Psychiatrists, etc.)	20% coinsurance, after deductible	30% coinsurance, after deductible
<b>Preventative Care Benefits</b> (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG, & mammography)	No Charge	30% coinsurance, after deductible
<b>Ambulance</b>	20% coinsurance, after deductible	20% coinsurance, after deductible
<b>Emergency Room</b> (Copay waived if admitted)	\$50 copay, plus 20% coinsurance	\$50 copay, plus 20% coinsurance
<b>Hospital Benefits</b> Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	30% coinsurance, after deductible
<b>Hospital Pre-Certification Penalty</b>	50% of benefits up to a maximum of \$5,000	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Mental and Substance Use Disorder</b> Inpatient	No Charge	30% coinsurance, after deductible
	20% coinsurance, after deductible	30% coinsurance, after deductible
Outpatient	20% coinsurance, after deductible	30% coinsurance, after deductible
<b>Home Health Care</b>	20% coinsurance, after deductible	30% coinsurance, after deductible
<b>Skilled Nursing Facility</b>	20% coinsurance, after deductible	30% coinsurance, after deductible
<b>Durable Medical Equipment</b> (Total rental not to exceed purchase price)	20% coinsurance, after deductible	30% coinsurance, after deductible
<b>External Prosthetic Devices</b>  -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)	30% coinsurance, after deductible	50% coinsurance, after deductible
	30% coinsurance, after deductible, and any amount over \$350 maximum	50% coinsurance, after deductible, and any amount over \$350 maximum
<b>Physical, Occupational and Speech Therapy</b> (excludes Chiropractic care)	20% coinsurance, after deductible	30% coinsurance, after deductible
<b>Chiropractic</b> (Limited up to 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
<b>Vision Benefits</b> (Payable during any (2) year period with maximums) Eye Exam	No Charge	No Charge
	Frame/Lenses	Covered in full up to \$100 per person
	Covered in full up to \$100 per person	Covered in full up to \$100 per person

### 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](http://www.deltadentalnj.com)

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Retail 30-Day Supply</b>		
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
<b>Mail-Order 90-Day Supply</b>		
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

### SHORT TERM DISABILITY

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

Weeks 1-26 ..... \$500