## II. SCHEDULE OF BENEFITS

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In- Network** | **Out-of-Network** |
| **Calendar Year Deductible** | | |
| Individual | $300 | $1,000 |
| Family | $600 | $2,000 |
| **Co-insurance After Deductible** | 20% | 50% |
| **Out-of-Pocket Maximum** (includes plan deductibles and copays) | | |
| Individual | $5,000 | $10,000 |
| Family | $10,000 | $20,000 |
| **Lifetime Maximum** (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits) | Unlimited | |
| **Physician Office Visits and Other Services** | | |
| Primary Care Physician | $25 copay | 50% co-insurance, after deductible |
| Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrist, etc.) | $40 copay | 50% co-insurance, after deductible |
| **Preventative Care Benefits** (One annual exam per calendar year. Includes: Physical exams, screening, immunization, Mammography, etc.) | No Charge | 50% co-insurance, after deductible |
| **Well Child Care/ Immunizations** | No Charge | 50% co-insurance, after deductible |
| **Well Women Care** | No Charge | 50% co-insurance, after deductible |
| **Infertility Treatment** | 20% co-insurance, after deductible | 50% co-insurance, after deductible |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Hospital Benefits**<br>Daily Hospital Room and Board, Semi Private and other allowable expenses<br>Inpatient | 20% co-insurance, after deductible, plus $500 copay per admission | 50% co-insurance, after deductible, plus $500 copay per admission |
| Outpatient (excludes Private Duty Nursing) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Ambulance** | 20% co-insurance, after deductible | 20% co-insurance, after deductible |
| **Emergency Care**<br>(copay waived if admitted)<br>Hospital Emergency Room | $200 copay | $200 copay |
| Urgent Care Center | $50 copay | $50 copay |
| **Outpatient Diagnostic X-ray and Laboratory** | $25 copay | 50% co-insurance, after deductible |
| **Outpatient Imaging Services**<br>(CT and MRI scans require prior authorization) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Outpatient Surgery** | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Transplant Services** | 20% co-insurance, after deductible, plus $500 copay per admission | 50% co-insurance, after deductible, plus $500 copay per admission |
| **Mental Health**<br>Inpatient | 20% co-insurance, after deductible, plus $500 copay per admission | 50% co-insurance, after deductible, plus $500 copay per admission |
| Outpatient | $40 copay | 50% co-insurance, after deductible |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Alcohol & Substance Abuse** | | |
| Inpatient | 20% co-insurance, after deductible, plus $500 copay per admission | 50% co-insurance, after deductible, plus $500 copay per admission |
| Outpatient | $40 copay | 50% co-insurance, after deductible |
| **Home Health Care** | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Outpatient Physical, Occupational, Speech Therapy** (Limited up to 24 combined visits per calendar year) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Skilled Nursing Care** (Limited up to 120 days per calendar year) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Durable Medical Equipment (DME) & Prosthetics** (Total rental not to exceed purchase price) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **External Prosthetic Devices**<br>-Wigs, toupees or hair pieces<br>(Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenetic alopecia- male pattern baldness) | 20% coinsurance, after deductible, and any amount over $350 maximum | 50% coinsurance, after deductible, and any amount over $350 maximum |
| **Hospice Care** | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Chiropractic** (Limited up to 24 visits per calendar year) | $40 copay | 50% co-insurance, after deductible |

| PRESCRIPTION DRUG BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** (No Deductibles) | **Out-of Network** |
| **Mandatory Generic Substitution Applies** | | |
| **Retail (30-Day Supply)** | | |
| Generic Drugs | $10 copay | Not Covered |
| Preferred Brand | 20% co-insurance** | Not Covered |
| Non-Preferred Brand | 20% co-insurance** | Not Covered |
| **Mail-Order (90-Day Supply)** Mail order is mandatory after 2 refills at your local store | | |
| Generic Drugs | $20 copay | Not Covered |
| Preferred Brand | 20% co-insurance** | Not Covered |
| Non-Preferred Brand | 20% co-insurance** | Not Covered |
| **Specialty Drug Copay** | 20% co-insurance | Not Covered |
| **If a brand name drug is prescribed where a generic equivalent is available, the member is responsible for the difference in cost between the brand name drug and the generic drug. | | |

**Dental Benefits**
Provided by Delta Dental

For Customer Service: 1-800-452-9310
For Providers in your area: 1-800-335-8265

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

**Vision Benefits**
Provided by VSP

For Customer Service: 1-800-877-7195

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