

## 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	\$500 \$1,000
<b>Coinsurance After Deductible</b>	20%	40%
<b>Lifetime Maximum</b> (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical, and prescription benefits)	Unlimited	
<b>Out-of-Pocket Maximum</b> Individual Family	\$6,850 \$13,700	\$13,700 \$41,100
<b>Physician Office Visits and other eligible office expenses</b>  Primary Doctor	20% coinsurance, after deductible	40% coinsurance, after deductible
Specialist (Includes Cardiologist, Psychiatrists, podiatrists, etc.)	20% coinsurance, after deductible	40% 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	40% coinsurance, after deductible
<b>Laboratory Services</b>	20% coinsurance, after deductible	40% coinsurance, after deductible
<b>Ambulance</b>	20% coinsurance, after deductible	20% coinsurance, after deductible
<b>Emergency Room</b> (Copay waived if admitted)	\$300 copay, plus 20% coinsurance	\$300 copay, plus 20% coinsurance
<b>Hospital Benefits</b> Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	40% 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>Ambulatory/Outpatient Hospital Surgery</b>		
Facility	No Charge	40% coinsurance, after deductible
Professional Fees	20% coinsurance, after deductible	40% coinsurance, after deductible
<b>Mental and Substance Use Disorder</b>		
Inpatient	No Charge	40% coinsurance, after deductible
Outpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
<b>Home Health Care</b>	20% coinsurance, after deductible	40% coinsurance, after deductible
<b>Skilled Nursing Facility</b>	20% coinsurance, after deductible	40% coinsurance, after deductible
<b>Durable Medical Equipment</b> (Total rental not to exceed purchase price)	20% coinsurance, after deductible	40% 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)	20% coinsurance, after deductible, and any amount over \$350 maximum	20% coinsurance, after deductible, and any amount over \$350 maximum
<b>Physical, Occupational and Speech Therapy</b>	20% coinsurance, after deductible	40% coinsurance, after deductible
<b>Chiropractic</b> (Up to 12 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Retail 30-Day Supply</b>		
Generic Drugs	15% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, after deductible	Not Covered
<b>Mail-Order 90-Day Supply</b>		
Generic Drugs	15% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	35% 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](http://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](http://www.vsp.com)