

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
Co-insurance 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 Individual Family	\$6,850 \$13,700	\$13,700 \$41,100
Physician Office Visits and other eligible office expenses Primary Doctor	20% co-insurance, after deductible	30% co-insurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	20% co-insurance, after deductible	30% co-insurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG, & mammography)	No Charge	30% co-insurance, after deductible
Laboratory Services	20% co-insurance, after deductible	30% co-insurance, after deductible
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Room (Copay waived if admitted)	\$50 copay plus 20% co-insurance	\$50 copay plus 20% co-insurance
Urgent Care	20% co-insurance, after deductible	20% co-insurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of \$5,000	
Imaging Services (CT and MRI scans require prior authorization)	20% co-insurance, after deductible	30% co-insurance, after deductible
Mental and Substance Use Disorder Inpatient	No Charge	30% co-insurance, after deductible
	Outpatient	30% co-insurance, after deductible
	20% co-insurance, after deductible	30% co-insurance, after deductible
Home Health Care	20% co-insurance, after deductible	30% co-insurance, after deductible
Skilled Nursing Facility	20% co-insurance, after deductible	30% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% co-insurance, after deductible	30% co-insurance, 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 androgenetic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over \$350 maximum	30% coinsurance, after deductible, and any amount over \$350 maximum
Breast Pumps	No Charge and any amount over \$250 maximum	30% coinsurance, after deductible and any amount over \$250 maximum
Physical, Occupational and Speech Therapy (Excludes Chiropractic)	20% co-insurance, after deductible	30% co-insurance, after deductible
Chiropractic (Up to 12 visits per calendar year)	20% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Hearing Aids	Limited to \$1,000 per ear every 3 years	
Vision Benefits Benefits payable during any two (2) year period with the following maximums. Eye Exam Frames/ Lenses	No Charge	No Charge
	Covered in Full up to \$100 per person every 24 months	Covered in Full up to \$100 per person every 24 months

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

Prescription Drug Benefits

Provided by EmpiRx Health: Call 1-877-241-7123 for Member Services

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

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