## II. SCHEDULE OF BENEFITS

## PLAN A

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Calendar Year Deductible**<br>Individual<br>Family | <br>$150<br>$450 | <br>$150<br>$450 |
| **Co-insurance After Deductible** | 20% | 40% |
| **Lifetime Maximum**<br>(Amount payable per eligible individual, includes all benefits paid for covered hospital, medical expenses, and prescription benefits) | Unlimited | |
| **Out-of-Pocket Maximum**<br>Individual<br>Family | <br>$1,500<br>$3,000 | <br>$1,500<br>$3,000 |
| **Physician Office Visits**<br>Primary Doctor | 20% co-insurance, after deductible | 40% co-insurance, after deductible |
| Specialist<br>(Includes cardiologist, psychiatrists, dermatologists, podiatrists, etc.) | 20% co-insurance, after deductible | 40% co-insurance, after deductible |
| **Preventative Care Benefits** | No Charge | 40% coinsurance, after deductible |
| **Hospital Benefits**<br>Daily Hospital Room and Board, Semi Private and other allowable expenses | 20% co-insurance, after deductible | 40% co-insurance, after deductible |
| **Hospital Pre-Certification Penalty** | 25% of benefits up to a maximum of $2,000 | |
| **Ambulance** | 20% co-insurance, after deductible | 20% co-insurance, after deductible |
| **Emergency Room** | 20% co-insurance, after deductible | 20% co-insurance, after deductible |

## PLAN A

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Mental and Substance Use Disorder**<br>Inpatient | 20% co-insurance, after deductible | 40% co-insurance, after deductible |
| Outpatient | 20% co-insurance, after deductible | 40% co-insurance, after deductible |
| **Home Health Care** | 20% co-insurance, after deductible | 40% co-insurance, after deductible |
| **Skilled Nursing Facility** | 50% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Durable Medical Equipment**<br>(Total rental not to exceed purchase price) | 20% co-insurance, after deductible | 40% 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 | 40% coinsurance, after deductible, and any amount over $350 maximum |
| **Breast Pump** | No Charge and any amount over $250 maximum | 40% coinsurance, after deductible and any amount over $250 maximum |
| **Hospice Care** | 20% coinsurance, after deductible | 40% coinsurance, after deductible |
| **Physical, Occupational and Speech Therapy** | 20% co-insurance, after deductible | 40% co-insurance, after deductible |
| **Chiropractic**<br>(Limited to 12 visits per calendar year) | 20% co-insurance, after deductible | 40% co-insurance, after deductible |

## PLAN A

| PRESCRIPTION DRUG PLAN | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** (No Deductibles) | **Out-of-Network** |
| **Mandatory Generic Substitution Applies** | | |
| **Retail 30-Day Supply** | | |
| Generic Drugs | $5 copay | Not Covered |
| Preferred Brand Name Drugs | $30 copay** | Not Covered |
| Non-Preferred Brand Name Drugs | $30 copay** | Not Covered |
| **Mail-Order 90-Day Supply** | | |
| Generic Drugs | $10 copay | Not Covered |
| Preferred Brand Name Drugs | $60 copay** | Not Covered |
| Non-Preferred Brand Name Drugs | $60 copay** | 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. | | |

**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

**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

## SHORT TERM DISABILITY BENEFIT

Benefits payable the 1st day of an accident, 7th day of a sickness, for 13 weeks

Weeks 1-13 .....$45 per week

## EMPLOYEE DEATH BENEFIT

Active Employee ..... $1,000

## EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
## (Employee coverage only)

For loss of:

Life ..... $1,000
Both Hands or Both Feet..... $1,000
Entire Sight of Both Eyes ..... $1,000
One Hand and One Foot..... $1,000
One Hand or One Foot and Entire Sight of One Eye ..... $1,000
One Hand or One Foot..... $500
Entire Sight of One Eye..... $500

Maximum payment for this benefit per occurrence is $1,000