II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual	$1,000	Not Covered
Family	$2,000	Not Covered
Coinsurance After Deductible	No Charge	Not Covered
Out-of-Pocket Maximum (Including deductible) Individual	$7,900	Not Covered
Family	$15, 800	Not Covered
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Physician Office Visits Primary Care Physician	$50 copay	Not Covered
Teledoc	$0 copay	
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$50 copay	Not Covered
Preventative Care Includes: Well Child Care, Routine Physical exams, Routine Mammogram, Routine colonoscopy, pap smear, and prostate exam and test.	No Charge	Not Covered
Infertility (Limited to 6 cycles for IVF-ET, ZIFT, GIFT, and NORIF/NORIVF)	No Charge, after deductible	Not Covered
Diagnostic Tests (X-rays and blood tests)	No Charge, after deductible	Not Covered
Laboratory Services	No Charge, after deductible	Not Covered
Imaging Services (CT and MRI scans require prior authorization)	No Charge, after deductible	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance	No Charge, after deductible	No Charge, after deductible
Emergency Care Hospital ER	$75 copay	$75 copay
Urgent Care	$50 copay	$50 copay
Hospital Pre-Certification Penalty	$500	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge, after deductible	Not Covered
Inpatient Facility	No Charge, after deductible	Not Covered
Outpatient Services	No Charge, after deductible	Not Covered
Outpatient Physician and Surgeon Fees	No Charge, after deductible	Not Covered
Outpatient Surgery	No Charge, after deductible	Not Covered
Organ/Tissue Transplants	No Charge, after deductible	Not Covered
Mastectomy Reconstruction	No Charge, after deductible	Not Covered
Mental and Substance Abuse -Inpatient	No Charge, after deductible	Not Covered
Teledoc	$0 copay	
-Outpatient	$50 copay	Not Covered
-Partial Hospitalization	No Charge, after deductible	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Autism Spectrum Disorder Care provided for members under 21 years of age for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders [DSM], or its successor including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.) which includes, pharmacy, psychiatric and psychological, rehabilitative and therapeutic care.		
-Pharmacy Care	Copayment per outpatient prescription drug plan	Not Covered
-Psychiatric and Psychological Care (Direct or consultative services provided by a psychiatrist or psychologist) • Individual therapy session	$50 copay	Not Covered
• Group therapy session	$50 copay	Not Covered
-Rehabilitative Care (Professional services and treatment programs, including applied behavioral analysis provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function)	$50 copay	Not Covered
-Therapeutic Care (Includes services provided by speech pathologists, occupational therapists or physical therapists)	$50 copay	Not Covered
Physical Rehabilitation Facility	No Charge, after deductible	Not Covered
Cardiac Rehabilitation	No Charge, after deductible	Not Covered
Physical, Occupational, and Speech Therapy (Limited to 60 visits per calendar year each)	$50 copay	Not Covered
Home Health/ Hospice Care	No Charge, after deductible	Not Covered
Inpatient Hospice Pre- Certification Penalty	$500	
Skilled Nursing Facility	No Charge, after deductible	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Durable Medical Equipment (Total rental not to exceed purchase price.) -Breast Prosthesis (2 per year)	No Charge, after deductible	Not Covered
-Mastectomy Bras (3 per year)	No Charge, after deductible	Not Covered
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)	No Charge, after deductible, and any amount over $350 maximum	Not Covered
Prosthetic Devices (Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years)	No Charge, after deductible	Not Covered
Orthotic Devices (Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by a participating provider)	No Charge, after deductible	Not Covered
Early Intervention Services	No Charge, after deductible	Not Covered
Chiropractic (Limited to 36 visits per calendar year)	$50 copay	Not Covered
Breast Pump	No Charge and any amount over $250 maximum	Not Covered
Enteral Formula and Modified Low Protein Food Products	No Charge, after deductible	Not Covered
Nutritional Counseling	No Charge, after deductible	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSES	
	In-Network	**Out-of-Network**
Diabetic Services -Diabetic eye exam	No Charge, after deductible	Not Covered
-Diabetic equipment (Includes blood glucose monitors, insulin pumps, infusion sites, and diabetic foot orthotics)	No Charge, after deductible	Not Covered
Temporomandibular Joint Disorder (TMJ) (Exams and X-Rays)	No Charge, after deductible	Not Covered
Oral Surgery (Limited to extraction of partially or totally bony impacted third molars)		
-Physician's office	$50 copay	Not Covered
-Hospital	Not Covered	Not Covered
-Ambulatory surgical center	Not Covered	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30- Day Supply		
Generic Drugs	$10 copay	Not Covered
Preferred Brand Name Drugs	$30 copay	Not Covered
Non-Preferred Brand Name Drugs	$50 copay	Not Covered
Specialty Drugs (out-of-pocket maximum up to $1,500 per benefit year)	$150 copay per injection applies	Not Covered
Retail 60- Day Supply		
Generic Drugs	$20 copay	Not Covered
Preferred Brand Name Drugs	$60 copay	Not Covered
Non-Preferred Brand Name Drugs	$100 copay	Not Covered
Retail and Mail Order 90- Day Supply		
Generic Drugs	$30 copay	Not Covered
Preferred Brand Name Drugs	$90 copay	Not Covered
Non-Preferred Brand Name Drugs	$150 copay	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

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