

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
\$0		
Out-of-Pocket Maximum		
Individual Family	\$1,000 \$2,000	Not Covered Not Covered
Coinsurance After Deductible	None	None
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical expenses and prescription benefits)	Unlimited	
Physician Office Visits and Other Eligible Office Expenses		
Primary Doctor	\$10 copay	Not Covered
Specialist (Includes cardiologists, dermatologists, podiatrists, etc.)	\$10 copay	Not Covered
Telehealth Platform, Powered by Teladoc™ (No member out-of-pocket, unlimited utilization) You may call if you have account questions or need assistance with creating an account at: 1-800-835-2362 (Teladoc)	\$0 copay	
Preventative Care Includes: Well baby and child care, routine physical, vision and hearing screenings, and immunization.	No Charge	Not Covered
Allergy Injections received in a Physician’s Office	\$10 copay	Not Covered

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	In-Network	Out-of-Network
Women's Pelvic Health through The Fund's partner Bloom (No member out-of-pocket, unlimited utilization) You may obtain information on their website at: https://join.hibloom.com	\$0	
Infertility (Limited to 6 cycles for IVF-ET, ZIFT, GIFT and NORIF/NORIVF)	\$10 copay	Not Covered
Diagnostic Services		
Diagnostic Tests (X-rays and blood tests)	No Charge	Not Covered
Imaging Services (CT and MRI scans require prior authorization)	No Charge	Not Covered
Emergency Care Services		
Ambulance	No Charge	Same as In-Network
Hospital Emergency Room (Copay waived if admitted)	\$30 copay	Same as In-Network
Urgent Care	\$30 copay	Same as In-Network
Hospital Services		
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	Not Covered
Professional Fees for Surgical and Medical Services	No Charge	Not Covered
Organ/Tissue Transplants	No Charge	Not Covered
Outpatient Surgery, Diagnostic and Therapeutic Services (Includes: surgery, lab and radiology/ X-rays, mammography, pap smear, prostate screening, colorectal screening, chemotherapy or intravenous infusion therapy.	No Charge	Not Covered

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	In-Network	Out-of-Network
Maternity Care Services		
Office Visits	\$10 copay, after deductible	Not Covered
Childbirth/professional delivery services (Obstetrician, surgeon, etc.)	No Charge	Not Covered
Childbirth/delivery facility services (Hospital, childbirth center, etc.)	No Charge,	Not Covered
Breast Pump (Limited to a maximum benefit of \$250)	No Charge	Not Covered
Behavioral Health Disorders (Mental Health and Substance Use Disorder)		
Mental and Nervous Expense		
Inpatient	No Charge	Not Covered
Outpatient (2 sessions may be substituted for one day inpatient mental services)	\$10 copay	Not Covered
Substance Abuse		
Inpatient (1 inpatient day may be substituted for 2 outpatient visits. 2 sessions of intermediate care, ie. partial hospitalization, may be substituted for 1 inpatient day)	No Charge	Not Covered
Outpatient (2 sessions of outpatient visits may be substituted for one day of inpatient services. 2 sessions of outpatient group therapy may be substituted for one outpatient visit)	\$10 copay	Not Covered
Long Term Care, Recovery and Special Health Needs		
Cancer Navigator Services (No member out-of-pocket) You may reach an Oncology Nurse Navigator at: 201-308-6555 (8am -6pm ET, M-F)	\$0 copay	

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	In-Network	Out-of-Network
Home Health Care	No Charge	Not Covered
Skilled Nursing Facility Care (Limited to 60 Inpatient days per calendar year)	No Charge	Not Covered
Hospice Care (Limited up to 360 days per lifetime)	No Charge	Not Covered
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% coinsurance	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/female pattern baldness. Limited to a maximum benefit of \$350.)	20% coinsurance	Not Covered
Prosthetic Devices (Includes: artificial limb, eye, and breast prosthesis. Limited to a single purchase of each type of prosthetic device every 3 calendar years. Benefits limited up to \$2,500 per calendar year)	20% coinsurance	Not Covered
Rehabilitation Services- Outpatient Therapy (Limited to 60 visits combined per calendar year) <ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy (To restore lost function after a stroke or during behavioral health treatment) Pulmonary rehabilitation therapy (Up to 20 visits per calendar year) Cardiac rehabilitation therapy (Up to 36 visits per calendar year)		
	No Charge	Not Covered
	No Charge	Not Covered
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	In-Network	Out-of-Network
Early Intervention Services	\$10 copay	Not Covered
Hearing Aids (Limited to \$2,500 per year. Limited to a single purchase every 3 years.)	No Charge	Not Covered
Accidental Dental Services	25% coinsurance	Not Covered
Chiropractic (Limited to 24 visits per calendar year)	\$10 copay	Not Covered
Routine Vision Exam (One exam every year)	Benefits are covered by VSP. See Separate Description.	

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic	\$9	Not Covered
Brand Formulary	\$18	Not Covered
Mail Order Specialty Drugs 30-Day Supply (Requires prior authorization)		
Specialty Drugs	10% coinsurance	Not Covered
Mail Order 90-Day Supply		
Generic	\$16	Not Covered
Brand Formulary	\$32	Not Covered

Prescription Drug Benefits

Provided by EmpiRx Health: Call 1-877-908-9438 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