II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	 $750 $1,500	 $1,500 $3,000
Coinsurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum (Includes Annual Deductible) Individual Family	 $2,500 $5,000	 $5,000 $10,000
Physician Office Visits Primary Care	$25 copay	40% coinsurance, after deductible
Specialist	$40 copay	40% coinsurance, after deductible
Office Services Includes: Diagnostic Laboratory and Pathology, CAT Scans, PET Scans, MRI, X-ray, Chemotherapy, Radiation Therapy, Hemodialysis and Diagnostic Imaging.	20% coinsurance, after deductible	40% coinsurance, after deductible
Routine Preventative Care Well Child (0-23 months covered in full) Immunizations covered in full up to age 19	No Charge	40% coinsurance, after deductible
Well Adult (Includes Mammogram, Gynecologist visits, Pap Smear, and Prostate Screening)	No Charge	40% coinsurance, after deductible

Schedule of Wellness Visits

Below is a table illustrating the frequency at which you can seek routine wellness visits. Any routine wellness visits in excess of this schedule will not be covered.

Age of Patient	Frequency of Exam
First Year	At 2-4 weeks At 2 months At 4 months At 6 months At 9 months At 12 months
Up to 2 years old	At 15 months At 18 months At 24 months
3-18 years old	Every Year
19-20 years old	Once in 2 years
21-40 years old	Once per calendar year
41-50 years old	Once per calendar year
51-59 years old	Once per calendar year
60+ years old	Once per calendar year
Routine GYN exam and Pap Smear	2 per year
Routine Mammogram between 35 to 39 years old	One baseline
Routine 40 to 49 years old	One every year
Routine Mammogram 50 and up	One every year
Prostate Screening between age 40-49 years old	Once a year for men who have family history of prostate cancer or have other risk factors
Prostate Screening 50 years and up	Every Year
Men with prior history of Prostate Cancer	We will provide coverage for standard diagnostic testing for men of any age who have had a prior history of prostate cancer

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Infertility (Covered when rendered by a Certified Reproductive Endrocrinologist; Limited to 6 cycles per lifetime) Includes: Hysterosalipingogram, Hysteroscopy, Endometrial Biopsy, Laparoscopy, Sona-Hysterogram, Post-Coital Tests, Testis Biopsy, Semen Analysis, Blood Tests, Ultrasounds, Artificial Insemination.	$40 copay	Not Covered
Elective Sterilization	20% coinsurance, after deductible	40% coinsurance, after deductible
Ambulance (Ground or Air)	$25 copay	$25 copay
Emergency Care		
Hospital ER	$100 copay, plus 20% coinsurance, after deductible	$100 copay, plus 20% coinsurance, after deductible
Urgent Care Center	20% coinsurance, after deductible	20% coinsurance, after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	20% coinsurance, after deductible	40% coinsurance, after deductible
Mental and Nervous Expense (Acute Mental Health)		
Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Day/Night Residential	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient		
- Office	$40 copay	40% coinsurance, after deductible
- Hospital	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Chemical Abuse Rehabilitation Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient - Office	$40 copay	40% coinsurance, after deductible
- Hospital	20% coinsurance, after deductible	40% coinsurance, after deductible
Detoxification Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
- Detox admission are combined with Chemical Dependency Rehab.	20% coinsurance, after deductible	40% coinsurance, after deductible
- Inpatient days are combined for Mental Health and Chemical Dependency.	20% coinsurance, after deductible	40% coinsurance, after deductible
- Inpatient days are reduced by one for each two residential day/night visits used and vice versa.	20% coinsurance, after deductible	40% coinsurance, after deductible
Physician's Inpatient Services (Includes: Physician Visits, Surgery, and Consultations)	20% coinsurance, after deductible	40% coinsurance, after deductible
- Anesthesia	20% coinsurance, after deductible	20% coinsurance, after deductible
Additional Surgical Opinion (In Office)	$40 copay	40% coinsurance, after deductible
Outpatient Hospital Services Includes: Diagnostic Imaging, MRI, CAT Scans, PET Scans, Laboratory & Pathology, Diagnostic Procedures (Colonoscopy, etc.), Chemotherapy, Radiation Therapy, Surgical Care, Surgicenters, Hemodialysis, External Prosthetics, Orthopaedic Braces and Supports	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
- Routine Mammogram, Pap Smear, or Prostate Screening	No Charge	40% coinsurance, after deductible
- Physical, Speech or Occupational Therapy- (Limited up to 45 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Office or Outpatient Surgery	20% coinsurance, after deductible	40% coinsurance, after deductible
Maternity Includes: Facility care for mother and newborn, physician care for mother and newborn.	20% coinsurance, after deductible	40% coinsurance, after deductible
Delivery Anesthesia	20% coinsurance, after deductible	20% coinsurance, after deductible
Inpatient Rehabilitation (Limited up to 60 days per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Physical, Speech & Occupational Therapy (Limited to 45 visits per calendar year each)	20% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% coinsurance, after deductible	40% coinsurance, after deductible
External Prosthetic Devices	20% coinsurance, after deductible	40% coinsurance, after deductible
-Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgentic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum
Skilled Nursing Facility (Limited to 120 days per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Private Duty Nursing (As medically necessary)	20% coinsurance, after deductible	40% coinsurance, after deductible
Home Health (Nursing) Care	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospice Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic Services (Limited to 30 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Therapeutic Injections		
Primary Care	$25 copay	40% coinsurance, after deductible
Specialist	$20 copay	40% coinsurance after deductible
Allergy Injections and Allergy Tests		
Primary Care	$25 copay	40% coinsurance, after deductible
Specialist	$40 copay	40% coinsurance, after deductible
Diabetic Education	$25 copay	40% coinsurance, after deductible
Acupuncture (10 visits per calendar year)	$40 copay	40% coinsurance, after deductible
Hearing Benefits		
Hearing Evaluation Routine and Diagnostic	$20 copay	40% coinsurance, after deductible
Hearing Aids (Limited to $700 per hearing aid)	20% coinsurance, after deductible	40% coinsurance, after deductible
Accidental Dental	20% coinsurance, after deductible	40% coinsurance, after deductible

All other dental services provided by Delta Dental

You may call
1-800- 452-9310 ....for Customer Service
1-800- 335-8265 (DELTA-OK) ....For Providers in your area

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

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Eye Exams Diagnostic	$20 copay	40% coinsurance, after deductible

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

PRESCRIPTION DRUG BENEFIT Mandatory Generic Substitution Applies	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail Copayment 30-Day Supply Generic Drug coinsurance 15%	Min $10/ Max $40	Not Covered
Brand Name Drug coinsurance 25%	Min $30/ Max $100	Not Covered
Non-Preferred Brand Name Drug coinsurance 35%	Min $50/ Max $200	Not Covered
Mail Order Copayment 90-Day Supply Generic Drug coinsurance 15%	Min $25/ Max $100	Not Covered
Brand Name Drug coinsurance 25%	Min $75/ Max $250	Not Covered
Non-Preferred Brand Name Drug coinsurance 35%	Min $125/ Max $500	Not Covered

Infertility Drug Therapy Benefit .... In-Network Only

Prescription Out-of-Pocket Maximum- Independent of Major Medical Out-of-Pocket

Coverage	Generic	Single Source Brand (No generic equivalent)
Single	$2,000	$2,000
Family	$4,000	$4,000

Generic Drug out-of-pocket maximum is independent of single source brand out-of-pocket maximum.

SHORT TERM DISABILITY

(Paid by your Employer)

Weekly disability benefits will commence after a seven (7) calendar day waiting period and will be payable for a maximum of 51 weeks for each separate and distinct period of disability.