II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $1,500 $3,000	 $3,000 $6,000
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 deductibles, coinsurance and copays) Individual Family	 $3,000 $6,000	 $9,000 $18,000
Physician Office Visits and Other In-office Services Primary Care Physician	 $30 copay	 40% coinsurance, after deductible
Specialist	$45 copay	40% coinsurance, after deductible
Allergy Treatment/Injections	No Charge	40% coinsurance, after deductible
Allergy Serum (dispensed by the Physician in the Office)	No Charge	40% coinsurance after deductible
Preventative Care Benefits (Routine annual exam per calendar year, immunization, including blood screening, mammography, vaccination, etc.)	No Charge	40% coinsurance, after deductible
Laboratory and Radiology Services	No Charge	40% coinsurance, after deductible
Infertility Treatment	Not Covered	Not Covered
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Emergency Room	$500 copay	$500 copay
Urgent Care	$45 copay	$45 copay
Imaging Services (CT and MRI scans requires prior authorization)	$200 copay	$200 copay
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient	20% coinsurance, plus $250 admission copay	40% coinsurance, after deductible
Outpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Maternity Care Services Prenatal and postnatal services	20% coinsurance, after deductible	40% coinsurance, after deductible
Physician services -Primary care physician	$30 copay	40% coinsurance, after deductible
-Specialist	$45 copay	40% coinsurance, after deductible
All other hospital services	20% coinsurance, plus $250 admission copay	40% coinsurance, after deductible
Organ Transplants	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient Surgery Center (Includes ambulatory surgery centers)	20% coinsurance, after deductible	40% coinsurance, after deductible
Surgery in doctor's office	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Substance Use Disorder Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient	$30 copay	40% coinsurance, after deductible
Residential	20% coinsurance, plus $250 admission copay	40% coinsurance, after deductible
Hospice Services	No Charge	40% coinsurance, after deductible
Home Health Care (Limited up to 100 days per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Skilled Nursing Facility (Limited to 60 days combined per calendar year)	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
Rehabilitative Therapy Services (Limited to 90 days combined per calendar year) -Physical, Occupational and Speech Therapy	20% coinsurance, after deductible	40% coinsurance, after deductible
-Pulmonary Rehab	20% coinsurance, after deductible	40% coinsurance, after deductible
-Cognitive Therapy	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Outpatient Cardiac Rehabilitation (Limited to 36 days per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic (Maximum of 30 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
Hearing Aids (Covered dependent children under age 18 Only. Limited to each hearing impaired ear every 3 years.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Diabetic Equipment	20% coinsurance, after deductible	40% coinsurance, after deductible
Nutritional Evaluation (Limited to 3 visits per person. The 3 visits limit does not apply to treatment of diabetes)		
-Physician's Office Visits	$30 copay	40% coinsurance, after deductible
-Specialist Office Visits	$45 copay	40% coinsurance, after deductible
-Inpatient Facility	20% coinsurance, plus $250 admission copay	40% coinsurance, after deductible
-Outpatient Facility	20% coinsurance, after deductible	40% coinsurance, after deductible
-Physician's Services	20% coinsurance, after deductible	40% coinsurance, after deductible
Special Formulas	20% coinsurance, after deductible	40% coinsurance, after deductible
Temporomandibular Joint Disorder	20% coinsurance, after deductible	40% coinsurance, after deductible
Dental and Anesthesia for Children Under the Age of 8 Years Old	20% coinsurance, after deductible	40% coinsurance, after deductible

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

PRESCRIPTION DRUG PLAN (Mandatory Generic Substitution Applies*)	**YOUR SHARE OF ELIGIBLE EXPENSE**	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$10 copay	Not Covered
Preferred Brand Name Drugs	$35 copay	Not Covered
Non-Preferred Brand Name Drugs	$50 copay	Not Covered
Specialty Drugs	$100 copay	Not Covered
Retail 90-Day Supply		
Generic Drugs	$30 copay	Not Covered
Preferred Brand Name Drugs	$105 copay	Not Covered
Non-Preferred Brand Name Drugs	$150 copay	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$20 copay	Not Covered
Preferred Brand Name Drugs	$70 copay	Not Covered
Non-Preferred Brand Name Drugs	$100 copay	Not Covered

*If a brand name 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.