II. SCHEDULE OF BENEFITS

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $150 $300	 $300 $600
Co-insurance After Deductible	10%	20%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $1,000 $3,000	 $2,000 $4,500
Physician Office Visits Primary Care Physician	$10 per visit	20% co-insurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$10 per visit	20% co-insurance, after deductible
Preventative Care (Includes immunizations and routine physical exam) Well Child Care	 No Charge	 20% co-insurance, after deductible
Well Adult	No Charge	20% co-insurance, after deductible
See Schedule of Wellness next page		

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
Under age 3 First 12 months of life 13th-24th months of life 25th-36th months of life	 7 exams 3 exams 3 exams
3-18 years old	Once per calendar year
Routine Gynecological and Pap Smears exam	Once per calendar year
Routine Mammogram (Age 40 and over)	One test per calendar year
Prostate Specific Antigen Test (Age 40 and over)	One test per calendar year
Routine Digital Rectal Exam (Age 40 and over)	One test per calendar year
Fecal Occult Blood Test	One test per calendar year
Sigmoidoscopy (Age 50 and over)	One test every five year period 10% after the deductible In-Network 20% after deductible Out-of-Network
Double Contrast Barium Enema (Age 50 and over)	One test every five year period 10% after the deductible In-Network 20% after deductible Out-of-Network
Colonoscopy (Age 50 and over)	One test every 10 year period 10% after the deductible In-Network 20% after deductible Out-of-Network

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Pre-Certification Penalty	$500	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	10% co-insurance, after deductible	$300 per admission after deductible plus 20% co-insurance
Administration of Anesthesia	10% co-insurance, after deductible	20% co-insurance, after deductible
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Care Hospital ER	10% co-insurance, No Deductible	10% co-insurance, No Deductible
Urgent Care Center	10% co-insurance, No Deductible	10% co-insurance, No Deductible
Non-Emergency Care in Hospital Emergency Room	10% co-insurance per visit, after deductible	50% co-insurance per visit, after deductible (waived if admitted to hospital)
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Diagnostic Laboratory Testing and Imaging Services (CT and MRI scans require prior authorization)	10% co-insurance, No Deductible	20% co-insurance, No Deductible
Outpatient Diagnostic and Preoperative Testing	10% co-insurance, No Deductible	20% co-insurance, No Deductible
- For office visits	$10 copay plus 10% co-insurance, No Deductible	20% co-insurance, after deductible

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Outpatient Surgery -At hospital or ambulatory	10% co-insurance, No Deductible	20% co-insurance, No Deductible
-At physician's office	$10 copay plus 10% co-insurance, No Deductible	20% co-insurance, after deductible
Transplant Services -At facility	10% co-insurance, after deductible	20% co-insurance per admission, after deductible
- At physician (Includes office visits)	10% co-insurance, after deductible	20% co-insurance per admission, after deductible
Mental and Nervous Expense Inpatient -Hospital facility -Residential treatment facility	10% co-insurance, after deductible	$300 per admission, after deductible plus 20% co-insurance
Outpatient	$10 copay	20% co-insurance, after deductible
Alcohol & Substance Abuse Inpatient -Hospital facility -Residential treatment facility	10% co-insurance, after deductible	$300 per admission after deductible, plus 20% coinsurance
Outpatient	$10 copay	20% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% co-insurance, after deductible	20% co-insurance, after deductible

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Prosthetic Devices	20% co-insurance, after deductible	20% co-insurance, after deductible
External Prosthetic Devices -Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	20% coinsurance, after deductible, and any amount over $350 maximum
Skilled Nursing Inpatient Facility Care (Up to 120 days per calendar year)	10% co-insurance, after deductible	$300 per admission, after deductible plus 20% co-insurance
Outpatient Home Health Care (Unlimited visits)	10% co-insurance, after deductible	20% co-insurance, after deductible
Outpatient Private Duty Nursing	20% co-insurance, after deductible	20% co-insurance, after deductible
Hospice Care (Room and board and other expenses)	10% co-insurance, after deductible	$300 per admission, after deductible plus 20% co-insurance
Outpatient Physical, Occupational and Speech Therapy (Up to 20 visits combined per calendar year)	20% co-insurance, after deductible	20% co-insurance, after deductible
Outpatient Therapies Chemotherapy	10% co-insurance, after deductible	20% co-insurance, after deductible
Infusion Therapy	10% co-insurance, after deductible	20% co-insurance, after deductible
Radiation Therapy	10% co-insurance, after deductible	20% co-insurance, after deductible
Infertility (For the diagnosis and treatment of the underlying medical condition causing the infertility only.)	10% co-insurance, after deductible	20% co-insurance, after deductible

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Therapeutic Injections (includes Gardasil Vaccine)	No Charge	No Charge
Allergy Tests (copay waived if no office visit)	$10 per visit	20% co-insurance, after deductible
Serum	20% co-insurance, after deductible	20% co-insurance, after deductible
Allergy Injections	20% co-insurance, after deductible	20% co-insurance, after deductible
Acupuncture	10% co-insurance, after deductible	20% co-insurance, after deductible
Chiropractic (Up to 24 visits)	10% co-insurance, after deductible	20% co-insurance, after deductible
Routine Vision Exam (One exam ever 2 years)	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 (90-Day Supply		
Generic	$16	Not Covered
Brand Formulary	$32	Not Covered
Specialty Drugs	10% co-insurance, No Deductibles	Not Covered

Dental Benefits
Provided by Delta Dental- call 1-800-452-9310 for Customer Service
1-800-335-8265 for Providers in your area.
(Delta-Ok)

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