II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	 $1,000 $2,000	 $1,500 $3,000
Coinsurance After Deductible	20%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $5,000 $10,000	 $7,500 $15,000
Physician Office Visits and other eligible office expenses Primary Doctor	$20 copay, before deductible	30% coinsurance, after deductible
Specialist (Includes Cardiologist, Psychiatrists, etc.)	$40 copay, before deductible	30% coinsurance, after deductible
Preventative Care Benefits (Routine exams, x-rays/tests, immunization, well baby care and mammograms)	No Charge	Not Covered
-Eye exam (Limited up to 1 visit per member per calendar year)	No Charge	Not Covered
-Hearing Exam (Limited up to 1 visit per member per calendar year)	No Charge	Not Covered
Urgent Care Center Services	20% coinsurance, after deductible	30% coinsurance, after deductible
Outpatient Services	20% coinsurance, after deductible	30% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	$100 copay, after deductible	$100 copay, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	20% coinsurance, after deductible	30% coinsurance, after deductible
-Inpatient Services	20% coinsurance, after deductible	30% coinsurance, after deductible
-Bariatric Services (Limited to 1 per member per lifetime)	20% coinsurance, after deductible	Not Covered
-Transplant Services	20% of the transplant payment allowance, after deductible	30% of the transplant payment allowance, after deductible
Diagnostic Tests (X-rays and blood work)	20% coinsurance, after deductible	30% coinsurance, after deductible
Imaging Services (CT and MRI scans- Requires prior authorization)	20% coinsurance, after deductible	30% coinsurance, after deductible
Maternity Services -Prenatal care	No Charge	30% coinsurance, after deductible
-All other hospital and physician services	20% coinsurance, after deductible	30% coinsurance, after deductible
Mental and Substance Use Disorder -Inpatient	20% coinsurance, after deductible	30% coinsurance, after deductible
-Intensive Outpatient Services	20% coinsurance, after deductible	30% coinsurance, after deductible
-Office Visits	$20 copay, before deductible	30% coinsurance, after deductible
Hospice Care Services	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Home Infusion and Suite Infusion Therapy Services	20% coinsurance, after deductible	30% coinsurance, after deductible
Home Health Care (Limited to 40 visits per member per calendar year. One Home Health Care visit following early maternity discharge does not apply to the 40 visits limit.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Skilled Nursing Facility (Limited to 120 days per member, per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	30% coinsurance, after deductible
External Prosthetic Devices	20% coinsurance, after deductible	30% 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	30% coinsurance, after deductible, and any amount over $350 maximum
Hearing Aids (Applies to children age 18 and younger. Maximum of one [1] hearing aid for each ear every three [3] years.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Physical and Occupational Therapies (Limited to 50 visits combined, per calendar year for physical and occupational therapies)	$40 copay, before deductible	30% coinsurance, after deductible
Speech Therapy	$40 copay, before deductible	30% coinsurance, after deductible
Chiropractic (Limited up to 24 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
Therapeutic Acupuncture Services (Limited to 12 visits per member, per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
Dental Anesthesia and Hospital Services for children under age of 5 or disabled	20% coinsurance, after deductible	30% coinsurance, after deductible
Enteral Formulas	20% coinsurance, after deductible	30% 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

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$10 copay	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, after deductible	Not Covered
Specialty Drugs	20% coinsurance, up to $200 maximum	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$20 copay	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, after deductible	Not Covered

IF YOU ELECT THIS BENEFIT:

SHORT TERM DISABILITY

Benefits payable the 1st day of an accident, 8th day of a sickness, for 26 weeks:

Weeks 1-26 .... $450

*Up to an amount equal to two-thirds (2/3) of your average weekly salary.

IF YOU ELECT THIS BENEFIT:

EMPLOYEE DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

Active Employee	$25,000
Spouse	$10,000
Child	$5,000

Accidental Death and Dismemberment Benefits

For the loss of:

Life	$25,000
Both Hands or Both Feet	$25,000
Entire Sight of Both Eyes	$25,000
One Hand and One Foot	$25,000
One Hand or One Foot and Entire Sight of One Eye	$25,000
One Hand or One Foot	$12,500
Entire Sight of One Eye	$12,500

Maximum benefit per occurrence is $25,000