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	 $1,000 $2,000
Co-insurance After Deductible	30%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (Includes deductible, co-insurance, and co-pays) Individual Family	 $2,000 $4,000	 $2,000 $4,000
Physician Office Visits Primary Care	$30 copay	30% co-insurance, after deductible
Specialist (includes cardiologists, psychiatrists, dermatologist, podiatrists, etc.)	30% co-insurance, after deductible	30% co-insurance, after deductible
Preventative Services	No Charge	30% co-insurance, after deductible
Maternity Care	30% co-insurance, after deductible	30% co-insurance, after deductible
Diagnostic Tests (X-rays and blood tests)	30% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient Services for Advance Imaging Services (Includes MRI, MRA, CT Scan, PET, Nuclear Cardiology)	30% co-insurance, after deductible	30% co-insurance, after deductible
Ambulance	30% co-insurance, after deductible	30% co-insurance, after deductible
Emergency Room	30% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	30% co-insurance, after deductible	30% co-insurance, after deductible
Mental and Chemical Dependency Expense Inpatient	30% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient	30% co-insurance, after deductible	30% co-insurance, after deductible
Home Health Care Services (Limited to 40 visits per calendar year	30% co-insurance, after deductible	30% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	30% co-insurance, after deductible	30% 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)	30% coinsurance, after deductible, and any amount over $350 maximum	30% coinsurance, after deductible, and any amount over $350 maximum
Rehabilitative Therapy Services (Includes Occupational, Physical and Speech. Limited to 30 combined visits per calendar year)	30% co-insurance, after deductible	30% co-insurance, after deductible
Chiropractic (Limited to 12 visits per calendar year)	30% co-insurance, after deductible	30% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic Drugs	$7.00	Not Covered
Preferred Brand Name with No Generic Equivalent Drugs	$30.00	Not Covered
Preferred Brand Name with Generic Equivalent	30% co-insurance	Not Covered
Non-Preferred Brand Drugs	30% co-insurance	Not Covered
Mail Order 90-Day Supply		
Generic Drugs	$0.00	Not Covered
Preferred Brand Name with No Generic Equivalent Drugs	$60.00	Not Covered
Preferred Brand Name with Generic Equivalent	30% co-insurance	Not Covered
Non-Preferred Brand Drugs	30% co-insurance	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

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.

SHORT TERM DISABILITY

Benefits payable the 8th day of an accident, 15th day of a sickness, for 25 weeks
Weeks 1-25 ..... $150

DEATH BENEFIT

Employee $10,000