II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible	None	Not Covered
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum		
Individual	$1,500	Not Covered
Family	$3,000	Not Covered
Physician Office Visits and other eligible expenses		
Primary Care Doctor	$25 copay	Not Covered
Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrists, etc)	$35 copay	Not Covered
Preventative Care (includes screenings and immunizations)	No Charge	Not Covered
Diagnostic Testing (X-rays and blood tests)	20% coinsurance	Not Covered
Infertility (Limited to 5 cycles for IVF-ET, ZIFT, GIFT, and NORIF/ NORIVF, including Artificial Insemination)		
Doctor's Office	$35 copay	Not Covered
Hospital	20% coinsurance	Not Covered
Maternity Care Services		
Inpatient	20% coinsurance	Not Covered
Outpatient	$25 copay	Not Covered
Prenatal and postnatal care	No Charge	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance	20% coinsurance	20% coinsurance
Urgent Care	$35 copay	$35 copay
Emergency Care (no coverage for non-emergency use)	$150 copay	$150 copay
Inpatient Hospital Benefits: Daily Hospital Room and Board, Semi Private and other allowable expenses	20% coinsurance	Not Covered
Outpatient Hospital Surgery	20% coinsurance	Not Covered
Imaging (Requires pre-authorization for CT/PET scan, MRIs)	$150 copay	Not Covered
Mental Health and Nervous Expenses Inpatient	20% coinsurance	Not Covered
Outpatient	$25 copay	Not Covered
Alcohol and Substance Abuse Inpatient	20% coinsurance	Not Covered
Outpatient	$25 copay	Not Covered
Durable Medical Equipment (Total rental not to exceed purchase price.)	50% coinsurance	Not Covered
-Diabetic supplies	20% coinsurance	Not Covered
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	Not Covered
Skilled Nursing Care (Limited to 45 days per calendar year)	20% coinsurance	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Hospice Care	No Charge	Not Covered
Home Health Care	$35 copay	Not Covered
Rehabilitation Services (Limited to 30 visits per calendar year)	$35 copay	Not Covered
Chiropractic (Limited to 30 visits per year)	$35 copay	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic	$15.00	Not Covered
Preferred Brand	$40.00	Not Covered
Non-Preferred Brand	$80.00	Not Covered
Preferred Specialty Drugs	20% co-ins., with $200 max.	Not Covered
Non Preferred Specialty Drugs	20% co-ins., with $300 max.	Not Covered
Mail Order 90-Day Supply		
Generic	$30.00	Not Covered
Preferred Brand	$80.00	Not Covered
Non-Preferred Brand	$160.00	Not Covered
Preferred Specialty Drugs	20% co-ins., with $400 max.	Not Covered
Non Preferred Specialty Drugs	20% co-ins., with $600 max.	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