II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In- Network	**Out-of-Network**
Calendar Year Deductible Individual	$300	$1,000
Family	$600	$2,000
Co-insurance After Deductible	20%	50%
Out-of-Pocket Maximum (Includes plan deductibles and copays) Individual	$5,000	$10,000
Family	$10,000	$20,000
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Physician Office Visits and Other Services Primary Care Physician	$25 copay	50% co-insurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$40 copay	50% co-insurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG & mammography)	No Charge	50% co-insurance, after deductible
Well Child Care/ Immunizations	No Charge	50% co-insurance, after deductible
Well Women Care	No Charge	50% co-insurance, after deductible
Infertility Treatment	20% co-insurance, after deductible	50% co-insurance, 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 Inpatient	20% co-insurance, after deductible, plus $500 copay per admission	50% co-insurance, after deductible, plus $500 copay per admission
Outpatient (excludes Private Duty Nursing)	20% co-insurance, after deductible	50% co-insurance, after deductible
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Care (copay waived if admitted) Hospital Emergency Room	$200 copay	$200 copay
Urgent Care Center	$50 copay	$50 copay
Outpatient Diagnostic X-ray and Laboratory	$25 copay	50% co-insurance, after deductible
Outpatient Imaging Services (CT and MRI scans require prior authorization)	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient Surgery	20% co-insurance, after deductible	50% co-insurance, after deductible
Transplant Services	20% co-insurance, after deductible, plus $500 copay per admission	50% co-insurance, after deductible, plus $500 copay per admission
Mental Health Inpatient	20% co-insurance, after deductible, plus $500 copay per admission	50% co-insurance, after deductible, plus $500 copay per admission
Outpatient	$40 copay	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Alcohol & Substance Abuse Inpatient	20% co-insurance, after deductible, plus $500 copay per admission	50% co-insurance, after deductible, plus $500 copay per admission
Outpatient	$40 copay	50% co-insurance, after deductible
Home Health Care	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited up to 24 combined visits per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
Skilled Nursing Care (Limited up to 120 days per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
Durable Medical Equipment (DME) & Prosthetics (Total rental not to exceed purchase price)	20% co-insurance, after deductible	50% 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 androgenetic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	50% coinsurance, after deductible, and any amount over $350 maximum
Hospice Care	20% co-insurance, after deductible	50% co-insurance, after deductible
Chiropractic (Limited up to 24 visits per calendar year)	$40 copay	50% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network (No Deductibles)	**Out-of Network**
Mandatory Generic Substitution Applies		
Retail (30-Day Supply)		
Generic Drugs	$10 copay	Not Covered
Preferred Brand	20% co-insurance**	Not Covered
Non-Preferred Brand	20% co-insurance**	Not Covered
Mail-Order (90-Day Supply) Mail order is mandatory after 2 refills at your local store		
Generic Drugs	$20 copay	Not Covered
Preferred Brand	20% co-insurance**	Not Covered
Non-Preferred Brand	20% co-insurance**	Not Covered
Specialty Drug Copay	20% co-insurance	Not Covered
**If a brand name drug 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.		

Dental Benefits

Provided by Delta Dental

For Customer Service: 1-800-452-9310
For Providers in your area: 1-800-335-8265

You may also obtain information on their website at www.deltadentalnj.com

Vision Benefits

Provided by VSP

For Customer Service: 1-800-877-7195

You may also obtain information on their website at www.vsp.com