II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $250 $500	 $500 $1,000
Co-insurance After Deductible	10%	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	 $1,000 $2,000	 $4,000 $8,000
Physician's Office Visits Primary Care Physician	$20 copay	30% co-insurance, after deductible
Specialist	$30 copay	30% co-insurance, after deductible
Preventative Care (Includes immunizations, routine physical exam, lab and X-ray testing)	No Charge	No Charge
Diagnostic Testing (X-ray, blood work)	10% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient Advance Imaging Services (MRI, MRA, CT Scan, PET, Nuclear)	10% co-insurance, after deductible	30% co-insurance, after deductible
Ambulance	10% co-insurance, after deductible	10% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Emergency Room (Waived if admitted) Hospital ER	$75 copay	$75 copay
Urgent Care Center	$30 copay	10% co-insurance, after deductible
Hospital or Surgical Facility Benefits Semi-private room and board, Intensive care, Coronary care, and Hospital special services	10% co-insurance, after deductible	30% co-insurance, after deductible
Transplantation Services	10% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient Surgery	$30 copay	30% co-insurance, after deductible
Infertility Counseling, Testing and Treatment	10% co-insurance, after deductible	30% co-insurance, after deductible
Mental and Substance Abuse Treatment Inpatient	10% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient	$30 copay	30% co-insurance, after deductible
Hospice Care	10% co-insurance, after deductible	30% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	10% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient Speech, Physical and Occupational Therapy (Up to 20 visits combined per calendar year)	$30 copay	30% co-insurance, after deductible
Skilled Nursing Facility Care (Limited to 100 days per calendar year)	10% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Home Health Care (Limited up to 100 days per calendar year)	10% co-insurance, after deductible	30% co-insurance, after deductible
Chiropractic Office Visits (Limited up to 20 visits per calendar year)	$30 copay	30% co-insurance, after deductible
Oral Treatment Accidental dental, bony, impacted molars	10% co-insurance, after deductible	30% co-insurance, after deductible
Oral surgery	10% co-insurance, after deductible	30% co-insurance, after deductible
Hearing Aids	10% co-insurance, after deductible	30% co-insurance, after deductible
Enteral Formulas	10% co-insurance, after deductible	30% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
<u>Retail (30-Day Supply)</u> Generic	10% co-insurance	Not Covered
Preferred Brand Name	10% co-insurance	Not Covered
Non-Preferred Brand Name	10% co-insurance	Not Covered
<u>Mail Order (90-Day Supply)</u> Generic	$5	Not Covered
Preferred Brand Name	$15	Not Covered
Non-Preferred Brand Name	$15	Not Covered
Specialty Drugs	$15	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