II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 None None	 $300 $600
Coinsurance After Deductible	10%	25%
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	 $2,000 $4,000
Physician Office Visits and other eligible office expense	$10 copay	25% coinsurance, after deductible
Preventative Care (One per calendar year) Pap Smear Benefit	No Charge	Not Covered
Mammograms -Age 39 and under	No Charge	Not Covered
-Age 40 and over	No Charge	Not Covered
Childhood Immunizations (Birth to age 5)	No Charge	Not Covered
Office visits for above services	$10 copay	Not Covered
Ambulance	10% coinsurance, after deductible	25% coinsurance, after deductible
Emergency Room	10% coinsurance, after deductible	25% coinsurance, after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	$150 admission copay, plus 10% coinsurance	25% coinsurance, after deductible
Hospital Pre-Certification Penalty	$250	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental Health		
Inpatient	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Outpatient	$10 copay	25% coinsurance, after deductible
Alcohol and Substance Abuse (Limited to 2 confinements per lifetime)		
Inpatient	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Outpatient	$10 copay	25% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	10% coinsurance, after deductible	25% coinsurance, after deductible
External Prosthetic Devices	10% coinsurance, after deductible	25% 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)	10% coinsurance, after deductible, up to a maximum of $350	25% coinsurance, after deductible, up to a maximum of $350
Home Health (Nursing) Care	10% coinsurance, after deductible	25% coinsurance, after deductible
Skilled Nursing Facility (120 allowable days of confinement per lifetime)	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Hospice Care (2 consecutive 6 month periods)	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Physical Therapy	$10 copay	25% coinsurance, after deductible
Chiropractic (Limited to 30 visits per calendar year)	$10 copay	25% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In- Network	Out-of-Network
Retail Copayment 30-Day Supply		
Generic Drugs	$7.50	Not Covered
Brand Name Drugs	$15.00	Not Covered
Mail-Order 90-Day Supply (mandatory for maintenance medications after 1 prescription at retail)		
Generic Drugs	$15.00	Not Covered
Brand Name Drugs	$30.00	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 1st day of an accident, 8th day of a sickness, for 26 weeks:

Weeks 1-4 .... $250
Weeks 5-26 .... $300

DEATH BENEFIT

Employee $20,000