II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $250 $500	 $250 $500
Coinsurance After Deductible	20%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum (includes deductibles and copays) Individual Family	 $7,900 $15,800	 None None
Physician Office Visits and Other In-office Services Primary Care Physician	20% coinsurance, after deductible	30% coinsurance, after deductible
Specialist	20% coinsurance, after deductible	30% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, urine, tests, chest x-ray, EKG, & mammography at in-network provider)	No Charge	30% coinsurance, after deductible
Diagnostic Tests (X-rays and blood work)	20% coinsurance, after deductible	30% coinsurance, after deductible
Imaging Services (CT and MRI scans requires prior authorization)	20% coinsurance, after deductible	30% coinsurance, after deductible
Outpatient Surgery Center Facility	No Charge	30% coinsurance, after deductible
Physician/Surgeon Fees	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Waived if admitted)	$50 copay, then 20% coinsurance	$50 copay, then 20% coinsurance
Urgent Care Center Services	20% coinsurance, after deductible	20% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses Facility	No Charge	30% coinsurance, after deductible
Physician/Surgeon Fees	20% coinsurance, after deductible	30% coinsurance, after deductible
Maternity Care Services Pre-natal & Postnatal Care	20% coinsurance, after deductible	30% coinsurance, after deductible
Delivery and all Inpatient Services	20% coinsurance, after deductible	30% coinsurance, after deductible
Mental and Substance Use Disorder Inpatient	No Charge	30% coinsurance, after deductible
Outpatient	20% coinsurance, after deductible	30% coinsurance, after deductible
Home Health (Nursing) Care	20% coinsurance, after deductible	30% coinsurance, after deductible
Skilled Nursing Facility	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	30% coinsurance, after deductible
External Prosthetic Devices	20% coinsurance, after deductible	30% 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)	20% coinsurance, after deductible, and any amount over $350 maximum	30% coinsurance, after deductible, and any amount over $350 maximum
Physical Therapy Services	20% coinsurance, after deductible	30% coinsurance, after deductible
Chiropractic Care (Maximum of 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible

Vision Benefits

Benefits payable during any two (2) year period with the following maximums:

Eye Exam 100%
Frames/Lenses ..... Up to $100

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

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Specialty Drugs	20% coinsurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered

EMPLOYEE DEATH BENEFIT

Employee Death Benefit..... $5,000

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life $5,000
Both Hands or Both Feet..... $5,000
Entire Sight of Both Eyes $5,000
One Hand and One Foot..... $5,000
One Hand or One Foot and Entire Sight of One Eye $5,000
One Hand or One Foot $2,500
Entire Sight of One Eye $2,500
Maximum payment for this benefit per occurrence is..... $5,000