II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $150 $450	 $150 $450
Co-insurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $1,500 $3,000	 $1,500 $3,000
Physician Office Visits Primary Doctor	 20% co-insurance, after deductible	 40% co-insurance, after deductible
Specialist (Includes Cardiologist, Psychiatrists, etc.)	20% co-insurance, after deductible	40% co-insurance, after deductible
Preventative Care Benefits	No Charge	40% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	20% co-insurance, after deductible	40% co-insurance, after deductible
Hospital Pre-Certification Penalty	25% of benefits up to a maximum of $2,000	
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Room	20% co-insurance, after deductible	20% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Substance Use Disorder		
Inpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
Outpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
Home Health Care	20% co-insurance, after deductible	40% co-insurance, after deductible
Skilled Nursing Facility	50% co-insurance, after deductible	50% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% co-insurance, after deductible	40% co-insurance, after deductible
Hospice Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Physical, Occupational and Speech Therapy	20% co-insurance, after deductible	40% co-insurance, after deductible
Chiropractic (Limited to 12 visits per calendar year)	20% co-insurance, after deductible	40% co-insurance, after deductible

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network (No Deductibles)	**Out-of-Network**
Mandatory Generic Substitution Applies		
Retail 30-Day Supply		
Generic Drugs	$5 copay	Not Covered
Preferred Brand Name Drugs	$30 copay**	Not Covered
Non-Preferred Brand Name Drugs	$30 copay**	Not Covered

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network (No Deductibles)	**Out-of-Network**
Mail-Order 90-Day Supply		
Generic Drugs	$10 copay	Not Covered
Preferred Brand Name Drugs	$60 copay**	Not Covered
Non-Preferred Brand Name Drugs	$60 copay**	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: 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