II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $325 $650	 $975 $1,950
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	 $3,250 $6,500	 None None
Physician Office Visits and Other In-office Services Primary Care Physician	$20 copay	30% coinsurance, after deductible
Specialist	$20 copay	30% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, mammography, vaccination, etc.)	No Charge	30% coinsurance, after deductible
Diagnostic Test (X-rays, 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
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	$50 copay	$50 copay
Urgent Care	20% coinsurance, after deductible	20% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
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		
-Inpatient	No Charge	30% coinsurance, after deductible
-Outpatient	20% coinsurance, after deductible	30% coinsurance, after deductible
-Physician & Surgeon Fees	20% coinsurance, after deductible	30% coinsurance, after deductible
Outpatient Surgery Facility	No Charge	30% coinsurance, after deductible
-Physician & Surgeon Fees	20% coinsurance, after deductible	30% coinsurance, after deductible
Mental and Substance Use Disorder		
-Inpatient	No Charge	30% coinsurance, after deductible
-Outpatient	$20 copay	30% coinsurance, after deductible
Maternity Care Services		
-Prenatal & postnatal	20% coinsurance, after deductible	30% coinsurance, after deductible
-Inpatient services	No Charge	30% coinsurance, after deductible
-Delivery	20% coinsurance, after deductible	30% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	30% coinsurance, after deductible
Skilled Nursing Facility	No Charge	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 -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, Occupational and Speech Therapy	20% coinsurance, after deductible	30% coinsurance, after deductible
Chiropractic (Maximum of 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
Hearing Aids	$1,000 per ear every 3 years	

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

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$5 copay	Not Covered
Preferred Brand Name Drugs	$25 copay	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance	Not Covered
Specialty Drugs	20% coinsurance, up to a $150 maximum	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$20 copay	Not Covered
Preferred Brand Name Drugs	$50 copay	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance	Not Covered

EMPLOYEE DEATH BENEFIT

Employee Death Benefit... $20,000

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life $20,000
Both Hands or Both Feet $20,000
Entire Sight of Both Eyes $20,000
One Hand and One Foot... $20,000
One Hand or One Foot and Entire Sight of One Eye $20,000
One Hand or One Foot $10,000
Entire Sight of One Eye $10,000
Maximum payment for this benefit per occurrence is...................................... $20,000