II. SCHEDULE OF BENEFITS

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible -Individual -Family	 $1,000 $2,000	 $1,000 $2,000
Co-insurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $3,000 $9,000	 $4,000 $12,500
Physician Office Visits -Primary Care Physician	$25 copay	20% co-insurance, after deductible
-Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$25 copay	20% co-insurance, after deductible
Preventative Care (One annual exam per calendar year, including blood screening, urine tests, chest x-ray, EKG & mammography)	No Charge	20% co-insurance, after deductible
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Care (Copay waived if admitted) -Hospital ER	$150 copay	$150 copay
-Urgent Care Center	$25 copay	$25 copay
Hospital Daily Hospital Room and Board, Semi-Private and other allowable expenses	20% co-insurance, after deductible	40% co-insurance, after deductible

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Diagnostic Test (X-rays and blood tests)	20% co-insurance, after deductible	40% co-insurance, after deductible
- Doctor's Office	No Charge	40% co-insurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% co-insurance, after deductible	40% co-insurance, after deductible
Outpatient Surgery Facility	20% co-insurance, after deductible	40% co-insurance, after deductible
-Physician & Surgeon Fees	20% co-insurance, after deductible	40% co-insurance, after deductible
Mental Health and Substance Abuse -Inpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
-Outpatient	$25 copay	40% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% co-insurance, after deductible	40% co-insurance, 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 androgenetic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum
Breast Pumps	No Charge and any amount up to a maximum of $250	40% coinsurance, after deductible, and any amount up to a maximum of $250
Physical, Occupational and Speech Therapy (Limited to 60 combined visits per calendar year)	$25 copay	20% co-insurance, after deductible

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Skilled Nursing Facility (Limited to 100 days per calendar year)	20% co-insurance, after deductible	40% co-insurance, after deductible
Home Health (Limited to 120 visits per calendar year)	20% co-insurance, after deductible	40% co-insurance, after deductible
Hospice Care	No Charge	20% coinsurance after deductible
Chiropractic Services (Limited to 30 visits per calendar year)	$25 copay	20% co-insurance, after deductible
Vision Benefits -Eye Exam (Once every year)	No Charge	No Charge
-Prescription Corrective Eyeglasses or Contact Lenses (Every year)	Up to $100	Up to $100

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail (30-Day Supply)		
Generic	$15	20% coinsurance
Preferred Brand Formulary	$25	20% coinsurance
Non-Preferred Brand	$40	20% coinsurance
Mail Order (90-Day Supply		
Generic	$45	Not Covered
Preferred Brand Formulary	$75	Not Covered
Non- Preferred Brand	$120	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