II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $250 $500	 $500 $1,000
Coinsurance 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	 $6,850 $13,700	 $13,700 $41,100
Physician Office Visits and other eligible office expenses Primary Doctor	20% coinsurance, after deductible	40% coinsurance, after deductible
Specialist (Includes Cardiologist, Psychiatrists, podiatrists, etc.)	20% coinsurance, after deductible	40% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG, & mammography)	No Charge	40% coinsurance, after deductible
Laboratory Services	20% coinsurance, after deductible	40% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	$300 copay, plus 20% coinsurance	$300 copay, plus 20% coinsurance
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	40% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulatory/Outpatient Hospital Surgery Facility	No Charge	40% coinsurance, after deductible
Professional Fees	20% coinsurance, after deductible	40% coinsurance, after deductible
Mental and Substance Use Disorder Inpatient	No Charge	40% coinsurance, after deductible
Outpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Skilled Nursing Facility	20% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	40% 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 androgenic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	20% coinsurance, after deductible, and any amount over $350 maximum
Physical, Occupational and Speech Therapy	20% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic (Up to 12 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic Drugs	15% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	15% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, after deductible	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