II. SCHEDULE OF BENEFITS

PLAN B

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $300 $750	 $500 $1,250
Co-insurance After Deductible	30%	50%
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	 $5,000 $10,000	 $5,000 $10,000
Physician Office Visits Primary Care Physician	30% co-insurance, after deductible	50% co-insurance, after deductible
Specialist (Includes cardiologist, psychiatrists, dermatologists, podiatrist, etc.)	30% co-insurance, after deductible	50% co-insurance, after deductible
Preventative Care Benefits	No Charge	50% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	30% co-insurance, after deductible	50% co-insurance, after deductible
Hospital Pre-Certification Penalty	25% of benefits up to a maximum of $2,000	
Ambulance	30% co-insurance, after deductible	30% co-insurance, after deductible
Emergency Room	30% co-insurance, after deductible	30% co-insurance, after deductible

PLAN B

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Substance Use Disorder Inpatient	30% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient	30% co-insurance, after deductible	50% co-insurance, after deductible
Home Health Care	30% co-insurance, after deductible	50% 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)	30% co-insurance, after deductible	50% 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)	30% coinsurance, after deductible, and any amount over $350 maximum	50% coinsurance, after deductible, and any amount over $350 maximum
Breast Pump	No Charge and any amount over $250 maximum	50% coinsurance, after deductible and any amount over $250 maximum
Hospice Care	30% coinsurance, after deductible	50% coinsurance, after deductible
Physical, Occupational and Speech Therapy	30% co-insurance, after deductible	50% co-insurance, after deductible
Chiropractic (Limited to 12 visits per calendar year)	30% co-insurance, after deductible	40% co-insurance, after deductible

PLAN B

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
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.		

Prescription Drug Benefits
Provided by EmpiRx Health: Call 1-877-241-7123 for Member Services

You may also obtain information on their website at www.empirxhealth.com

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

SHORT TERM DISABILITY BENEFIT

Benefits payable the 1st day of an accident, 7th day of a sickness, for 13 weeks

Weeks 1-13 .....$45 per week

EMPLOYEE DEATH BENEFIT

Active Employee $1,000

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(Employee coverage only)

For loss of:

Life $1,000
Both Hands or Both Feet..... $1,000
Entire Sight of Both Eyes $1,000
One Hand and One Foot..... $1,000
One Hand or One Foot and Entire Sight of One Eye $1,000
One Hand or One Foot..... $500
Entire Sight of One Eye..... $500

Maximum payment for this benefit per occurrence is $1,000