II. SCHEDULE OF BENEFITS
PLAN A - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
-Individual	$300	$300
-Family	$900	$900
Co-insurance After Deductible	35%	35%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum	$7,000	$7,000
Physician Office Visits		
-Primary Care Physician	35% co-insurance, after deductible	35% co-insurance, after deductible
-Specialist	35% co-insurance, after deductible	35% co-insurance, after deductible
Preventative Care (routine exams, x-rays/ tests, immunizations, well baby care and mammograms)	No Charge	35% co-insurance, after deductible
Diagnostic Test (X-rays and blood work)	35% co-insurance, after deductible	35% co-insurance, after deductible
Imaging Services (MRI, CT and PET scans- requires prior authorization)	35% co-insurance, after deductible	35% co-insurance, after deductible
Ambulance	35% co-insurance, after deductible	35% co-insurance, after deductible
Emergency Room (copay waived if admitted)	$100 copay	$100 copay
Urgent Care Center Services	35% co-insurance, after deductible	35% co-insurance, after deductible

PLAN A - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Pre-Certification Penalty	$200 maximum	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses -Inpatient	35% co-insurance, after deductible	35% co-insurance, after deductible
-Outpatient	35% co-insurance, after deductible	35% co-insurance, after deductible
Organ Transplantation (Limited up to $225,000 per transplant)	35% co-insurance, after deductible	35% co-insurance, after deductible
Maternity Care Services (Does not apply for dependent children) -Prenatal and postnatal care	35% co-insurance, after deductible	35% co-insurance, after deductible
-All other hospital and physician services	35% co-insurance, after deductible	35% co-insurance, after deductible
Outpatient Services	35% co-insurance, after deductible	35% co-insurance, after deductible
Mental Health and Substance Abuse Expense -Inpatient	35% co-insurance, after deductible	35% co-insurance, after deductible
-Outpatient	35% co-insurance, after deductible	35% co-insurance, after deductible
Hospice (Requires prior authorization. Limited up to 12 days in 6 months period or 120 hours every 3 months.)	No Charge	No Charge
Home Health Care (Requires prior authorization)	No Charge	No Charge
Skilled Nursing Facility	35% co-insurance, after deductible	35% co-insurance, after deductible

PLAN A - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In- Network	Out-of-Network
Durable Medical Equipment (Total rental not to exceed purchase price.)	35% co-insurance, after deductible	35% co-insurance, after deductible
External Prosthetic Devices	35% co-insurance, after deductible	35% co-insurance, after deductible
-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)	35% coinsurance, after deductible, and any amount over $350 maximum	35% coinsurance, after deductible, and any amount over $350 maximum
Occupational, Physical, and Speech Therapy Services	35% co-insurance, after deductible	35% co-insurance, after deductible
Chiropractic Services	Any amount over $25 maximum per visit	Any amount over $25 maximum per visit
Hearing exams and aids (Benefits payable during any 24 months period)	Any amount over $500 maximum	Any amount over $500 maximum

PLAN B - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
-Individual	$350	$350
-Family	$900	$900
Co-insurance After Deductible	25%	25%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum	$5,500	$5,500

PLAN B – PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Physician Office Visits		
-Primary Care Physician	25% co-insurance, after deductible	25% co-insurance, after deductible
-Specialist	25% co-insurance, after deductible	25% co-insurance, after deductible
Preventative Care (routine exams, x-rays/ tests, immunizations, well baby care and mammograms)	No Charge	25% co-insurance, after deductible
Diagnostic Test (X-rays and blood work)	25% co-insurance, after deductible	25% co-insurance, after deductible
Imaging Services (MRI, CT and PET scans- requires prior authorization)	25% co-insurance, after deductible	25% co-insurance, after deductible
Ambulance	25% co-insurance, after deductible	25% co-insurance, after deductible
Emergency Room (copay waived if admitted)	$100 copay	$100 copay
Urgent Care Center Services	35% co-insurance, after deductible	35% co-insurance, after deductible
Hospital Pre-Certification Penalty	$200 maximum	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses		
-Inpatient	25% co-insurance, after deductible	25% co-insurance, after deductible
-Outpatient	25% co-insurance, after deductible	25% co-insurance, after deductible
Organ Transplantation (Limited up to $225,000 per transplant)	25% co-insurance, after deductible	25% co-insurance, after deductible

PLAN B – PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In- Network	Out-of-Network
Maternity Care Services (Does not apply for dependent children) -Prenatal and postnatal care	25% co-insurance, after deductible	25% co-insurance, after deductible
-All other hospital and physician services	25% co-insurance, after deductible	25% co-insurance, after deductible
Outpatient Services	25% co-insurance, after deductible	25% co-insurance, after deductible
Mental Health and Substance Abuse Expense -Inpatient	25% co-insurance, after deductible	25% co-insurance, after deductible
-Outpatient	25% co-insurance, after deductible	25% co-insurance, after deductible
Hospice (Requires prior authorization. Limited up to 12 days in 6 months period or 120 hours every 3 months.)	No Charge	No Charge
Home Health Care (Requires prior authorization)	No Charge	No Charge
Skilled Nursing Facility	25% co-insurance, after deductible	25% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	25% co-insurance, after deductible	25% co-insurance, after deductible
External Prosthetic Devices	25% co-insurance, after deductible	25% co-insurance, after deductible
-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)	25% coinsurance, after deductible, and any amount over $350 maximum	25% coinsurance, after deductible, and any amount over $350 maximum
Occupational, Physical, and Speech Therapy Services	25% co-insurance, after deductible	25% co-insurance, after deductible

PLAN B – PPO

SUMMARY OF BENEFITS	YOUR ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Chiropractic Services	Any amount over $25 maximum per visit	Any amount over $25 maximum per visit
Hearing exams and aids (Benefits payable during any 24 months period)	Any amount over $500 maximum	Any amount over $500 maximum

PLAN A & PLAN B

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Out-of-Pocket Maximum	$1,650 (individual) / $3,300 (family)	
Retail 30-Day Supply		
Generic Drugs	$5 copay	Not Covered
Preferred Brand Name Drugs	$20 copay	Not Covered
Non-Preferred Brand Name Drugs	$40 copay	Not Covered
Specialty Drugs	$100 copay	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$15 copay	Not Covered
Preferred Brand Name Drugs	$60 copay	Not Covered
Non-Preferred Brand Name Drugs	$120 copay	Not Covered
Specialty Drugs	$100 copay	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

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

<u>Plan A</u>

Benefits payable the 1st day of an accident, 7th day of a sickness, for 26 weeks
Weeks 1 – 26 ....65% of weekly salary up to $100

<u>Plan B</u>

Benefits payable the 1st day of an accident, 7th day of a sickness, for 26 weeks
Weeks 1 – 26 ....65% of weekly salary up to $150

EMPLOYEE DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

Death Benefit for You $3,000

Death Benefit for Your Dependents

Spouse $1,000
Each child.. $1,000

Accidental Death and Dismemberment for you up to $3,000
(There are no dependent coverage for AD&D)

For loss of:

Life $3,000
Both Hands or Both Feet.. $3,000
Entire Sight of Both Eyes $3,000
One Hand and One Foot.. $3,000
One Hand or One Foot and Entire Sight of One Eye $3,000
One Hand or One Eye.. $1,500
Entire Sight of One Eye.. $1,500

Maximum payment for this benefit per occurrence is $3,000