II. SCHEDULE OF BENEFITS

PLAN A - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual	$250	$250
Family	$750	$750
Co-insurance After Deductible	20%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum Individual	$6,850	$6,850
Family	$13,700	$13,700
Physician Office Visits Primary Care Physician	$10 copay, after deductible, plus 20% co-insurance	$10 copay, after deductible, plus 30% co-insurance
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrist, etc.)	$10 copay, after deductible, plus 20% co-insurance	$10 copay, after deductible, plus 30% co-insurance
Preventative Care	No Charge	No Charge, after deductible
Diagnostic Test (X-ray, blood tests)	20% co-insurance, after deductible	30% co-insurance, after deductible
Advanced Imaging Services for Outpatient Services Only (MRI, MRA, CT scan, PET, Nuclear)	20% co-insurance, after deductible	30% co-insurance, after deductible
Allergy Testing and Treatment	20% co-insurance, after deductible	30% co-insurance, after deductible

PLAN A - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Human Growth Hormone Treatment (Treatment is for 6 months up to $3,200)	20% co-insurance, after deductible	30% co-insurance, after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	$100 copay per admission, plus 20% co-insurance, after deductible	$100 copay per admission, plus 30% co-insurance, after deductible
Hospital Pre-Certification Penalty	15%	
Outpatient Surgery	20% co-insurance, after deductible	30% co-insurance, after deductible
Surgical Facility	20% co-insurance, after deductible	30% co-insurance, after deductible
Anesthesia	20% co-insurance, after deductible	30% co-insurance, after deductible
Radiation / Chemotherapy	20% co-insurance, after deductible	30% co-insurance, after deductible
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Care (Copay waived if admitted)	$100 copay, after deductible, plus 20% co-insurance	$100 copay, after deductible, plus 20% co-insurance
Mental Health and Substance Abuse Expense		
Inpatient	20% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient	$10 copay, after deductible, plus 20% co-insurance	$10 copay, after deductible, plus 30% co-insurance
Hospice and Skilled Nursing Care	20% co-insurance, after deductible	30% co-insurance, after deductible

PLAN A - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In- Network	**Out-of-Network**
Home Health Care (Limited to 120 visits per calendar year)	20% co-insurance, after deductible	30% co-insurance, after deductible
Skilled Nursing Facility (Limited to 120 visits per calendar year)	20% co-insurance, after deductible	30% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% co-insurance, after deductible	30% 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)	25% coinsurance, after deductible, and any amount over $350 maximum	30% coinsurance, after deductible, and any amount over $350 maximum
Outpatient Occupational, Physical, and Speech Therapy Services (Limited up to 30 visits each per calendar year)	$10 copay, after deductible, plus 20% co-insurance	$10 copay, after deductible, plus 30% co-insurance
Chiropractic (Limited up to 30 visits per calendar year)	$10 copay, after deductible, plus 20% co-insurance	$10 copay, after deductible, plus 30% co-insurance

PLAN B - PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$250	$250
Family	$750	$750
Co-insurance After Deductible	25%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum		
Individual	$6,850	$6,850
Family	$13,700	$13,700
Physician Office Visits		
Primary Care Physician	$10 copay, after deductible, plus 25% co-insurance	$10 copay, after deductible, plus 30% co-insurance
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$10 copay, after deductible, plus 25% co-insurance	$10 copay, after deductible, plus 30% co-insurance
Preventative Care	No Charge	No Charge, after deductible
Diagnostic Test (X-ray, blood work)	25% co-insurance, after deductible	30% co-insurance, after deductible
Advanced Imaging Services for Outpatient Services Only (MRI, MRA, CT scan, PET, Nuclear)	25% co-insurance, after deductible	30% co-insurance, after deductible
Allergy Testing and Treatment	25% co-insurance, after deductible	30% co-insurance, after deductible
Human Growth Hormone Treatment (Treatment is for 6 months up to $3,200)	25% co-insurance, after deductible	30% co-insurance, after deductible

PLAN B – PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	$100 copay per admission, plus 25% co-insurance, after deductible	$100 copay per admission, plus 30% co-insurance, after deductible
Hospital Pre-Certification Penalty	15%	
Outpatient Surgery	25% co-insurance, after deductible	30% co-insurance, after deductible
Surgical Facility	25% co-insurance, after deductible	30% co-insurance, after deductible
Anesthesia	25% co-insurance, after deductible	30% co-insurance, after deductible
Radiation / Chemotherapy	25% co-insurance, after deductible	30% co-insurance, after deductible
Ambulance	25% co-insurance, after deductible	25% co-insurance, after deductible
Emergency Care (Copay waived if admitted)	$100 copay, plus 25% co-insurance, after deductible	$100 copay, plus 25% co-insurance, after deductible
Mental Health and Substance Abuse Expense Inpatient	25% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient	$10 copay, plus 25% co-insurance, after deductible	$10 copay, plus 30% co-insurance, after deductible
Hospice and Skilled Nursing Care	25% co-insurance, after deductible	30% co-insurance, after deductible
Home Health Care (Limited to 120 visits per calendar year)	25% co-insurance, after deductible	30% co-insurance, after deductible
Skilled Nursing Facility (Limited to 120 visits per calendar year)	25% co-insurance, after deductible	30% co-insurance, after deductible

PLAN B – PPO

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Durable Medical Equipment (Total rental not to exceed purchase price.)	25% co-insurance, after deductible	30% 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)	25% coinsurance, after deductible, and any amount over $350 maximum	30% coinsurance, after deductible, and any amount over $350 maximum
Outpatient Occupational, Physical, and Speech Therapy Services (Limited up to 30 visits each per calendar year)	$10 copay, plus 25% co-insurance, after deductible	$10 copay, plus 30% co-insurance, after deductible
Chiropractic (Limited up to 30 visits per calendar year)	$10 copay, plus 25% co-insurance, after deductible	$10 copay, plus 30% co-insurance, after deductible

PLAN A & PLAN B

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE		
	PREFERRED IN-NETWORK	**STANDARD IN-NETWORK**	**OUT-OF-NETWORK**
Retail 30 Day Supply			
Generic	$10	$12	Not Covered
Brand	20% co-insurance	25% co-insurance	Not Covered
Mail Order 90 Day Supply			
Generic	$20	$24	Not Covered
Brand	20% co-insurance	25% co-insurance	Not Covered
Preferred Network means:	Albertson's Pharmacy and Smith's Food and Drugs		
Standard Network means:	EmpiRx Health Pharmacy Participants		
Out-of-Network means:	Walmart, Costco and Fred Meyer		
Clerks	The above schedule applies to the first $200 in prescription benefits per year. Thereafter, you must satisfy the annual Medical benefit deductible. After satisfying the deductible for expenses in excess of $200, prescription benefits will then be paid according to the above schedule.		
Meat cutters	The above schedule applies after satisfying the annual Medical benefit deductible.		

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

Benefits payable the 1st day of an accident, 8th day of sickness, for 13 weeks
Weeks 1 – 13 .... $100

EMPLOYEE DEATH BENEFIT

Plan A – Active Employees $20,000
Plan B – Active Employees $10,000

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(Employee coverage only)

For loss of:

Life .... Full Benefit
Both Hands or Both Feet.. Full Benefit
Entire Sight of Both Eyes .... Full Benefit
One Hand and One Foot .... Full Benefit
One Hand or One Foot and Entire Sight of One Eye .... Full Benefit
One Hand or One Eye... One Half of Benefit
Entire Sight of One Eye.. One Half of Benefit
Thumb and index finger of same hand .... One Quarter of Benefit

Maximum payment for this benefit per occurrence is .... Full Benefit