II. SCHEDULE OF BENEFITS

PPO 90/70 PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $200 $500	 $300 $600
Co-insurance After Deductible	10%	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 Family	 $1,500 $3,000	 $3,000 $6,000
Physician Office Visits -Primary Care Physician	$15 copay	30% co-insurance, after deductible
-Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$15 copay	30% co-insurance, after deductible
Preventative Care	No Charge	No Charge
Diagnostic Test (X-ray, blood tests)	10% co-insurance, after deductible	30% co-insurance, after deductible
Ambulance	10% co-insurance, after deductible	10% co-insurance, after deductible
Emergency Care Services -Emergency Room (Copay waived if admitted)	10% co-insurance, after deductible	10% co-insurance, after deductible
-Urgent Care	10% co-insurance, after deductible	10% co-insurance, after deductible
Imaging Services for Outpatient Services Only (MRI, MRA, CT scan, PET, Nuclear require prior authorization)	10% co-insurance, after deductible	30% co-insurance, after deductible

PPO 90/70 PLAN

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	10% co-insurance, after deductible	30% co-insurance, after deductible
Transplantation Services	10% co-insurance, after deductible	30% co-insurance, after deductible
Anesthesia	10% co-insurance, after deductible	30% co-insurance, after deductible
Radiation / Chemotherapy	10% co-insurance, after deductible	30% co-insurance, after deductible
Outpatient Surgery	10% co-insurance, after deductible	30% co-insurance, after deductible
Mental Health and Substance Abuse Expense Residential Treatment Facility -Inpatient	10% co-insurance, after deductible	30% co-insurance, after deductible
-Outpatient	$15 copay	30% co-insurance, after deductible
Partial Hospitalization/ Day Treatment -Inpatient	10% co-insurance, after deductible	30% co-insurance, after deductible
-Outpatient	$15 copay	30% co-insurance, after deductible
Intensive Outpatient Treatment	$15 copay	30% co-insurance, after deductible
Hospice Care Services (Limited up to 210 days per calendar year)	No Charge	No Charge
Home Health Care (Limited to 40 visits per calendar year)	No Charge	No Charge

PPO 90/70 PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In- Network	**Out-of-Network**
Skilled Nursing Facility (Limited to 120 visits per calendar year)	10% co-insurance, after deductible	30% co-insurance, after deductible
Durable Medical Equipment (Includes Wigs. Total rental not to exceed purchase price.)	10% 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 androgenic alopecia- male pattern baldness)	10% co-insurance, after deductible, and any amount over $350 maximum	30% co-insurance, after deductible, and any amount over $350 maximum
Outpatient Rehabilitation and Habilitative Services -Occupational Therapy (Limited up to 25 visits each per calendar year)	$15 copay	30% co-insurance, after deductible
-Physical Therapy (Limited to 25 visits per calendar year)	$15 copay	30% co-insurance, after deductible
-Speech Therapy (Limited to 25 visits per calendar year)	$15 copay	30% co-insurance, after deductible
Chiropractic (Limited up to 25 visits per calendar year)	$15 copay	30% co-insurance, after deductible
Temporomandibular Joint Disorder (TMJ) Treatment	10% co-insurance, after deductible	30% co-insurance, after deductible
Accidental dental and impacted wisdom tooth removal	10% co-insurance, after deductible	30% co-insurance, after deductible
Infertility -Doctor's office	$15 copay	30% co-insurance, after deductible
-Hospital	10% co-insurance, after deductible	30% co-insurance, after deductible

PPO 90/70 PLAN

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Annual Prescription Out-of-Pocket Maximum		
Individual	$1,500	$0
Family	$3,000	$0
Retail (30-Day Supply)		
Generic	$16 copay	Not Covered
Preferred Brand	$16 copay	Not Covered
Non-Preferred Brand	$28 copay	Not Covered
Mail Order (90-Day Supply)		
Generic	$32 copay	Not Covered
Preferred Brand	$32 copay	Not Covered
Non-Preferred Brand	$54 copay	Not Covered
Specialty Drugs	$54 copay	Not Covered

ELITE PPO 100/50 PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 None None	 $250 $500
Co-insurance After Deductible	No Charge	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	 $3,000 $6,000	 $10,000 $20,000
Physician Office Visits -Primary Care Physician	$15 copay	50% co-insurance, after deductible
-Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$25 copay	50% co-insurance, after deductible
Preventative Care	No Charge	Not Covered
Diagnostic Test (X-ray, blood tests)	No Charge	50% co-insurance, after deductible
Ambulance	No Charge	No Charge
Emergency Care Services -Emergency Room (Copay waived if admitted)	$75 copay	$75 copay
-Urgent Care	$50 copay	$50 copay
Imaging Services for Outpatient Services Only (MRI, MRA, CT scan, PET, Nuclear requires prior authorization)	No Charge	50% co-insurance, after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	$200 copay per admission	50% co-insurance, after deductible

ELITE PPO 100/50 PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Transplantation Services	$200 copay per admission	Not Covered
Anesthesia	No Charge	50% co-insurance, after deductible
Radiation / Chemotherapy	No Charge	50% co-insurance, after deductible
Outpatient Surgery	$50 copay	50% co-insurance, after deductible
Mental Health and Substance Abuse Expense Residential Treatment Facility -Inpatient	$200 copay per admission	50% co-insurance, after deductible
-Outpatient	$15 copay	50% co-insurance, after deductible
Partial Hospitalization/ Day Treatment -Inpatient	$200 copay per admission	50% co-insurance, after deductible
-Outpatient	$15 copay	50% co-insurance, after deductible
Intensive Outpatient Treatment	$15 copay	50% co-insurance, after deductible
Hospice Care Services (Limited to 6 months per calendar year	No Charge	No Charge
Home Health Care (Limited to 40 visits per calendar year)	No Charge	50% co-insurance, after deductible

ELITE PPO 100/50 PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Skilled Nursing Facility (limited to 120 visits per calendar year)	$200 copay per admission	50% co-insurance, after deductible
Durable Medical Equipment (Includes Wigs. Total rental not to exceed purchase price.)	No Charge	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 androgenic alopecia- male pattern baldness)	No Charge up to a maximum of $350	50% coinsurance, after deductible, and any amount over $350 maximum
Outpatient Rehabilitation and Habilitative Services -Occupational and Physical Therapy (Limited up to 30 visits per calendar year.)	$25 copay	50% co-insurance, after deductible
-Physical Therapy (Limited up to 30 visits per calendar year.)	$25 copay	50% co-insurance, after deductible
-Speech Therapy (Limited to 20 visits per calendar year)	$25 copay	50% co-insurance, after deductible
Chiropractic (Limited up to 12 visits per calendar year)	$25 copay	50% co-insurance, after deductible
Temporomandibular Joint Disorder (TMJ) Treatment	No Charge	50% co-insurance, after deductible
Accidental dental and impacted wisdom tooth removal	No Charge	50% co-insurance, after deductible
Infertility -Doctor's office	$25 copay	50% co-insurance, after deductible
-Hospital	$200 copay per admission	50% co-insurance, after deductible

ELITE PPO 100/50 PLAN

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Annual Prescription Out-of-Pocket Maximum		
Individual	$1,500	$0
Family	$3,000	$0
Retail (30-Day Supply)		
Generic	$16 copay	Not Covered
Preferred Brand	$16 copay	Not Covered
Non-Preferred Brand	$28 copay	Not Covered
Mail Order (90-Day Supply)		
Generic	$32 copay	Not Covered
Preferred Brand	$32 copay	Not Covered
Non-Preferred Brand	$54 copay	Not Covered
Specialty Drugs	$54 copay	Not Covered

HMO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 None None	 Not Covered Not Covered
Co-insurance After Deductible	No Charge	Not Covered
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	 $1,500 $3,000	 Not Covered Not Covered
Physician Office Visits -Primary Care Physician	$15 copay	Not Covered
-Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$35 copay	Not Covered
Preventative Care	No Charge	Not Covered
Diagnostic Test (X-ray, blood tests)	No Charge	Not Covered
Ambulance	No Charge	No Charge
Emergency Care Services -Emergency Room (Copay waived if admitted)	$150 copay	$150 copay
-Urgent Care	$15 copay	$15 copay
Imaging Services for Outpatient Services Only (MRI, MRA, CT scan, PET, Nuclear requires prior authorization)	No Charge	Not Covered
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	$100 copay per admission	Not Covered
Transplantation Services	No Charge	Not Covered

HMO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Anesthesia	No Charge	Not Covered
Radiation / Chemotherapy	No Charge	Not Covered
Outpatient Surgery	$50 copay	Not Covered
Mental Health and Substance Abuse Expense Residential Treatment Facility -Inpatient	$100 copay per admission	Not Covered
-Outpatient	$15 copay	Not Covered
Partial Hospitalization/ Day Treatment -Inpatient	$100 copay per admission	Not Covered
-Outpatient	$15 copay	Not Covered
Intensive Outpatient Treatment	$15 copay	Not Covered
Hospice Care Services	No Charge	Not Covered
Home Health Care	No Charge	Not Covered
Skilled Nursing Facility	$100 copay per admission	Not Covered
Durable Medical Equipment (Includes Wigs. Total rental not to exceed purchase price.)	No Charge	Not Covered
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)	No Charge up to a $350 maximum	50% coinsurance, after deductible, and any amount over $350 maximum

HMO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Outpatient Occupational, Physical, and Speech Therapy Services (Limited up to 60 visits combined per calendar year)	No Charge	Not Covered
Habilitative Services	No Charge	Not Covered
Chiropractic	$15 copay	Not Covered
Temporomandibular Joint Disorder (TMJ) Treatment	No Charge	Not Covered
Accidental dental and impacted wisdom tooth removal	No Charge	Not Covered
Infertility		
-Doctor's Office	$35 copay	Not Covered
-Hospital	$100 copay per admission	Not Covered

HMO PLAN

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Annual Prescription Out-of-Pocket Maximum		
Individual	$1,000	$0
Family	$2,000	$0
Retail (30-Day Supply)		
Generic	$10 copay	Not Covered
Preferred Brand	$40 copay	Not Covered
Non-Preferred Brand	$60 copay	Not Covered

HMO PLAN

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mail Order (90-Day Supply)		
Generic	$20 copay	Not Covered
Preferred Brand	$60 copay	Not Covered
Non-Preferred Brand	$120 copay	Not Covered
Specialty	$120 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

Benefits payable the 1st day of an accident, hospitalization or outpatient surgery, 4th day of sickness, for 26 weeks

Weeks 1 – 26 .....70 % of weekly salary