II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $250 $750	 $500 $1,500
Co-insurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual	 $3,000	 $6,000
Physician Office Visits and other eligible office expenses	$20 copay	40% co-insurance, after deductible
Allergy Injections	$20 copay	40% co-insurance, after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	20% co-insurance, after deductible	40% co-insurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Emergency Care Hospital ER	20% co-insurance, after deductible	40% co-insurance, after deductible
Urgent Care Center	20% co-insurance, after deductible	40% co-insurance, after deductible
Laboratory Services	20% co-insurance, after deductible	40% co-insurance, after deductible
Mental and Nervous Expense Inpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
Outpatient	$20 copay	40% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Alcohol and Substance Abuse Inpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
Outpatient	$20 copay	40% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% co-insurance, after deductible	40% co-insurance, after deductible
Cardiac Rehabilitation	20% co-insurance, after deductible	40% co-insurance, after deductible
Physical Therapy	20% co-insurance, after deductible	40% co-insurance, after deductible
Home Health (Nursing) Care	20% co-insurance, after deductible	40% co-insurance, after deductible
Chiropractic (12 visits per calendar year)	20% co-insurance, after deductible	40% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network (No Deductible)	**Out-of-Network** (After Deductible)
Retail 30 – Day Supply		
Generic	20% co-insurance	40% co-insurance
Brand Formulary Drugs	20% co-insurance	40% co-insurance
Non-Formulary Drugs	20% co-insurance	40% co-insurance
Mail Order 90 – Day Supply		
Generic Drugs	20% co-insurance	Not Covered
Brand Formulary Drugs	20% co-insurance	Not Covered
Non-Formulary Drugs	20% co-insurance	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

Payable at 65% of hourly base pay scale on the date disability commences multiplied by 40, subject to a maximum weekly benefit of ***$550*** for up to 52 weeks.

EMPLOYEE DEATH BENEFIT

Active Employee $20,000
Retired Employee..... $2,500
Temporary absent by direct payment..... $5,000
Monthly direct payment amount $9.85

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Employee coverage only)

For loss of:

Life $2,500
Both Hands or Both Feet..... $2,500
Entire Sight of Both Eyes $2,500
One Hand and One Foot..... $2,500
One Hand or One Foot and Entire Sight of One Eye $2,500
One Hand or One Foot..... $1,250
Entire Sight of One Eye..... $1,250

Maximum payment for this benefit per occurrence is $2,500