II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	None	$300 $600
Coinsurance After Deductible	10%	25%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual Family	$1,000 $2,000	$2,000 $4,000
Physician Office Visits and other eligible office expenses	$25 copay	25% co-insurance, after deductible
Preventative Care Benefits Pap Smear Benefits	No Charge	Not Covered
Mammogram (Age 40 and over only)	No Charge	Not Covered
Childhood Immunizations (Up to age 5)	No Charge	Not Covered
Office visits for above services	$25 copay	Not Covered
Hospital Daily Hospital Room and Board Semi Private and other allowable expenses	$150 admission copay, plus 10% co-insurance	25% co-insurance, after deductible
Hospital Pre- Certification Penalty	$250	
Ambulance	10% co-insurance, after deductible	25% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Emergency Care Hospital ER	10% co-insurance, after deductible	25% co-insurance, after deductible
Urgent Care Center	10% co-insurance, after deductible	25% co-insurance, after deductible
Laboratory Services	10% co-insurance, after deductible	25% co-insurance, after deductible
Mental Health and Nervous Expense Inpatient	$150 admission copay, plus 10% co-insurance	25% co-insurance, after deductible
Outpatient	$25 copay	25% co-insurance, after deductible
Alcohol & Substance Abuse Inpatient	$150 admission copay, plus 10% co-insurance	25% co-insurance, after deductible
Outpatient	$25 copay	25% co-insurance, after deductible
Cardiac Rehabilitation	10% co-insurance, after deductible	25% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	10% co-insurance, after deductible	25% co-insurance, after deductible
Physical Therapy	$25 copay	25% co-insurance, after deductible
Chiropractic (Limited to 30 visits per calendar year)	$25 copay	25% co-insurance, after deductible
Hospice Care (2 consecutive 6 months period of allowable benefits)	$150 admission copay, plus 10% co-insurance	25% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Skilled Nursing Facility (120 days of confinement per lifetime)	10% co-insurance, after deductible	25% co-insurance, after deductible
Home Health Care (As Medically Necessary)	10% co-insurance, after deductible	25% co-insurance, after deductible

Vision Benefits	
Covered Services	Maximum Allowance
Eye Exam by MD or OD (Ophthamalogist or Optometrist)	$35.00
Lenses and Frames (Combined allowance)	
Single Vision	$60.00
Bifocal Vision	$70.00
Trifocal Vision	$80.00
Lenticular	$110.00
Contact Lenses	
Medically Necessary*	$150.00
Elective	$60.00
Including Exam	$95.00

*This is allowed for expenses incurred for contact lenses only if necessary after cataract surgery, or where visual acuity is not correctable 20/70 in either eye with conventional lenses; but, can be corrected to at least 20/70 in one eye with contact lenses.

PRESCRIPTION DRUG BENEFITS (Mandatory Generic Substitution)*	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	15% co-insurance, after deductible	Not Covered
Preferred Brand Drugs	20% co-insurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	30% co-insurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	5% co-insurance, after deductible	Not Covered
Preferred Brand Drugs	15% co-insurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% co-insurance, after deductible	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.		

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

SHORT TERM DISABILITY BENEFITS

Benefits payable the 1st day of an accident, 8th day of a sickness, for 26 weeks

Weeks 1-4 ..... $250
Weeks 5-26 ..... $300

DEATH BENEFIT

Employee $20,000

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

For loss of:

Life	Full Benefit
Both Hands	Full Benefit
Both Feet	Full Benefit
Both Eyes	Full Benefit
One Hand and One Foot	Full Benefit
One Hand One Eye	Full Benefit
One Foot and One Eye	Full Benefit
One Hand	One-Half of the Full Benefit
One Foot	One-Half of the Full Benefit
One Eye	One-Half of the Full Benefit

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means the total and permanent loss of the sight of the eye.