II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual	$250	$500
Family	$750	$1,500
Co-insurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	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
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
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	20% co-insurance, after deductible	40% co-insurance, after deductible
Laboratory Services	20% co-insurance, after deductible	40% co-insurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% co-insurance, after deductible	40% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Nervous Expense Inpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
Outpatient	$20 copay	40% co-insurance, after deductible
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
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)	20% coinsurance, after deductible, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum
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

Benefits payable, on the 1st day of an accident, 8th day of a sickness for a weekly benefit of $600 for up 52 Weeks.

EMPLOYEE DEATH BENEFIT

Active Employee $75,000
Retired Employee..... $5,000

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