

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.

Weeks 1-52 \$600

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