II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $250 $750	 $250 $750
Coinsurance After Deductible	20%	35%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum	$2,000 per person includes Annual Deductible	$2,000 per person includes Annual Deductible
Hospital Pre-Certification Penalty	$100	
Physician Office Visits -Primary Care Physician	20% coinsurance, after deductible	35% coinsurance, after deductible
-Specialist	20% coinsurance, after deductible	35% coinsurance, after deductible
Preventative Care (Includes immunizations, routine physical exam, Pap, colon, blood, sigmoidoscopy, lab and X-ray testing)	20% coinsurance, after deductible	35% coinsurance, after deductible
Well Child Care and Immunization	No Charge	No Charge
Mammogram Age 35-39- One baseline mammogram Age 40 & Up- Annually	20% coinsurance, after deductible less $85 paid at 100%	20% coinsurance, after deductible less $85 paid at 100%
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	15% coinsurance, after deductible	$350 plus 35% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	35% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Organ Transplant	20% coinsurance, after deductible	35% coinsurance, after deductible
Hospital Charges for Dental Surgery (Up to $5,000 per event)	50% coinsurance, after deductible	35% coinsurance, after deductible
Self-Inflicted Injuries (Up to $5,000 per event)	50% coinsurance, after deductible	35% coinsurance, after deductible
Treatment of Varicose Veins	20% coinsurance, after deductible	35% coinsurance, after deductible
Mental and Nervous Expense -Inpatient	15% coinsurance, after deductible	35% coinsurance, after deductible
-Outpatient • Office	20% coinsurance, after deductible	35% coinsurance, after deductible
• Hospital	15% coinsurance, after deductible	35% coinsurance, after deductible
Substance Abuse -Inpatient	15% coinsurance, after deductible	35% coinsurance, after deductible
-Outpatient • Office	20% coinsurance, after deductible	35% coinsurance, after deductible
• Hospital	15% coinsurance, after deductible	35% coinsurance, after deductible
Cardiac Rehabilitation	20% coinsurance, after deductible	35% coinsurance, after deductible
Skilled Nursing Facility & Rehabilitation Therapy (Covered if pre-certified only)	20% coinsurance, after deductible	35% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Home Health Care	20% coinsurance, after deductible	35% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed the purchase price)	20% coinsurance, after deductible	35% coinsurance, after deductible
External Prosthetic Devices	20% coinsurance, after deductible	35% coinsurance, after deductible
-Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgentic alopecia- male pattern baldness)	20% coinsurance, after deductible, up to a maximum of $350	35% coinsurance, after deductible, up to a maximum of $350
Oxygen, Outpatient or portable (The one-time cost of an oxygen concentrator, if applicable)	20% coinsurance, after deductible	35% coinsurance, after deductible
Physical, Occupational, and Speech Therapy	20% coinsurance, after deductible	35% coinsurance, after deductible
Chiropractic Therapy	20% coinsurance, after deductible	35% coinsurance, after deductible
Prolo Therapy	20% coinsurance, after deductible	35% coinsurance, after deductible
Acupuncture	20% coinsurance, after deductible	35% coinsurance, after deductible
Hearing Aid (One pair in any 5-consecutive year period)	20% coinsurance, after deductible	35% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail (30-Day Supply)		
Generic	$7	Not Covered
Brand Name	$15	Not Covered
Preferred Drugs (Applies to Lovestatin, OTC Prilosec & OTC Loratidine only)	No Charge	Not Covered
Non Preferred Brand	$25	Not Covered
Mail Order (90-Day Supply)		
Generic	$14	Not Covered
Brand Name	$30	Not Covered
Non Preferred Brand	$50	Not Covered

Vision Benefit for You and Your Dependents

Annual Benefit Maximum ..... $135 per person
Annual Deductible ..... None
Percentage Paid ..... Plan pays 100%

SHORT TERM DISABILITY

Maximum Benefit ..... 55% of weekly earnings, up to $250 per week
Maximum Payment Period ..... 26 weeks
Benefits Begin ..... 1st day of disability due to accident
..... 1st day of hospitalization
..... 1st day of outpatient surgery
..... 8th day of disability due to sickness

EMPLOYEE DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

Death Benefit for You $15,000

Death Benefit for Your Dependents

Spouse	$2,500
Child	
15 days but less than 1 year old	$100
1 year but less than 18 years old	$2,500

Accidental Death and Dismemberment for you up to $7,500
(determined by severity of injury)

Loss of:

Life	$7,500
Both hands or both feet or sight of both eyes	$7,500
One hand and one foot	$7,500
One hand and the sight of one eye	$7,500
One foot and the sight of one eye	$7,500
One hand or one foot	$3,750
Sight of one eye	$3,750

Dental Benefits provided by Delta Dental

You may call

1-800-452-9310	for Customer Service
1-800-335-8265 (DELTA-OK)	For Providers in your area

You may also obtain information on their visit their website at www.deltadentalnj.com