## II. SCHEDULE OF BENEFITS

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Calendar Year Deductible**<br>-Individual | $150 | $150 |
| -Family | $450 | $450 |
| **Coinsurance After Deductible** | 20% | 30% |
| **Lifetime Maximum**<br>(Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits) | Unlimited | |
| **Out-of-Pocket Maximum**<br>-Individual | $5,000 | $5,000 |
| -Family | None | None |
| **Physician Office Visits**<br>-"MyHealth Center" (Worksite Health Clinic) | $10 copay | |
| -Primary Care Physician | $20 copay | 30% coinsurance, after deductible |
| -Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrist, etc.) | $20 copay | 30% coinsurance, after deductible |
| **Telehealth Platform, Powered by Teladoc™** (No member out-of-pocket, unlimited utilization)<br>You may call if you have account questions or need assistance with creating an account at:<br>1-800-835-2362 (Teladoc) | $0 copay | |
| **Preventative Care Benefits**<br>(One annual exam per calendar year, includes blood screening, urine tests, chest x-ray, EKG & mammography) | No Charge | 30% coinsurance, after deductible |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Women's Pelvic Health through The Fund's partner Bloom** (No member out-of-pocket, unlimited utilization)<br>You may obtain information on their website at:<br>https://join.hibloom.com | $0 copay | |
| **Diagnostic Tests** (X-rays and blood tests) | 20% co-insurance, after deductible | 30% co-insurance, after deductible |
| **Imaging Services** (CT and MRI scans require prior authorization) | 20% co-insurance, after deductible | 30% co-insurance, after deductible |
| **Ambulance** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Emergency Room**<br>(Waived if admitted) | $50 copay | $50 copay plus 30% coinsurance, after deductible |
| **Hospital Pre-Certification Penalty** | 50% of benefits up to a maximum of $5,000 | |
| **Hospital**<br>Daily Hospital Room and Board, Semi-Private and other allowable expenses | No Charge | 30% coinsurance, after deductible |
| **Maternity Care Services**<br>-Office Visits | $20 copay | 30% coinsurance, after deductible |
| -Childbirth/ professional delivery services (Obstetrician, surgeon, etc.) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| -Childbirth/ delivery facility services (Hospital, childbirth center, etc.) | No Charge | 30% coinsurance, after deductible |
| **Outpatient Hospital Services**<br>-Surgical | No Charge | 30% coinsurance, after deductible |
| -Non-Surgical | 20% coinsurance, after deductible | 30% coinsurance, after deductible |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Mental Health and Substance Abuse**<br>-Inpatient | No Charge | 30% coinsurance, after deductible |
| -Teladoc™ | $0 Copay | |
| -Outpatient<br>• Office | $20 copay | 30% coinsurance, after deductible |
| • Hospital | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Cancer Navigator Services** (No member out-of-pocket)<br>You may reach an Oncology Nurse Navigator at: 201-308-6555 (8am -6pm ET, M-F) | $0 copay | |
| **Skilled Nursing Care** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Home Health** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Durable Medical Equipment**<br>Total rental not to exceed purchase price | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **External Prosthetic Devices**<br>-Wigs, toupees or hair pieces<br>(Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenetic alopecia- male pattern baldness. Limited to a maximum benefit of $350.) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Physical, Occupational, and Speech Therapy** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Virtual Physical Therapy** (No member out-of-pocket, unlimited utilization)<br>You may obtain information on their website at:<br>**https://meet.swordhealth.com/ufcwnational** | $0 copay | |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Chiropractic Benefits** (Maximum of 12 visits per calendar year) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Hearing Aids** (Limited to $1,000 per year every 3 years) | No Charge | No Charge |

| VISION SERVICES | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| Benefits payable every 12 months with the following maximums. | | |
| Eye Exam | No Charge | No Charge |
| Frames/ Lenses | Covered in full up to $300 per person | Covered in full up to $300 per person |

| PRESCRIPTION DRUG BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Retail 30-Day Supply** | | |
| Generic | $5 copay | Not Covered |
| Preferred Brand Name | 20% coinsurance | Not Covered |
| Non-Preferred Brand Name | 20% coinsurance | Not Covered |
| **Mail Order Specialty Drugs 30-Day Supply (Requires prior authorization)** | | |
| Generic | $5 copay | Not Covered |
| Preferred Brand Name | 20% coinsurance | Not Covered |
| Non-Preferred Brand Name | 20% coinsurance | Not Covered |

| PRESCRIPTION DRUG BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Mail Order 90-Day Supply** | | |
| Generic | $10 copay | Not Covered |
| Preferred Brand Name | 20% coinsurance | Not Covered |
| Non-Preferred Brand Name | 20% coinsurance | Not Covered |

**Prescription Drug Benefits**
Provided by EmpiRx Health: Call 1-877-241-7123 for Member Services

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

## EMPLOYEE DEATH BENEFIT

Employee Death Benefit..... $20,000

## EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life ..... $20,000
Both Hands or Both Feet..... $10,000
Entire Sight of Both Eyes ..... $10,000
One Hand and One Foot..... $10,000
One Hand or One Foot and Entire Sight of One Eye ..... $10,000
One Hand or One Foot ..... $5,000
Entire Sight of One Eye ..... $5,000

Maximum payment for this benefit per occurrence is..... $10,000