II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
-Individual	$150	$150
-Family	$450	$450
Coinsurance After Deductible	20%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum		
-Individual	$5,000	$5,000
-Family	None	None
Physician Office Visits		
-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) You may call if you have account questions or need assistance with creating an account at: 1-800-835-2362 (Teladoc)	$0 copay	
Preventative Care Benefits (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) You may obtain information on their website at: 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 (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 Daily Hospital Room and Board, Semi-Private and other allowable expenses	No Charge	30% coinsurance, after deductible
Maternity Care Services -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 -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 -Inpatient	No Charge	30% coinsurance, after deductible
-Teledoc™	$0 copay	
-Outpatient • Office	$20 copay	30% coinsurance, after deductible
• Hospital	20% coinsurance, after deductible	30% coinsurance, after deductible
Cancer Navigator Services (No member out-of-pocket) 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 Total rental not to exceed purchase price	20% coinsurance, after deductible	30% coinsurance, 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. 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) You may obtain information on their website at: **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

VISION SERVICES	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Benefits payable during any two (2) year period with the following maximums		
Eye Exam	No Charge	No Charge
Frames/ Lenses	Covered in full up to $100 per person	Covered in full up to $100 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
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..... $50,000

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life	$50,000
Both Hands or Both Feet.....	$25,000
Entire Sight of Both Eyes	$25,000
One Hand and One Foot.....	$25,000
One Hand or One Foot and Entire Sight of One Eye	$25,000
One Hand or One Foot	$12,500
Entire Sight of One Eye	$12,500

Maximum payment for this benefit per occurrence is $25,000