II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $250 $500	 $250 $500
Coinsurance After Deductible	20%	30%
Out-of-Pocket Maximum Individual Family	 $6,850 $13,700	 $13,700 $41,000
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical expenses and prescription benefits)	Unlimited	
Physician Office Visits and Other Eligible Office Expenses Primary Doctor	20% coinsurance, after deductible	30% coinsurance, after deductible
Specialist (Includes cardiologist, psychiatrists, dermatologists, podiatrists, etc.)	20% coinsurance, after deductible	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 including 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	
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	$50 copay, plus 20% coinsurance	$50 copay, plus 20% coinsurance
Urgent Care	20% coinsurance, after deductible	20% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	30% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	30% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Hospital Benefits Daily Hospital Room and Board, Semi-Private and other allowable expenses	No Charge	30% coinsurance, after deductible
Maternity Care Services Office Visits	20% coinsurance, after deductible	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
Breast Pump (Limited to a maximum benefit of $250)	No Charge	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Substance Use Disorder Inpatient	No Charge	30% coinsurance, after deductible
Teledoc™	$0 copay	
Outpatient	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 Facility	20% coinsurance, after deductible	30% coinsurance, after deductible
Home Health Care	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.)	30% coinsurance, after deductible	50% coinsurance, after deductible
Physical, Occupational and Speech Therapy (excludes Chiropractic care)	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	
Chiropractic (Limited up to 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Vision Benefits (Payable during any (2) year period with maximums)		
Eye Exam	No Charge	No Charge
Frame/Lenses	Covered in full up to $100 per person	Covered in full up to $100 per person

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Mail-Order Specialty Drugs 30-Day Supply (Requires prior authorization)		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	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

Dental Benefits
Provided by Delta Dental- call 1-800-452-9310 for Customer Service
1-800-335-8265 for Providers in your area

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

SHORT TERM DISABILITY

Benefits payable the 1st day of an accident, 7th day of a sickness, for 26 weeks:

Weeks 1-26 ..... $500