II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $300 $600	 $10,000 $20,000
Out-of-Pocket Maximum (Includes deductibles, copays and coinsurance) Individual Family	 $5,000 $10,000	 $30,000 $60,000
Coinsurance After Deductible	20%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits.)	Unlimited	
Physician Office Visits and Other In-office Services -Primary Care Physician	$30 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
-Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$50 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% 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	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Preventative Care Benefits (Routine exams, x-rays/ tests, immunization, well baby care and mammograms)	No Charge	50% coinsurance, after deductible
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	
Urgent Care Center Services -General Physician	$30 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
-Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	$50 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (copay waived if admitted)	20% coinsurance, after deductible	20% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi-Private and other allowable expenses Inpatient	20% coinsurance, after deductible	50% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Outpatient	20% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Hospital and Physician Services	20% coinsurance, after deductible	50% coinsurance, after deductible
- Ambulatory Surgery Center and Physician Services	No Charge	50% coinsurance, after deductible
Maternity Care Services -Prenatal Care	No Charge	No Charge
-Postnatal Care	20% coinsurance, after deductible	50% coinsurance, after deductible
-All other hospital and physician services	20% coinsurance, after deductible	50% coinsurance, after deductible
Breast Pump (Limited to a maximum benefit of $250)	No Charge	50% coinsurance, after deductible
Mental and Substance Abuse Services		
-Inpatient	20% coinsurance, after deductible	50% coinsurance, after deductible
Teledoc™	$0 copay	
-Outpatient	$30 copay	50% coinsurance, after deductible
• Other covered services	10% coinsurance No deductible	50% 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	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospice	20% coinsurance, after deductible	Not Covered
Skilled Nursing Facility (Limited up to 120 days per confinement)	20% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	Not Covered
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	50% coinsurance, after deductible
External Prosthetic Devices -Wigs, toupees or hairpieces (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	50% coinsurance, after deductible
Physical, Occupational and Speech Therapy	20% coinsurance, after deductible	50% 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 Services	20% coinsurance, after deductible	50% coinsurance, after deductible
Eyewear for children under the age of 19 (1 pair standard frame and lenses or contact lenses)	20% coinsurance, after deductible	Not Covered

PRESCRIPTION DRUG PLAN (Mandatory Generic Substitution Applies*)	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$10 copay	Not Covered
Brand Formulary Drugs	$50 copay	Not Covered
Brand Non-Formulary Drugs	$150 copay	Not Covered
Mail Order Specialty Drugs 30-Day Supply (Requires Prior Authorization)		
Specialty Drugs	20% coinsurance to a maximum of $300	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$30 copay	Not Covered
Brand Formulary Drugs	$150 copay	Not Covered
Brand Non-Formulary Drugs	$450 copay	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.