II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 None None	 $300 $600
Coinsurance After Deductible	10%	25%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $1,000 $2,000	 $2,000 $4,000
Physician Office Visits and other eligible office expense	$10 copay	25% 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 (One per calendar year) Pap Smear Benefit	 No Charge	 Not Covered
Mammograms -Age 39 and under	 No Charge	 Not Covered
-Age 40 and over	No Charge	Not Covered
Childhood Immunizations (Birth to age 5)	No Charge	Not Covered
Office visits for above services	$10 copay	Not Covered

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	10% coinsurance, after deductible	25% coinsurance, after deductible
Emergency Room	10% coinsurance, after deductible	25% coinsurance, after deductible
Hospital Pre-Certification Penalty	$250	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	$150 admission copay, plus 10% coinsurance	25% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	10% coinsurance, after deductible	25% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	10% coinsurance, after deductible	25% coinsurance, after deductible
Maternity Care Services Office Visits	$10 copay	25% coinsurance, after deductible
Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	$150 copay plus 10% coinsurance, after deductible	25% coinsurance, after deductible
Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	10% coinsurance, after deductible	25% coinsurance, after deductible
Mental Health Inpatient	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Teladoc™	$0 copay	
Outpatient	$10 copay	25% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Alcohol and Substance Abuse (Limited to 2 confinements per lifetime) Inpatient	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Teladoc™	$0 copay	
Outpatient	$10 copay	25% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	10% coinsurance, after deductible	25% 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)	10% coinsurance, after deductible	25% 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 (120 allowable days of confinement per lifetime)	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Home Health (Nursing) Care	10% coinsurance, after deductible	25% coinsurance, after deductible
Hospice Care (2 consecutive 6-month periods)	$150 admission copay plus 10% coinsurance	25% coinsurance, after deductible
Physical Therapy	$10 copay	25% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
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 to 30 visits per calendar year)	$10 copay	25% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In- Network	**Out-of-Network**
Retail Copayment 30-Day Supply		
Generic Drugs	$7.50	Not Covered
Brand Name Drugs	$15.00	Not Covered
Non- Preferred Brand Name Drugs	$15.00	Not Covered
Mail Order Specialty Drugs 30-Day Supply (Requires prior authorization)		
Generic Drugs	$7.50	Not Covered
Brand Name Drugs	$15.00	Not Covered
Non- Preferred Brand Name Drugs	$15.00	Not Covered
Mail-Order 90-Day Supply (mandatory for maintenance medications after 1 prescription at retail)		
Generic Drugs	$15.00	Not Covered
Brand Name Drugs	$30.00	Not Covered
Non- Preferred Brand Name Drugs	$30.00	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

Vision Benefits
Provided by VSP- call 1-800-877-7195 for Customer Service

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

SHORT TERM DISABILITY

Benefits payable the 1st day of an accident, 8th day of a sickness, for 26 weeks:

Weeks 1-4 ..... $250
Weeks 5-26 ..... $300

DEATH BENEFIT

Employee $20,000