

II. SCHEDULE OF BENEFITS

CORE PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
Out-of-Pocket Maximum		
Individual	\$9,200	Unlimited
Family	\$18,400	Unlimited
Co-insurance After Deductible	30%	60%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits.)	Unlimited	
Physician Office Visits		
Primary Physician	\$50 copay	60% co-insurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	\$75 copay	60% co-insurance, 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	
Preventive Care	No Charge	60% co-insurance, No Deductible

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	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	
Infertility Counseling and Testing	30% co-insurance, after deductible	60% co-insurance, after deductible
Allergy Testing and Injections	30% co-insurance, after deductible	60% co-insurance, after deductible
Radiology (X-ray) and Laboratory Services Diagnostic	30% co-insurance, after deductible	60% co-insurance, after deductible
Routine Preventative Radiology and Laboratory Testing	No Charge	60% co-insurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	30% co-insurance, after deductible	60% co-insurance, after deductible
Ambulance Emergent Non-Emergent	30% co-insurance, after deductible	30% co-insurance, after deductible
	30% co-insurance, after deductible	30% co-insurance, after deductible
Emergency Care Hospital ER (Copay waived if admitted) Urgent Care Center	\$750 copay	\$750 copay
	\$35 copay	\$35 copay
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient Services	30% co-insurance, after deductible	60% co-insurance, after deductible

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	In-Network	Out-of-Network
Outpatient Services	30% co-insurance, after deductible	60% co-insurance, after deductible
Maternity Care Services		
Office visits	\$50 copay	60% co-insurance, after deductible
Childbirth/ Delivery Professional Services (Obstetricians, surgeons, etc.)	30% co-insurance, after deductible	60% co-insurance, after deductible
Childbirth/ Delivery Facility Services (Hospital, birthing centers, etc.)	30% co-insurance, after deductible	60% co-insurance, after deductible
Breast Pump (Limited to a maximum benefit of \$250)	No Charge	60% coinsurance, after deductible
Mental and Substance Abuse		
Inpatient Hospital	30% co-insurance, after deductible	60% co-insurance, after deductible
Teladoc™	\$0 copay	
Outpatient		
-Hospital	30% co-insurance, after deductible	60% co-insurance, after deductible
-Office	\$50 copay	60% co-insurance, 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 Limited 100 days per calendar year.	30% co-insurance, after deductible	60% co-insurance, after deductible
Private Duty Nursing	30% co-insurance, after deductible	60% co-insurance, after deductible

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	In-Network	Out-of-Network
Home Health Care	30% co-insurance, after deductible	60% co-insurance, after deductible
Hospice	30% co-insurance, after deductible	60% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	30% co-insurance, after deductible	60% co-insurance, 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% co-insurance, after deductible	60% co-insurance, after deductible
Respiratory Therapy	30% co-insurance, after deductible	60% co-insurance, after deductible
Physical Therapy Limited to 20 visits per calendar year	\$75 copay	60% co-insurance, 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	
Speech and Occupational Therapy Limited to 20 visits per calendar year. Other Therapies	\$75 copay	60% co-insurance, after deductible
	30% co-insurance, after deductible	60% co-insurance, after deductible
Chiropractic Services Limited to 20 visits per calendar year.	\$75 copay	60% co-insurance, after deductible
Accidental Dental Treatment	30% co-insurance, after deductible	60% co-insurance, after deductible

CORE PLAN

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic Drugs	\$15 copay	Not Covered
Brand Name Drugs	\$50 copay	Not Covered
Non – Preferred Brand Name Drugs	\$75 copay	Not Covered
Mail Order Specialty Drugs 30-Day Supply (Requires prior authorization)		
Specialty Prescription Drugs	\$300 copay	Not Covered
Mail Order 90-Day Supply		
Generic Drugs	\$37.50 copay	Not Covered
Brand Name Drugs	\$125 copay	Not Covered
Non – Preferred Brand Name Drugs	\$187.50 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.