II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $3,300 $6,600	 $3,300 $6,600
Coinsurance After Deductible	20%	40%
Out-of-Pocket Maximum (Includes deductible) Individual Family	 $6,000 $12,000	 $6,000 $12,000
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Physician Office Visits Primary care physician	20% coinsurance, after deductible	40% coinsurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	20% coinsurance, after deductible	40% 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 (Physical exams, lab, x-ray, immunization, vaccinations, Pap smears, mammogram, PSA tests, well childcare visits, eye & ear exams)	No Charge	40% 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	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance (Medically necessary transportation to the nearest facility)	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Waived if admitted)	$50 copay	$50 copay
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	40% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	40% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $250	
Hospital Daily Hospital Room and Board Semi Private and other allowable expenses	20% coinsurance, after deductible	40% coinsurance, after deductible
Maternity Services		
Office Visits	20% coinsurance, after deductible	40% coinsurance, after deductible
Prenatal and postnatal services	20% coinsurance, after deductible	40% coinsurance, after deductible
All other hospital and physician services	20% coinsurance, after deductible	40% coinsurance, after deductible
Breast Pump (Limited to a maximum benefit of $250)	No Charge	40% coinsurance, after deductible
Mental and Substance Use Disorder		
Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Teledoc™	$0 copay	
Outpatient	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
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	
Cardiac Rehabilitation	20% coinsurance, after deductible	40% coinsurance, after deductible
Hospice Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Skilled Nursing Facility (60 day maximum)	20% coinsurance, after deductible	Not Covered
Home Health Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% coinsurance, after deductible	40% 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	40% coinsurance, after deductible
Physical, Speech & Occupational Therapy (Each therapy requires a maximum of 24 visits per calendar year.)	20% coinsurance, after deductible	40% 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 to 40 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Dental Care*	20% coinsurance, after deductible	40% coinsurance, after deductible
*Accidental injury to sound natural teeth; treatment of cleft lip and palate for a dependent child under under 18; anesthesia and inpatient and outpatient hospital charges for dental care provided to a covered person who is: a child under age 5; or is severely disabled; or has a medical condition that requires hospitalization.		

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network Only	**Out-of-Network**
Retail 30-Day Supply Generic	$10 copay	Not Covered
Preferred Brand Name Drugs	20% coinsurance, up to $40 maximum	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, up to $60 maximum	Not Covered
Mail-Order Specialty Drugs 30-Day Supply (Requires prior authorization)		
Specialty Drugs	20% coinsurance, up to $100 maximum	Not Covered
Mail-Order or Retail 90-Day Supply Generic	$20 copay	Not Covered
Preferred Brand Name Drugs	20% coinsurance, up to $80 maximum	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, up to $120 maximum	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