

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$750	\$1,500
Family	\$2,250	\$4,500
Coinsurance After Deductible	20%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum		
Individual	\$6,350	\$12,700
Family	\$12,700	\$38,100
Physician Office Visits		
Primary Care Physician	20% co-insurance, No Deductible	50% co-insurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	20% co-insurance, No Deductible	50% 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	
Preventative Care Members Age 19 & Older Physical exams, immunization, diagnostic X-ray & Lab, mammogram (one per calendar year)	No Charge	No Charge

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Well Child Care for Dependent Children Routine Physical exam & immunization from Birth – Age 18 (Up to 3 visits per calendar year from Age 12-18)	No Charge	No Charge
Eye Refraction Examination (Limited to 1 per calendar year)	No Charge	No Charge
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	
Ambulatory Surgical Centers	10% co-insurance, after deductible	50% co-insurance, after deductible
Emergency Room (Waived if admitted)	\$150 copay plus 25% co-insurance	\$150 copay plus 25% co-insurance
Hospital Pre-Certification Penalty	\$600	
Hospital (Pre-Certification required) Daily Hospital Room and Board, Semi Private and other allowable expenses	20% co-insurance, after deductible	50% co-insurance, after deductible
Diagnostic Tests (X-rays and blood tests)	20% co-insurance, after deductible	50% co-insurance, after deductible
Imaging Services (CT and MRI require prior authorization)	20% co-insurance, after deductible	50% co-insurance, after deductible
Maternity Care Services		
Office Visits	20% co-insurance, after deductible (waived for office visits)	50% co-insurance, after deductible
Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	20% co-insurance, after deductible	50% co-insurance, after deductible
Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	20% co-insurance, after deductible	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Breast Pump (Limited to a maximum benefit of \$250)	No Charge	50% co-insurance, after deductible
Mental, Nervous and Substance Abuse Expense		
Inpatient	20% co-insurance, after deductible	50% co-insurance, after deductible
Teladoc™	\$0 copay	
Outpatient	20% co-insurance, after deductible	50% 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	
Hospice Care (Limited to 6 months during each insured person's lifetime for inpatient, home hospice & bereavement counseling services)	10% co-insurance, after deductible	50% co-insurance, after deductible
Skilled Nursing Facility	10% co-insurance, after deductible	50% co-insurance, after deductible
Home Health Care (Up to 100 visits per calendar year, 1 visit by home health aide equals 4 hours or less. Not covered while insure person receives hospice care)	10% co-insurance, after deductible	50% co-insurance, after deductible
Durable Medical Equipment & Prosthetics (As medically necessary. Total rental not to exceed purchase price)	20% co-insurance, after deductible	50% 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.)	20% coinsurance, after deductible	50% coinsurance, after deductible

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	In-Network	Out-of-Network
Temporomandibular Joint Disorders	20% co-insurance, after deductible	50% co-insurance, after deductible
Rehabilitative Services		
Physical Therapy (Limited to 60 visits per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
-Physical Medicine (Limited to 60 visits per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
-Occupational Therapy (Limited to 60 visits per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
-Chiropractic Services (Limited to 60 visits per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
-Speech Therapy (Limited to 50 visits per calendar year)	20% co-insurance, after deductible	50% 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	
Acupuncture (Up to 12 visits per calendar year and limited to \$30 per visit)	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient Medical Services & Supplies, Inc. (i.e. ground & air ambulance transportation, services & disposable supplies, blood transfusions, blood processing & the cost of unreplaced blood & blood products, autologue blood)	20% co-insurance, after deductible	50% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic Drugs	20% (\$15 min, \$30 max)	50% (\$15 min, \$30 max)
Formulary Brand Name Drugs	30% (\$30 min, \$60 max)	50% (\$30 min, \$60 max)
Non-Formulary Brand Name Drugs	30% (\$45 min, \$90 max)	50% (\$45 min, \$90 max)
Mail Order Specialty Drugs 30-Day Supply (Requires prior authorization)		
Specialty Drugs (except insulin)	20% of covered expense. Up to \$150 copay maximum	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	20% (\$30 min, \$60 max)	50% (\$15 min, \$30 max)
Formulary Brand Name Drugs	30% (\$60 min, \$120 max)	50% (\$30 min, \$60 max)
Non-Formulary Brand Name Drugs	30% (\$90 min, \$180 max)	50% (\$45 min, \$90 max)

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