

## II. SCHEDULE OF BENEFITS

<b>SUMMARY OF BENEFITS</b>	<b>YOUR SHARE OF ELIGIBLE EXPENSE</b>	
	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Calendar Year Deductible</b> Individual Family	\$5,000 \$10,000	\$10,000 \$30,000
<b>Coinsurance After Deductible</b>	20%	50%
<b>Lifetime Maximum</b> (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
<b>Out-of-Pocket Maximum</b> Individual Family	\$6,600 \$13,200	\$13,200 \$39,600
<b>Physician Office Visits</b> Primary Care Physician	No Cost for the first 3 visits.  After first 3 visits, 20% co-insurance, after deductible	50% co-insurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrist, etc.)	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Telehealth Platform, Powered by Teladoc™</b> (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	

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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Preventative Care</b> (One exam per year for adults. Includes Physical Exams, Mammography, etc.)	No Charge	50% co-insurance, after deductible
	No Charge	50% co-insurance, after deductible
	No Charge	50% co-insurance, after deductible
<b>Women's Pelvic Health through The Fund's partner Bloom</b> (No member out-of-pocket, unlimited utilization) You may obtain information on their website at: <a href="https://join.hibloom.com">https://join.hibloom.com</a>	\$0 copay	
<b>Infertility Treatment</b>	Not Covered	Not Covered
<b>Diagnostic Tests</b> (X-rays and blood tests)	20% coinsurance, after deductible	50% coinsurance, after deductible
<b>Imaging Services</b> (CT and MRI scans require prior authorization)	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Ambulance</b>	20% co-insurance, after deductible	20% co-insurance, after deductible
<b>Emergency Room</b>	20% co-insurance, after deductible	20% co-insurance, after deductible
<b>Hospital</b> Daily Hospital Room and Board, Semi Private and other allowable expenses	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Pregnancy &amp; Maternity</b>	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Breast Pump</b> (Limited to a maximum benefit of \$250)	No Charge	50% coinsurance, after deductible

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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Mental, Nervous and Substance Abuse Expense</b>		
Inpatient	20% co-insurance, after deductible	50% co-insurance, after deductible
Teladoc™	\$0 Copay	
<b>Outpatient</b>	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Outpatient X-ray and Laboratory</b>	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
	\$0 copay	
<b>Cancer Navigator Services</b> (No member out-of-pocket)  You may reach an Oncology Nurse Navigator at:  201-308-6555 (8am -6pm ET, M-F)		
	\$0 copay	
<b>Skilled Nursing Facility</b> (Limited up to 100 facility days per calendar year.)	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Home Health Care</b> (Limited up to 100 days per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Durable Medical Equipment &amp; Prosthetics</b> (As medically necessary. Total rental not to exceed purchase price)	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>External Prosthetic Devices</b>  -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
	20% coinsurance, after deductible	50% coinsurance, after deductible
	20% coinsurance, after deductible	50% coinsurance, after deductible

<b>SUMMARY OF BENEFITS</b>	<b>YOUR SHARE OF ELIGIBLE EXPENSE</b>	
	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Physical Therapy</b> (Includes chiropractic)	20% co-insurance, after deductible	50% co-insurance, after deductible
<b>Virtual Physical Therapy</b> (No member out-of-pocket, unlimited utilization)  You may obtain information on their website at: <a href="https://meet.swordhealth.com/ufcwnational">https://meet.swordhealth.com/ufcwnational</a>		\$0 copay
<b>Speech &amp; Occupational Therapy</b>	20% co-insurance, after deductible	50% co-insurance, after deductible

<b>PRESCRIPTION DRUG BENEFITS</b>	<b>YOUR SHARE OF ELIGIBLE EXPENSE</b>	
	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Retail 30-Day Supply</b>		
Generic Drugs	20% co-insurance, after deductible	Not Covered
Formulary Brand Drugs	20% co-insurance, after deductible	Not Covered
Non-Formulary Brand Drugs	20% co-insurance, after deductible	Not Covered
<b>Mail Order 30-Day Supply</b>		
<b>Specialty Drugs</b> (Requires prior authorization)	20% co-insurance, after deductible	Not Covered
<b>Mail Order 90-Day Supply</b>		
Generic Drugs	20% co-insurance, after deductible	Not Covered
Formulary Brand Drugs	20% co-insurance, after deductible	Not Covered
Non-Formulary Brand Drugs	20% co-insurance, after deductible	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](http://www.empirxhealth.com)