II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual	$250	$250
Family	$500	$500
Coinsurance After Deductible	20%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (includes deductibles and copays) Individual	$7,900	None
Family	$15,800	None
Physician Office Visits and Other In-Office Services Primary Care Physician	20% coinsurance, after deductible	30% coinsurance, after deductible
Specialist (Includes cardiologists, dermatologists, podiatrist, etc.)	20% coinsurance, after deductible	30% 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 (One annual exam per calendar year including blood screening, urine, tests, chest x-ray, EKG, & mammography at in-network provider)	No Charge	30% coinsurance, after deductible

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	
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	30% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	30% coinsurance, after deductible
Outpatient Surgery Center Facility	No Charge	30% coinsurance, after deductible
Physician/Surgeon Fees	20% coinsurance, after deductible	30% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Waived if admitted)	$50 copay, then 20% coinsurance	$50 copay, then 20% coinsurance
Urgent Care Center Services	20% coinsurance, after deductible	20% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses Facility	No Charge	30% coinsurance, after deductible
Physician/Surgeon Fees	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Maternity Care Services Office Visits	20% coinsurance, after deductible	30% coinsurance, after deductible
Childbirth/professional delivery services (Obstetrician, surgeon, etc.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Breast Pump (Limited to a maximum benefit of $250)	No Charge	30% coinsurance, after deductible
Mental Health and Substance Use Disorder Inpatient	No Charge	No Charge
Teladoc™	$0 copay	
Outpatient	0% coinsurance, after deductible	30% 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	
Home Health (Nursing) Care	20% coinsurance, after deductible	30% coinsurance, after deductible
Skilled Nursing Facility	20% coinsurance, after deductible	30% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	30% 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/female pattern baldness. Limited to a maximum benefit of $350.)	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Speech Therapy (To restore lost function after a stroke or during behavioral health treatment)	20% coinsurance, after deductible	30% coinsurance, after deductible
Physical & Occupational Therapy Services	20% coinsurance, after deductible	30% 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 Care (Maximum of 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
Vision Benefits Benefits payable during any two (2) year period with the following maximums		
Eye Exam	No Charge	No Charge
Frames/Lenses	Up to $100	Up to a $100

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Mail Order 30-Day Supply		
Specialty Drugs (Requires prior authorization)	20% coinsurance, after deductible	Not Covered

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Mail Order 90-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered

Prescription Drug Benefits
Provided by EmpiRx Health: Call 1-877-908-9438 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

EMPLOYEE DEATH BENEFIT

Employee Death Benefit..... $5,000

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life $5,000
Both Hands or Both Feet..... $5,000
Entire Sight of Both Eyes $5,000
One Hand and One Foot..... $5,000
One Hand or One Foot and Entire Sight of One Eye $5,000
One Hand or One Foot $2,500
Entire Sight of One Eye $2,500

Maximum payment for this benefit per occurrence is..... $5,000