II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	 $250 $500	 $500 $1,000
Out-of-Pocket Maximum Individual Family	 $6,850 $13,700	 $13,700 $41,100
Coinsurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital medical and prescription benefits)	Unlimited	
Physician, Telehealth Office Visits and other eligible office expenses Primary Doctor	$10 copay	40% coinsurance, after deductible
Specialist (Includes cardiologists, dermatologists, podiatrists, etc.)	$25 copay	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 (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG, & mammography)	No Charge	40% 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	
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	$100 copay, plus 20% coinsurance	$100 copay, plus 20% coinsurance
Urgent Care	$25 copay	$25 copay
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	20% coinsurance, after deductible	40% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	40% coinsurance, after deductible
Laboratory Services	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
Outpatient Surgery Facility	No Charge	40% coinsurance, after deductible
-Physician and Surgeon Fees	20% coinsurance, after deductible	40% coinsurance, after deductible
Maternity Care Services Office Visits	$25 copay/visits	40% coinsurance, after deductible
Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	20% coinsurance, after deductible	40% coinsurance, after deductible
Breast Pump (Limited to a maximum benefit of $250)	No Charge	40% coinsurance, after deductible
Mental Health and Substance Use Disorder Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Teladoc™	$0 copay	
Outpatient	20% coinsurance, after deductible	40% 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 Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Skilled Nursing Facility (Inpatient)	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/female pattern baldness. Limited to a maximum benefit of $350.)	20% coinsurance, after deductible	40% coinsurance, after deductible
Physical and Occupational	20% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
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 Therapy (To restore lost function after a stroke or during behavioral health treatment)	20% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic (Up to 12 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$5 copay	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 Specialty Drugs 30-Day Supply (Requires prior authorization)		
Specialty Drugs	20% coinsurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$10 copay	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

IF YOU ELECTED THESE ANCILLARY BENEFITS:

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

Vision Benefits
Provided by VSP: Call 1-800-877-7195 for Customer Service

You may also obtain information on their website at www.vsp.com