

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	\$250 \$500	\$250 \$500
Out-of-Pocket Maximum Individual Family	\$6,850 \$13,700	\$13,700 \$41,100
Coinsurance After Deductible	20%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical, and prescription benefits)	Unlimited	
Physician Office Visits and other eligible office expenses Primary Doctor Specialist (Includes cardiologist, dermatologist, podiatrists, etc.)	20% coinsurance, after deductible 20% coinsurance, after deductible	30% 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)	No Charge	30% 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
Laboratory Services	20% coinsurance, after deductible	30% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	\$50 copay, plus 20% coinsurance	\$50 copay, plus 20% coinsurance
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 facility expenses	No Charge	30% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	30% coinsurance, after deductible
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.)	No Charge	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		
-Hospital Services		
• Inpatient Hospital	No Charge	30% coinsurance, after deductible
• Outpatient Hospital	No Charge	30% coinsurance, after deductible
-Outpatient Doctor's Visits	20% coinsurance, after deductible	30% coinsurance, after deductible

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	In-Network	Out-of-Network
-Teladoc™	\$0 copay	
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	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 androgenic alopecia- male/female pattern baldness. Limited to a maximum of \$350.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Speech Therapy (To restore lost function after a stroke or during behavioral health treatment)	20% coinsurance, after deductible	30% coinsurance, after deductible
Physical and Occupational	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 (Up to 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible

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 (Requires prior authorization)		
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 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.

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.