

## II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Calendar Year Deductible</b> Individual Family	\$250 \$750	\$250 \$750
<b>Out-of-Pocket Maximum</b>	\$2,000 per person includes Annual Deductible	\$2,000 per person includes Annual Deductible
<b>Coinsurance After Deductible</b>	20%	35%
<b>Lifetime Maximum</b> (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
<b>Physician Office Visits</b> -Primary Care Physician	20% coinsurance, after deductible	35% coinsurance, after deductible
-Specialist (Includes cardiologists, dermatologists, podiatrist, etc.)	20% coinsurance, after deductible	35% coinsurance, 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	
<b>Preventative Care</b> (Includes immunizations, routine physical exam, Pap, colon, blood, sigmoidoscopy, lab and X-ray testing)	20% coinsurance, after deductible	35% coinsurance, after deductible
-Well Child Care and Immunization	No Charge	No Charge
-Mammogram Age 35-39- One baseline mammogram Age 40 & Up- Annually	20% coinsurance, after deductible less \$85 paid at 100%	20% coinsurance, after deductible less \$85 paid at 100%

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<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>Ambulance</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Emergency Room Care</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Urgent Care</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Hospital Pre-Certification Penalty</b>	\$100	
<b>Hospital</b> Daily Hospital Room and Board, Semi Private and other allowable expenses	15% coinsurance, after deductible	\$350 plus 35% coinsurance, after deductible
<b>Diagnostic Tests</b> (X-rays and blood tests)	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Imaging Services</b> (CT and MRI require prior authorization)	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Maternity Care Services</b>		
-Office Visits	20% coinsurance, after deductible	35% coinsurance, after deductible
-Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	20% coinsurance, after deductible	35% coinsurance, after deductible
-Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	15% coinsurance, after deductible	35% coinsurance, after deductible
<b>Organ Transplant</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Hospital Charges for Dental Surgery</b> (Up to \$5,000 per event)	50% coinsurance, after deductible	35% coinsurance, after deductible

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	In-Network	Out-of-Network
<b>Treatment of Varicose Veins</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Mental Health and Nervous Expense</b>		
-Inpatient	15% coinsurance, after deductible	35% coinsurance, after deductible
-Teladoc™	\$0 copay	
-Outpatient		
• Office	20% coinsurance, after deductible	35% coinsurance, after deductible
• Hospital	0% coinsurance, after deductible	35% coinsurance, after deductible
<b>Substance Abuse</b>		
-Inpatient	15% coinsurance, after deductible	35% coinsurance, after deductible
-Teladoc™	\$0 copay	
-Outpatient		
• Office	20% coinsurance, after deductible	35% coinsurance, after deductible
• Hospital	0% coinsurance, after deductible	35% coinsurance, after deductible
<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 &amp; Rehabilitation Therapy</b> (Covered if pre-certified <u>only</u> )	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Home Health Care</b>	20% coinsurance, after deductible	35% coinsurance, after deductible

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<b>Cardiac Rehabilitation</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Durable Medical Equipment</b> (Total rental not to exceed the purchase price)	20% coinsurance, after deductible	35% coinsurance, 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/female pattern baldness. Limited to a maximum benefit of \$350.)	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Oxygen, Outpatient or portable</b> (The one-time cost of an oxygen concentrator, if applicable)	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Physical and Occupational Therapy</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Speech Therapy</b> (To restore lost function after a stroke or during behavioral health treatment)	20% coinsurance, after deductible	35% coinsurance, 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>Chiropractic Therapy</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Prolo Therapy</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Acupuncture</b>	20% coinsurance, after deductible	35% coinsurance, after deductible
<b>Hearing Aid</b> (One pair in any 5-consecutive year period)	20% coinsurance, after deductible	35% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Retail 30-Day Supply</b>		
Generic	\$7	Not Covered
Brand Name	\$15	Not Covered
Preferred Drugs (Applies to Lovestatin, OTC Prilosec & OTC Loratidine only)	No Charge	Not Covered
Non-Preferred Brand	\$25	Not Covered
<b>Mail Order Specialty Drugs 30-Day Supply (Requires prior authorization)</b>		
Generic	\$7	Not Covered
Brand	\$15	Not Covered
Non-Preferred Brand	\$25	Not Covered
<b>Mail Order 90 Day Supply</b>		
Generic	\$14	Not Covered
Brand Name	\$30	Not Covered
Non-Preferred Brand	\$50	Not Covered

### Vision Benefit for You and Your Dependents

Annual Benefit Maximum ..... \$135 per person  
 Annual Deductible ..... None  
 Percentage Paid..... Plan pays 100%

### 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](http://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](http://www.deltadentalnj.com)

## SHORT TERM DISABILITY

Maximum Benefit .....	55% of weekly earnings, up to \$250 per week
Maximum Payment Period .....	26 weeks
Benefits Begin.....	1 <sup>st</sup> day of disability due to accident
.....	1 <sup>st</sup> day of hospitalization
.....	1 <sup>st</sup> day of outpatient surgery
.....	8 <sup>th</sup> day of disability due to sickness

## EMPLOYEE DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

Death Benefit for You ..... \$15,000

### Death Benefit for Your Dependents

Spouse.....	\$2,500
Child	
15 days but less than 1 year old .....	\$100
1 year but less than 18 years old .....	\$2,500

Accidental Death and Dismemberment for you up to ..... \$7,500  
(determined by severity of injury)

### Loss of:

Life .....	\$7,500
Both hands or both feet or sight of both eyes .....	\$7,500
One hand and one foot.....	\$7,500
One hand and the sight of one eye .....	\$7,500
One foot and the sight of one eye .....	\$7,500
One hand or one foot .....	\$3,750
Sight of one eye .....	\$3,750