II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $3,400 $6,800	 $3,400 $6,800
Out-of-Pocket Maximum (Includes deductible) Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance After Deductible	10% coinsurance	20% coinsurance
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Physician Office Visits Primary Care Doctor	10% coinsurance, after deductible	20% coinsurance, after deductible
Specialist (Includes cardiologists, dermatologists, podiatrists, etc.)	10% coinsurance, after deductible	20% 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	
Preventive Services/ Immunizations	No Charge	Not Covered
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 THE ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance	10% coinsurance, after deductible	10% coinsurance, after deductible
Emergency Room (Waived if admitted)	10% coinsurance, after deductible	10% coinsurance, after deductible
Urgent Care	10% coinsurance, after deductible	10% coinsurance, after deductible
Outpatient Emergency Services	10% coinsurance, after deductible	10% coinsurance, after deductible
Diagnostic Test (X-rays and blood tests)	10% coinsurance, after deductible	20% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	10% coinsurance, after deductible	20% coinsurance, after deductible
Hospital Pre-Certification Penalty	$250	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses		
Inpatient		
• Facility	10% coinsurance, after deductible	20% coinsurance, after deductible
• Physician/Surgeon Fees	10% coinsurance, after deductible	20% coinsurance, after deductible
Outpatient		
• Services	10% coinsurance, after deductible	20% coinsurance, after deductible
• Surgery Facility	10% coinsurance, after deductible	20% coinsurance, after deductible
• Physician/Surgeon Fees	10% coinsurance, after deductible	20% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Organ Transplants	10% coinsurance, after deductible	Not Covered
Maternity Care Services • Office visits	10% coinsurance, after deductible	20% coinsurance, after deductible
• Inpatient	10% coinsurance, after deductible	20% coinsurance, after deductible
• Outpatient	10% coinsurance, after deductible	20% coinsurance, after deductible
• Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	10% coinsurance, after deductible	20% coinsurance, after deductible
• Childbirth/ delivery facility services (Hospital, childbirth center, etc.) Inpatient Hospital Pre-certification required	10% coinsurance, after deductible	20% coinsurance, after deductible
• Breast Pump (Limited to a maximum benefit of $250)	No Charge	20% coinsurance, after deductible
Mental Health • Inpatient	10% coinsurance, after deductible	20% coinsurance, after deductible
• Teladoc™	$0 Copay	
• Outpatient	No Charge, after deductible	20% coinsurance, after deductible
Substance Abuse • Inpatient	10% coinsurance, after deductible	20% coinsurance, after deductible
• Teladoc™	$0 Copay	
• Outpatient	No Charge, after deductible	20% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Dental Anesthesia and outpatient hospital charges for children under age 5, severely disabled, or has a medical condition requiring hospitalization or general anesthesia for dental treatment	10% coinsurance, after deductible	20% 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 (100 visit maximum per calendar year)	10% coinsurance, after deductible	20% coinsurance, after deductible
Skilled Nursing Facility (60 days calendar year maximum)	10% coinsurance, after deductible	20% coinsurance, after deductible
Hospice Care ($5,000 lifetime maximum)	10% coinsurance, after deductible	20% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price. Includes: corrective lenses for aphakia)	10% coinsurance, after deductible	20% 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.)	10% coinsurance, after deductible	20% coinsurance, after deductible
Physical & Occupational Therapy	10% coinsurance, after deductible	20% coinsurance, after deductible
Speech Therapy (To restore lost function after a stroke or during behavioral health treatment)	10% coinsurance, after deductible	20% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF THE 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	
Chiropractic	10% coinsurance, after deductible	20% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network **(After the deductible)**	**Out-of-Network** **(After the deductible)**
Retail 30-Day Supply		
Generic	10% coinsurance, after deductible	20% coinsurance, after deductible
Preferred Brand Formulary	10% coinsurance, after deductible	20% coinsurance, after deductible
Non-Preferred Brand	10% coinsurance, after deductible	20% coinsurance, after deductible
Retail 90-Day Supply ***(Maintenance Drugs used for long term use/ chronic condition)***		
Generic	10% coinsurance, after deductible	Not Covered
Preferred Brand Formulary	10% coinsurance, after deductible	Not Covered
Non-Preferred Brand	10% coinsurance, after deductible	Not Covered
Mail Order 30-Day Supply Only **Specialty Drugs** (Requires prior authorization)	10% coinsurance, after deductible	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network (After the deductible)	**Out-of-Network** (After the deductible)
Mail Order 90-Day Supply		
Generic	10% coinsurance, after deductible	Not Covered
Brand Formulary	10% coinsurance, after deductible	Not Covered
Non-Preferred Brand	10% coinsurance, after deductible	Not Covered

Provided by EmpiRx Health: Call 1-877-908-9438 for Member Services

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