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	20% coinsurance, after deductible	30% coinsurance, after deductible
Specialist (Includes cardiologist, dermatologist, podiatrists, 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)	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

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	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.