

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual Family	\$150 \$300	\$300 \$600
Out-of-Pocket Maximum		
Individual Family	\$1,000 \$3,000	\$2,000 \$4,500
Co-insurance After Deductible	10%	20%
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 Care Physician	\$10 per visit	20% co-insurance, after deductible
Specialist (Includes cardiologists, dermatologists, podiatrists, etc.)	\$10 per visit	20% co-insurance, 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 (Includes immunizations and routine physical exam)		
Well Child Care	No Charge	20% co-insurance, after deductible
Well Adult	No Charge	20% co-insurance, after deductible

See Schedule of Wellness next page

Schedule of Wellness Visits

Below is a table illustrating the frequency at which you can seek routine wellness visits. Any routine wellness visits in excess of this schedule will not be covered.

Age of Patient	Frequency of Exam
Under age 3 First 12 months of life 13 th -24 th months of life 25 th -36 th months of life	 7 exams 3 exams 3 exams
3-18 years old	Once per calendar year
Routine Gynecological and Pap Smears exam	Once per calendar year
Routine Mammogram (Age 40 and over)	One test per calendar year
Prostate Specific Antigen Test (Age 40 and over)	One test per calendar year
Routine Digital Rectal Exam (Age 40 and over)	One test per calendar year
Fecal Occult Blood Test	One test per calendar year
Sigmoidoscopy (Age 50 and over)	One test every five year period 10% after the deductible In-Network 20% after deductible Out-of-Network
Double Contrast Barium Enema (Age 50 and over)	One test every five year period 10% after the deductible In-Network 20% after deductible Out-of-Network
Colonoscopy (Age 50 and over)	One test every 10 year period 10% after the deductible In-Network 20% after deductible Out-of-Network

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	
Infertility (For the diagnosis and treatment of the underlying medical condition causing the infertility only.)	10% co-insurance, after deductible	20% co-insurance, after deductible
Therapeutic Injections (includes Gardasil Vaccine)	No Charge	No Charge
Allergy Tests (copay waived if no office visit) Serum Allergy Injections	\$10 per visit	20% co-insurance, after deductible
	20% co-insurance, after deductible	20% co-insurance, after deductible
	20% co-insurance, after deductible	20% co-insurance, after deductible
Diagnostic Services		
Diagnostic Laboratory Testing and Imaging Services (CT and MRI scans require prior authorization)	10% co-insurance, No Deductible	20% co-insurance, No Deductible
Outpatient Diagnostic and Preoperative Testing - For office visits	10% co-insurance, No Deductible	20% co-insurance, No Deductible
	\$10 copay plus 10% co-insurance, No Deductible	20% co-insurance, after deductible
Emergency Care Services		
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Care Hospital ER	10% co-insurance, No Deductible	10% co-insurance, No Deductible

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	In-Network	Out-of-Network
Urgent Care Center	10% co-insurance, No Deductible	10% co-insurance, No Deductible
Non-Emergency Care in Hospital Emergency Room	10% co-insurance per visit, after deductible	50% co-insurance per visit, after deductible (waived if admitted to hospital)
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Hospital Services		
Hospital Pre-Certification Penalty	\$500	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	10% co-insurance, after deductible	\$300 per admission after deductible plus 20% co-insurance
Administration of Anesthesia	10% co-insurance, after deductible	20% co-insurance, after deductible
Outpatient Surgery -At hospital or ambulatory	10% co-insurance, No Deductible	20% co-insurance, No Deductible
-At physician's office	\$10 copay plus 10% co-insurance, No Deductible	20% co-insurance, after deductible
Transplant Services -At facility	10% co-insurance, after deductible	20% co-insurance per admission, after deductible
- At physician (Includes office visits)	10% co-insurance, after deductible	20% co-insurance per admission, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Maternity Care Services		
Office Visits	\$10 copay	20% co-insurance, after deductible
Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	10% co-insurance, after deductible	20% co-insurance, after deductible
Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	10% co-insurance, after deductible	20% co-insurance, after deductible
Breast Pump (Limited to a maximum benefit of \$250)	No Charge	20% co-insurance, after deductible
Behavioral Health Disorders (Mental Health and Substance Use Disorders)		
Mental Health and Nervous Expense		
Inpatient		
-Hospital facility	10% co-insurance, after deductible	\$300 per admission, after deductible plus 20% co-insurance
-Residential treatment facility		
Outpatient	\$10 copay	20% co-insurance, after deductible
Alcohol & Substance Abuse		
Inpatient		
-Hospital facility	10% co-insurance, after deductible	\$300 per admission after deductible, plus 20% coinsurance
-Residential treatment facility		
Outpatient	\$10 copay	20% co-insurance, after deductible
Long Term Care, Recovery and Special Health Needs		
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	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Outpatient Therapies <ul style="list-style-type: none"> Chemotherapy Infusion Therapy Radiation Therapy 	10% co-insurance, after deductible	20% co-insurance, after deductible
	10% co-insurance, after deductible	20% co-insurance, after deductible
	10% co-insurance, after deductible	20% co-insurance, after deductible
Hospice Care (Room and board and other expenses)	10% co-insurance, after deductible	\$300 per admission, after deductible plus 20% co-insurance
Skilled Nursing Inpatient Facility Care (Up to 120 days per calendar year)	10% co-insurance, after deductible	\$300 per admission, after deductible plus 20% co-insurance
Outpatient Private Duty Nursing	20% co-insurance, after deductible	20% co-insurance, after deductible
Outpatient Home Health Care (Unlimited visits)	10% co-insurance, after deductible	20% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% co-insurance, after deductible	20% co-insurance, after deductible
Prosthetic Devices	20% co-insurance, after deductible	20% co-insurance, 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 benefits of \$350.)	20% coinsurance, after deductible	20% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Outpatient Therapy (Up to 20 visits combined per calendar year)		
• Physical Therapy	20% co-insurance, after deductible	20% co-insurance, after deductible
• Occupational Therapy	20% co-insurance, after deductible	20% co-insurance, after deductible
• Speech Therapy (To restore lost function after a stroke or during behavioral health treatment)	20% co-insurance, after deductible	20% co-insurance, 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	
Acupuncture	10% co-insurance, after deductible	20% co-insurance, after deductible
Chiropractic (Up to 24 visits)	10% co-insurance, after deductible	20% co-insurance, after deductible
Routine Vision Exam (One exam ever 2 years)	Benefits are covered by VSP. See Separate Description.	

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic	\$9	Not Covered
Brand Formulary	\$18	Not Covered
Mail Order Specialty Drugs 30- Day Supply (Requires prior authorization)		
Specialty Drugs	10% co-insurance, No Deductibles	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Mail Order 90-Day Supply		
Generic	\$16	Not Covered
Brand Formulary	\$32	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.
(Delta-Ok)

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