

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$250	\$350
Family	\$450	\$550
Out-of-Pocket Maximum		
Individual	\$2,000	\$3,000
Family	\$4,000	\$5,000
Co-insurance After Deductible	10%	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		
<ul style="list-style-type: none">• Non-Specialist• Specialist (Includes cardiologists, dermatologists, podiatrists, etc.)• Emergency Room Visits• Inpatient Services• Outpatient Services (Includes surgery and diagnostic lab/ X-rays)	\$20 copay	30% co-insurance, after deductible
	\$25 copay	30% co-insurance, after deductible
	10% co-insurance, after deductible	30% co-insurance, after deductible
	10% co-insurance, after deductible	30% co-insurance, after deductible
	10% co-insurance, after deductible	30% 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	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Preventative Care (Calendar Year Deductible Waived) <ul style="list-style-type: none"> Routine Mammogram Routine Cancer Screening 	No Charge	30% co-insurance, after deductible
	No Charge	30% co-insurance, 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	
Allergy Immunizations	10% co-insurance, after deductible	30% co-insurance, after deductible
Diagnostic Services		
Diagnostic Tests (X-rays and blood tests)	10% co-insurance, after deductible	30% co-insurance, after deductible
Imaging Services (CT and MRI scans require prior authorizations)	10% co-insurance, after deductible	30% co-insurance, after deductible
Emergency Care Services		
Ambulance	20% co-insurance, after deductible	30% co-insurance, after deductible
Emergency Room Visit	\$50 copay	30% co-insurance, after deductible
Urgent Care	\$20 copay	30% co-insurance, after deductible
Hospital Services		
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of \$5,000	
Hospital (Daily Hospital Room and Board, Semi Private and other allowable expenses)	10% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Organ Transplants Limited to Heart, Liver (Until Age 18), Kidney and Bone Marrow	No Charge	Not Covered
Outpatient Surgical Services and Non-Surgical Services	10% co-insurance, after deductible	30% co-insurance, after deductible
Maternity Care Services		
• Office Visits	\$20 copay	30% co-insurance after deductible
• Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	10% co-insurance, after deductible	30% co-insurance, after deductible
• Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	10% co-insurance, after deductible	30% co-insurance, after deductible
Behavioral Health Disorders (Mental Health and Substance Use Disorder)		
Mental and Nervous Expense		
• Inpatient	10% co-insurance, after deductible	30% co-insurance, after deductible
• Teladoc™	\$0 Copay	
• Outpatient	\$25 copay	30% co-insurance, after deductible
• Group Therapy	\$25 copay	30% co-insurance, after deductible
Alcohol and Substance Abuse		
• Inpatient	10% co-insurance, after deductible	30% co-insurance, after deductible
• Teladoc™	\$0 Copay	
• Outpatient	\$25 copay	30% co-insurance, after deductible
• Group Therapy	\$25 copay	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<ul style="list-style-type: none"> Residential Rehabilitation Services <ul style="list-style-type: none"> Facility 	20% co-insurance, after deductible	30% co-insurance, after deductible
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Doctor 	No Charge	30% 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	
Hospice <ul style="list-style-type: none"> Inpatient 	\$150 per day	\$150 per day
<ul style="list-style-type: none"> Outpatient 	\$50 per day	\$50 per day
Home Health (Nursing) Care (Maximum of 40 visits per calendar year)	20% co-insurance, after deductible	20% co-insurance, after deductible
Skilled Nursing Facility	20% co-insurance, after deductible	20% co-insurance, after deductible
Private Duty Nursing	20% 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
External Prosthetic Devices <ul style="list-style-type: none"> Wigs, toupees or hairpieces (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% co-insurance, after deductible	20% co-insurance, after deductible
Cardiac Rehabilitation	20% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Therapies (Maximum of 20 visits per calendar year)		
<ul style="list-style-type: none"> Physical Therapy Speech Therapy (To restore lost function after a stroke or during behavioral health treatment) Hearing Therapy 	20% co-insurance, after deductible	30% co-insurance, after deductible
	20% co-insurance, after deductible	30% co-insurance, after deductible
	20% co-insurance, after deductible	30% 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	
Chiropractic Benefits (Maximum of 12 visits per calendar year)	\$20 copay	30% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic	\$10 copay	Not Covered
Brand Formulary	\$20 copay	Not Covered
Non-Formulary	\$30 copay	Not Covered
Mail-Order Specialty Drugs 30-Supply (Requires prior authorization)		
Generic	\$10 copay	Not Covered
Brand Formulary	\$20 copay	Not Covered
Non-Formulary	\$30 copay	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Mail Order 90-Day Supply		
Generic	\$20 copay	Not Covered
Brand Formulary	\$40 copay	Not Covered
Non-Formulary	\$60 copay	Not Covered

Prescription Drug Benefits

Provided by EmpiRx Health: Call 1-877-241-7123 for Member Services.

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

Death Benefit for Retired Employee \$10,000

CONTINUATION OF COVERAGE FOR RETIREES

Eligibility – Retirement on/or after age..... 50
 Period of CoverageUp to Age 65 or Medicare Eligibility