

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$1,000	\$1,000
Family	\$2,000	\$2,000
Out-of-Pocket Maximum		
Individual	\$7,900	\$15,800
Family	\$15,800	\$47,400
Coinsurance After Deductible	30%	50%
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	30% coinsurance, after deductible	50% coinsurance, after deductible
Specialist (Includes cardiologists, dermatologists, podiatrist, etc.)	30% coinsurance, after deductible	50% 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	50% 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
Diagnostic Services		
Diagnostic Tests (X-rays and blood tests)	30% coinsurance, after deductible	50% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	30% co-insurance, after deductible	50% co-insurance, after deductible
Emergency Care Services		
Ambulance	30% coinsurance, after deductible	Same as in-network
Emergency Room (Copay waived if admitted)	\$50 copay, plus 30% coinsurance	Same as in-network
Urgent Care	30% coinsurance, after deductible	Same as in-network
Hospital Services		
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 expenses <ul style="list-style-type: none"> Inpatient Hospital physician/surgeon fees Inpatient Facility Outpatient Services Outpatient Surgery Facility Outpatient Hospital physician/surgeon fees 	No Charge	50% coinsurance, after deductible
	30% coinsurance, after deductible	50% coinsurance, after deductible
	No Charge	50% coinsurance, after deductible
	30% coinsurance, after deductible	50% coinsurance, after deductible
	No Charge	50% coinsurance, after deductible
	30% coinsurance, after deductible	50% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Maternity Care Services		
Office Visits	30% co-insurance, after deductible	50% co-insurance, after deductible
Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	30% co-insurance, after deductible	50% co-insurance, after deductible
Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	No Charge	50% coinsurance, after deductible
Breast Pump (Limited to a maximum benefit of \$250)	No Charge	50% coinsurance, after deductible
Behavioral Health Disorders (Mental Health and Substance Use Disorder)		
Inpatient Hospital	No Charge	50% coinsurance, after deductible
Teladoc™	\$0 Copay	
Outpatient Hospital	30% co-insurance, after deductible	50% coinsurance, 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	
Home Health Care (100 visits maximum per calendar year)	30% coinsurance, after deductible	50% coinsurance, after deductible
Skilled Nursing Facility (A maximum of 60 days per calendar year)	30% coinsurance, after deductible	50% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	30% coinsurance, after deductible	50% 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.)	30% coinsurance, after deductible	50% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Speech Therapy (To restore lost function after a stroke or during behavioral health treatment)	30% coinsurance, after deductible	50% coinsurance after deductible
Physical and Occupational Therapy (excludes Chiropractic)	30% coinsurance, after deductible	50% 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)	30% coinsurance, after deductible	50% 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 Specialty Drugs 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

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
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 1-877-241-7123 for Member Services

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

IF ELECTED

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.