

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual Family	\$1,200 \$2,400	\$1,200 \$2,400
Out-of-Pocket Maximum		
Individual Family	\$9,000 \$18,000	\$18,000 \$54,000
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 cardiologist, dermatologist, podiatrists, 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	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 ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Diagnostic Services		
Diagnostic Testing (X-rays and blood tests)	30% coinsurance, after deductible	50% coinsurance, after deductible
Imaging Services (MRIs, CT/PET Scans)	30% coinsurance, after deductible	50% coinsurance, after deductible
Emergency Care Services		
Ambulance	30% coinsurance, after deductible	30% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	\$100 copay, plus 30% coinsurance	\$100 copay, plus 30% coinsurance
Urgent Care	30% coinsurance, after deductible	30% coinsurance, after deductible
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		
Inpatient Facility	30% coinsurance, after deductible	50% coinsurance, after deductible
Inpatient Hospital – physician/ surgeon fees	30% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services	30% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Surgery Facility	30% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient – physician/ surgeon fees	30% coinsurance, after deductible	50% coinsurance, after deductible

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	In-Network	Out-of-Network
Maternity Care Services		
Office Visits	30% coinsurance, after deductible	50% coinsurance, after deductible
Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	30% coinsurance, after deductible	50% coinsurance, after deductible
Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	30% coinsurance, after deductible	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	No Charge	50% coinsurance, after deductible
Teladoc™	\$0 copay	
Outpatient	No Charge, 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 (60 days calendar year maximum)	No Charge, after deductible	50% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	30% coinsurance, after deductible	50% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
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 Therapy (excludes Chiropractic)	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 Services (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

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
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.

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.