

II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
-Individual -Family	\$250 \$750	\$250 \$750
Out-of-Pocket Maximum		
\$2,000 per person includes Annual Deductible		
Coinsurance After Deductible	20%	35%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Physician's Office Visits		
-Primary Care Physician	20% coinsurance, after deductible	35% coinsurance, after deductible
-Specialist (Includes cardiologists, dermatologists, podiatrist, etc.)	20% coinsurance, after deductible	35% 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 (Includes immunizations, routine physical exam, Pap, colon, blood, sigmoidoscopy, lab and X-ray testing)	20% coinsurance, after deductible	35% coinsurance, after deductible
-Well Child Care and Immunization (No Charges apply for well child care and children's immunization under the age of 2 years)	No Charge	No Charge

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
-Mammogram Age 35-39- One baseline mammogram Age 40 & Up- Annually	20% coinsurance, after deductible less \$85 paid at 100%	20% coinsurance, after deductible less \$85 paid at 100%
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	
Emergency Care Services		
Ambulance	20% coinsurance, after deductible	35% coinsurance, after deductible
Emergency Room Care	20% coinsurance, after deductible	35% coinsurance, after deductible
Urgent Care	20% coinsurance, after deductible	35% coinsurance, after deductible
Hospital Pre-Certification Penalty	\$100	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	15% coinsurance, after deductible	\$350 plus 35% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	35% coinsurance, after deductible
Imaging Services (CT and MRI require prior authorization)	20% coinsurance, after deductible	35% coinsurance, after deductible
Organ Transplant	20% coinsurance, after deductible	35% coinsurance, after deductible
Hospital Charges for Dental Surgery (Up to \$5,000 per event)	50% coinsurance, after deductible	35% coinsurance, after deductible
Treatment of Varicose Veins	20% coinsurance, after deductible	35% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Maternity Care Services		
-Office Visits	20% coinsurance, after deductible	35% coinsurance, after deductible
-Childbirth/ professional delivery services (Obstetrician, surgeon, etc.)	20% coinsurance, after deductible	35% coinsurance, after deductible
-Childbirth/ delivery facility services (Hospital, childbirth center, etc.)	15% coinsurance, after deductible	35% coinsurance, after deductible
Behavioral Health Disorders (Mental Health and Substance Use Disorders)		
-Inpatient	15% coinsurance, after deductible	35% coinsurance, after deductible
-Teladoc™	\$0 copay	
-Outpatient		
• Office	20% coinsurance, after deductible	35% coinsurance, after deductible
• Hospital	0% coinsurance, after deductible	35% 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	
Skilled Nursing Facility & Rehabilitation Therapy (Covered if pre-certified <u>only</u>)	20% coinsurance, after deductible	35% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	35% coinsurance, after deductible
Cardiac Rehabilitation	20% coinsurance, after deductible	35% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed the purchase price)	20% coinsurance, after deductible	35% 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 androgenetic alopecia- male/female pattern baldness. Limited to a maximum benefit of \$350.)	20% coinsurance, after deductible	35% coinsurance, after deductible
Oxygen, Outpatient or portable (The one-time cost of an oxygen concentrator, if applicable)	20% coinsurance, after deductible	35% coinsurance, after deductible
Physical and Occupational Therapy	20% coinsurance, after deductible	35% coinsurance, after deductible
Speech Therapy (To restore lost function after a stroke or during behavioral health treatment)	20% coinsurance, after deductible	35% 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 Therapy	20% coinsurance, after deductible	35% coinsurance, after deductible
Prolo Therapy	20% coinsurance, after deductible	35% coinsurance, after deductible
Acupuncture	20% coinsurance, after deductible	35% coinsurance, after deductible
Hearing Aid (One pair in any 5-consecutive year period)	20% coinsurance, after deductible	35% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic	\$7	Not Covered
Brand Name	\$15	Not Covered
Preferred Drugs (Applies to Lovestatin, OTC Prilosec & OTC Loratidine only)	No Charge	Not Covered
Non-Preferred Brand	\$25	Not Covered
Mail Order Specialty Drugs 30-Day Supply (Requires prior authorization)		
Generic	\$7	Not Covered
Brand	\$15	Not Covered
Non-Preferred Brand	\$25	Not Covered
Mail Order 90-Day Supply		
Generic	\$14	Not Covered
Brand Name	\$30	Not Covered
Non-Preferred Brand	\$50	Not Covered

Vision Benefit for You and Your Dependents

Annual Benefit Maximum \$135 per person
Annual Deductible None
Percentage Paid Plan pays 100%

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

SHORT TERM DISABILITY

Maximum Benefit	55% of weekly earnings, up to \$250 per week
Maximum Payment Period	26 weeks
Benefits Begin	1 st day of disability due to accident
.....	1 st day of hospitalization
.....	1 st day of outpatient surgery
.....	8 th day of disability due to sickness

EMPLOYEE DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

Death Benefit for You \$15,000

Death Benefit for Your Dependents

Spouse	\$2,500
Child	
15 days but less than 1 year old	\$100
1 year but less than 18 years old	\$2,500

Accidental Death and Dismemberment for you up to \$7,500
(determined by severity of injury)

Loss of:

Life	\$7,500
Both hands or both feet or sight of both eyes	\$7,500
One hand and one foot	\$7,500
One hand and the sight of one eye	\$7,500
One foot and the sight of one eye	\$7,500
One hand or one foot	\$3,750
Sight of one eye	\$3,750