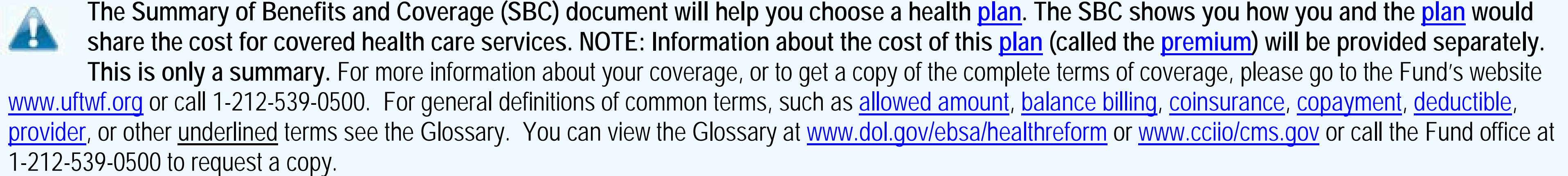
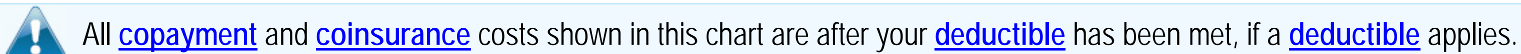


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please go to the Fund's website www.uftwf.org or call 1-212-539-0500. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio/cms.gov or call the Fund office at 1-212-539-0500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Not Applicable**	There is no deductible.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	**Yes**	There is a maximum prescription drug out-of-pocket expense of $1,000. After a covered family has reached $1,000 in copayments, no further copayments will be collected except for those drugs obtained in Tier 3 (Non-Preferred Brand Not on Formulary) where you are responsible for the appropriate co-payment.
What is not included in the out-of-pocket limit?		All drug copayments count toward reaching the $1,000 maximum out-of-pocket limit; however, after a covered family has reached $1,000 in copayments, no further copayments will be collected except for those drugs obtained in Tier 3 (Non-Preferred Brand Not on Formulary) where you are responsible for the appropriate co-payment.
Will you pay less if you use a network provider?	Yes. For a list of **preferred providers**, see www.express-scripts.com or call 800-723-9182.	If you use an in-network pharmacy, this plan will pay some or all of the costs of covered prescriptions. Plans use the term in-network, **preferred**, or participant for **providers** in their **network**. See chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	Not Applicable	This plan is limited to prescription drug coverage only.


All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	This plan is limited to prescription drug coverage only.
	Specialist visit	Not covered	Not covered	This plan is limited to prescription drug coverage only.
	Preventive care/screening/ immunization	Not covered	Not covered	This plan is limited to prescription drug coverage only.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	This plan is limited to prescription drug coverage only.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	This plan is limited to prescription drug coverage only.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.uftwf.org	Generic drugs	At Retail (up to 30 day supply) - $5 By Mail (up to 90 day supply) - $10	The applicable copayment plus the difference in the cost of the drug charged by the pharmacy and the plan's contracted rate with network pharmacies (calculated fee schedule)	Some of the prescriptions this plan doesn't cover are listed on page 4. See *The Red Apple* for additional information about excluded services.
	Preferred brand drugs	At Retail - $15 By Mail - $30	The applicable copayment plus the difference in the cost of the drug charged by the pharmacy and the plan's contracted rate with network pharmacies (calculated fee schedule)	Some of the prescriptions this plan doesn't cover are listed on page 4. See *The Red Apple* for additional information about excluded services.
	Non-preferred brand drugs	At retail - $35 By Mail - $70	The applicable copayment plus the difference in the cost of the drug charged by the pharmacy and the plan's contracted rate with network pharmacies (calculated fee schedule)	Some of the prescriptions this plan doesn't cover are listed on page 4. See *The Red Apple* for additional information about excluded services.
	Specialty drugs	Generic - $10 Preferred - $30	Not covered	Due to the nature of specialty medications, Accredo will only dispense a 30-day supply.

[* For more information about limitations and exceptions, see the Red Apple at www.uftwf.org.]

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Non-Preferred - $70		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Plan covers prescription drugs only.
	Physician/surgeon fees	Not covered	Not covered	Plan covers prescription drugs only.
If you need immediate medical attention	Emergency room care	Not covered	Not covered	Plan covers prescription drugs only.
	Emergency medical transportation	Not covered	Not covered	Plan covers prescription drugs only.
	Urgent care	Not covered	Not covered	Plan covers prescription drugs only.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Plan covers prescription drugs only.
	Physician/surgeon fees	Not covered	Not covered	Plan covers prescription drugs only.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Plan covers prescription drugs only.
	Inpatient services	Not covered	Not covered	Plan covers prescription drugs only.
If you are pregnant	Office visits	Not covered	Not covered	Plan covers prescription drugs only.
	Childbirth/delivery professional services	Not covered	Not covered	Plan covers prescription drugs only.
	Childbirth/delivery facility services	Not covered	Not covered	Plan covers prescription drugs only.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Plan covers prescription drugs only.
	Rehabilitation services	Not covered	Not covered	Plan covers prescription drugs only.
	Habilitation services	Not covered	Not covered	Plan covers prescription drugs only.
	Skilled nursing care	Not covered	Not covered	Plan covers prescription drugs only.
	Durable medical equipment	Not covered	Not covered	Plan covers prescription drugs only.
	Hospice services	Not covered	Not covered	Plan covers prescription drugs only.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	This summary pertain to the prescription drug plan only.
	Children's glasses	Not covered	Not covered	This summary pertain to the prescription drug plan only.
	Children's dental check-up	Not covered	Not covered	This summary pertain to the prescription drug plan only.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check the Red Apple for more information and a list of any other excluded services.)		
• Drugs used for cosmetic purposes • GHI-CBP and HIP HMO ACA Preventive drugs (www.emblemhealth.com)	• Drugs covered under the NYC PICA program (injectable and chemotherapy medication for members with a NYC health plan)	• Drugs used for the treatment of diabetes.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• This plan covers only prescription drug benefits.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may all apply.

For more information on your rights to continue coverage, contact the Fund at 212-539-0500. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. Decisions of the Executive Director and the Fund staff are subject to review by the Trustees upon appeal. The Fund Office uniformly applies all rules. The action of the Fund Office is subject only to review by the Board of Trustees. An appeal must be filed with the Fund Office within sixty (60) days of denial of the claim, by submitting notice in writing to the Board of Trustees, United Federation of Teachers Welfare Fund, 52 Broadway 7th Floor, New York, New York 10004. The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final, conclusive, and binding on all person.

Does this plan provide Minimum Essential Coverage?

The Affordable care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan covers prescription drugs only. You should confirm that your basic health plan provides minimum essential coverage.

Does this plan meet the Minimum Value Standards?

The Affordable Care Act establishes a minimum value of standard benefits of a health plan. The minimum value is 60% (actuarial value). This plan covers prescription drugs only. You should confirm that your basic health plan meets the minimum value standard.

Language Access Services:

Para obtener asistencia en Español, llame al 212-539-0500.

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next section.––––––––––––––––––––––

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Having a Baby
(normal delivery)

- Amount owed for prescriptions: $200
- Plan pays $165
- Patient pays $35

Sample Care costs:

Prescriptions	$200

Cost Sharing	
Deductibles	$0
Copayments	$35
Coinsurance	$0
Limits or exclusions*	$0
Total	**$35**

*Over the counter medications, such as stool softeners are not covered by the plan

Managing type 2 Diabetes
(routine maintenance of a well-controlled condition)

- Amount owed for prescriptions $2,9000
- Plan pays $68
- Patient pays $2,832*

Sample care costs:

Prescriptions	$2,900

Patient pays:

Cost Sharing	
Deductibles	$0
Copayments	$40*
Coinsurance	$0
Limits or exclusions	$2,832**
Total	**$2,9000**

*The Fund does not cover diabetic drugs or supplies. Over the counter medications, such as aspirin are not covered by the plan.

**Check your basic health plan for coverage of diabetes drugs, ancillary devices and management education programs.