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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Not Applicable</td>
<td>There is no deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>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.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of preferred providers, see <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 800-723-9182.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Not Applicable</td>
<td>This plan is limited to prescription drug coverage only.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>At Retail (up to 30-day supply) - $5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By Mail (up to 90-day supply) or Smart 90 (Walgreens/Duane Reade Network) - $10</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>At Retail - $15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By Mail or Smart 90 (Walgreens/Duane Reade Network) - $30</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>At retail - $35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By Mail or Smart 90 (Walgreens/Duane Reade Network) - $70</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Generic - $10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preferred - $30</td>
</tr>
</tbody>
</table>

[* For more information about limitations and exceptions, see the Red Apple at www.uftwf.org.]
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

[* For more information about limitations and exceptions, see the Red Apple at www.uftwf.org.]
Excluded Services & Other Covered Services:

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

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 also 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.

[* For more information about limitations and exceptions, see the Red Apple at www.uftwf.org.]*
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.
### 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:** $2,900
- **Plan pays:** $68
- **Patient pays:** $2,832*

**Sample care costs:**

| Prescriptions | $2,900 |

**Patient pays:**

| 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.