UCE of FIT Welfare Trust Fund

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: [10/1/2017-9/30/2018]

Coverage for: Family | Plan Type: Drugs Only

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.uce-fit.org or by calling 1-212-217-3370.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$50 per year per covered individual**	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**Yes**	• Fertility Drugs - 50% of the amount the Fund would have paid for the generic equivalent. • Growth Hormones - 50% of the amount the Fund would have paid for the generic equivalent. See the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	This plan has no **out-of-pocket limit.**	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit.**	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Will you pay less if you use a network provider?	Yes. For a list of **preferred providers**, go to wwwProAct.com or call the Fund at 212-217-3370	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 participating for **providers** in their **network**. See the 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 reimburses for covered prescription drugs only.

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 by calling the Fund at 212-217-3370.	Generic drugs	At Retail (up to 30 day supply) - $20 By Mail (up to 90 day supply) - $40	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 Fund's Benefits Booklet* for additional information about **excluded services.**
	Preferred brand drugs	At Retail - $30 By Mail - $60	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 Fund's Benefits Booklet* for additional information about **excluded services.**
	Non-preferred brand drugs	At Retail - $50 By Mail - $100	The applicable copayment plus the	Some of the prescriptions this plan doesn't cover are listed on page 4. See

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)	
			difference in the cost of the drug charged by the pharmacy and the plan's contracted rate with network pharmacies (calculated fee schedule).	*The Fund's Benefits Booklet* for additional information about **excluded services.**
	Specialty drugs	Generic - $40 Preferred - $60 Non-Preferred- $100	Not covered	All specialty medications be obtained through the Noble pharmacy located at 8001 Route 31, Bridgeport, NY 13030. Members are allowed one fill of a specialty medication at a retail pharmacy. Once the retail prescription is received, Noble will contact you.
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	Not covered	Not covered	Plan covers prescription drugs only.

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)	
	services			
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 pertains to the prescription drug plan only.
	Children's glasses	Not covered	Not covered	This summary pertains to the prescription drug plan only.
	Children's dental check-up	Not covered	Not covered	This summary pertains to the prescription drug plan only.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check the Fund's Benefits Booklet for more information and a list of any other excluded services.)

- Drugs used for cosmetic purposes
- Drugs, vitamins, foods, diet supplements, etc., which can be purchased without a prescription.
- Medications used for intravenous administration

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 induration 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 plan at 212-217-3370. 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 Fund Office and the 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 College Employees of Fashion Institute of Technology Welfare Trust Fund, Seventh Avenue at 27th Street Room B902, New York, New York 10001. 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 persons.

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 212-217-3370

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** $____*
- **Patient pays** $____

Sample care costs:

Prescriptions	$200
Total	**$200**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

***The Fund will pay the cost, less the applicable co-payment.**

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

- **Amount owed for prescriptions:** $2,900
- **Plan pays** $____*
- **Patient pays** $____

Sample care costs:

Prescriptions	$2,900
Total	**$2,900**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

***The Fund will pay the cost, less the applicable co-payment.**