UCE of FIT Welfare Trust Fund

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

Coverage Period: [1/1/2013-12/31/2013]

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 other deductibles for specific services?	**Yes**	• Fertility Drugs - 50% of the amount the Fund would have paid for the generic equivalent. $10,000 total maximum lifetime benefit. • Growth Hormones - 50% of the amount the Fund would have paid for the generic equivalent. $10,000 total maximum lifetime benefit. 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?	**No**	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.**
Is there an overall annual limit on what the plan pays?	**No**	None
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.medco.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 I need a referral to see a specialist?	**No**	While you can see the **specialist** you choose without permission from this plan, this plan reimburses for covered prescription drugs only.
Are there services this plan doesn't cover?	**Yes**	Some of the prescriptions this plan doesn't cover are listed on page 6. See *The Red Apple* for additional information about **excluded services.**

Questions: Call 212-217-3370

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-212-217-3370 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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.
	Other practitioner office 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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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 6. 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 6. 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 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 6. See *The Red Apple* for additional information about **excluded services.**
	Specialty drugs	Generic - $40 Preferred - $60 Non-Preferred- $100	Not covered	After one fill the precription must be filled through the Accredo Pharmacy.
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 services	Not covered	Not covered	Plan covers prescription drugs only.
	Emergency medical transportation	Not covered	Not covered	Plan covers prescription drugs only.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	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 fee	Not covered	Not covered	Plan covers prescription drugs only.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Plan covers prescription drugs only.
	Mental/Behavioral health inpatient services	Not covered	Not covered	Plan covers prescription drugs only.
	Substance use disorder outpatient services	Not covered	Not covered	Plan covers prescription drugs only.
	Substance use disorder inpatient services	Not covered	Not covered	Plan covers prescription drugs only.
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	Plan covers prescription drugs only.
	Delivery and all inpatient services	Not covered	Not covered	Plan covers prescription drugs only.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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 service	Not covered	Not covered	Plan covers prescription drugs only.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	This summary pertains to the prescription drug plan only.
	Glasses	Not covered	Not covered	This summary pertains to the prescription drug plan only.
	Dental check-up	Not covered	Not covered	This summary pertains to the prescription drug plan only.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nurisng
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- 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 Employeess 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.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations.

Please contact your major medical/hospital plan(s) to find out what coverage is available for other care costs associated with these situations.
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This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

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.**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.