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, go to www.psccunywf.org or call 212-354-5230. 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.psccunywf.org or www.dol.gov/ebsa/healthreform or by call 212-354-5230 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
Are there other deductibles for specific services?	Yes. Extended Medical if enrolled in GHI-CBP and optional rider elected: $1,000/individual, $2,000/family; Extended Medical if enrolled in GHI-CBP and optional rider not elected: $4,000/individual, $8,000/family. First $2,500 in out-of-pocket expenses/individual under High-Cost Rx Program. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Prescription drugs, dental and vision benefits: Not applicable Extended Medical: $3,000/individual, $6,000/ family	Prescription drugs, dental, vision and hearing aid benefits: This plan does not have an out-of-pocket limit on these expenses. Extended Medical: The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Extended Medical: premiums, balance-billing charges, deductibles, GHI-CBP copayments, health care GHI-CBP does not cover and penalties for failure to obtain pre-authorization for services under GHI-CBP. Prescription drugs, dental, vision, hearing aid benefits: Not applicable.	Extended Medical: Even though you pay these expenses, they don't count toward the out-of-pocket limit. Prescription drugs, dental, vision and hearing aid benefits: This plan does not have an out-of-pocket limit on these expenses.
Will you pay less if you use a network provider?	Yes. Call 1-866-209-6177 or see www.caremark.com for a list of participating pharmacies; See www.psccunywf.org for a list of participating dentists and vision providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	There is no coverage for this type of medical event. You must pay 100% of these expenses, even in-network. If you are enrolled in GHI- CBP, the Extended Medical Benefits pay 60% and you pay 40% of the difference between the amount reimbursed by GHI-CBP for out-of- network non-hospital physician fees and the allowed amount plus balance-billing charges after the deductible. After reaching the out-of-pocket limit, you only pay balance-billing charges. *See Extended Medical Benefits Section of plan document.
	Specialist visit	Not covered	Not covered	
	Preventive care/screening/ immunization	Not covered	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	

* For more information about limitations and exceptions, see the plan document at www.psccunywf.org

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	***Welfare Fund expenses up to $10,000***: Retail - first 3 fills: 20% coinsurance ($5 min); Subsequent refills: 35% coinsurance ($5 min); Mail Order: 20% coinsurance ($10 min); No charge for $0 Generic Copay Formulary drugs filled at CVS or CVS Mail Order; 10% coinsurance for Generic drugs filled at CVS or CVS Mail Order; ***Welfare Fund expenses $10,001 - $15,000***: Retail - first 3 fills: 50% coinsurance ($5 min); Subsequent refills: 60% coinsurance ($5 min); Mail Order: 50% coinsurance ($10 min) ***Welfare Fund expenses over $15,000***: Retail - first 3 fills: 80% coinsurance ($5 min); Subsequent refills: 90% coinsurance ($5 min); Mail Order: 80% coinsurance ($10 min)	Amount over participating pharmacy rate, adjusted for applicable coinsurance/co-payment	Retail: Up to 30-day supply; Mail order: up to 90-day supply. If you choose a brand name drug when a generic equivalent is available, you will pay the brand name drug's coinsurance plus the difference in cost between the generic drug and the brand name drug. High-Cost Rx Program provides reimbursement when prescription drug expenses exceed $10,000 and eligible out-of-pocket costs exceed $2,500 per Plan year. Plan will reimburse up to $25,000 per person per Plan year. The first $2,500 in out-of-pocket expenses is treated as a deductible and not eligible for reimbursement. Drugs for erectile dysfunction are limited to $500 annual maximum and 18 tablets every 90 days. Over-the-counter drugs (those that do not require a prescription) are not covered. This Plan does not cover injectable and chemotherapy drugs which are available under the PICA program. This Plan does not cover the ACA-required contraceptive and other preventive drugs (for members enrolled in the GHI-CBP and HIP HMO Prime Plans) or diabetic medications (for all members). Opioid addiction are not covered if mandated and covered under your NYC Health Benefits Plan Refer to your NYC Health Benefits Plan carrier for information on these medications. *See CVS/Caremark Prescription Drug Program Section of plan document.
	Preferred formulary brand drugs	***Welfare Fund expenses up to $10,000***: Retail - first 3 fills: 20% coinsurance ($15 min); Subsequent refills: 35% coinsurance ($15 min) Mail order: 20% coinsurance ($30 min) ***Welfare Fund expenses $10,001 - $15,000***: Retail - first 3 fills: 50% coinsurance ($15 min); Retail - subsequent refills: 60% coinsurance ($15 min); Mail order: 50% coinsurance ($30 min) ***Welfare Fund expenses over $15,000***: Retail - first 3 fills: 80% coinsurance ($15 min); Subsequent refills: 90% coinsurance ($15 min); Mail order: 80% coinsurance ($30 min)	Amount over participating pharmacy rate, adjusted for applicable coinsurance/co-payment	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Non-preferred formulary brand drugs	***Welfare Fund expenses up to $10,000***: Retail - first 3 fills: 20% coinsurance ($30 min); Subsequent refills: 35% coinsurance ($30 min); Mail order: 20% coinsurance ($60 min) ***Welfare Fund expenses $10,001 - $15,000***: Retail - first 3 fills: 50% coinsurance ($30 min); Subsequent refills: 60% coinsurance ($30 min); Mail order: 50% coinsurance ($60 min) ***Welfare Fund expenses over $15,000***: Retail - first 3 fills: 80% coinsurance ($30 min); Subsequent refills: 90% coinsurance ($30 min); Mail order: 80% coinsurance ($60 min)	Amount over participating pharmacy rate, adjusted for applicable coinsurance/co-payment	Retail: Up to 31-day supply; Mail order: up to 90-day supply. If you choose a brand name drug when a generic equivalent is available, you will pay the brand name drug's coinsurance plus the difference in cost between the generic drug and the brand name drug. High-Cost Rx Program provides reimbursement when prescription drug expenses exceed $10,000 and eligible out-of-pocket costs exceed $2,500 per Plan year. Plan will reimburse up to $25,000 per person per Plan year. The first $2,500 in out-of-pocket expenses is treated as a deductible and not eligible for reimbursement. Smoking cessation drugs are limited to an 84-day supply. Drugs for erectile dysfunction are limited to $500 annual maximum and 18 tablets every 90 days. Over-the-counter drugs (those that do not require a prescription) are not covered. This Plan does not cover injectable and chemotherapy drugs which are available under the PICA program. This Plan does not cover the ACA-required contraceptive and other preventive drugs for members enrolled in the GHI-CBP and HIP HMO Prime Plans or diabetic medications (for all members). Refer to your NYC Health Benefits Plan carrier for information on these medications. *See CVS/Caremark Prescription Drug Program Section of plan document.
	Specialty drugs	Covered same as other drugs	Covered same as other drugs	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	There is no coverage for this type of medical event. You must pay 100% of these expenses, even in-network. If you are enrolled in GHI- CBP, the Extended Medical Benefit pays 60% and you pay 40% of the difference between the amount reimbursed by GHI-CBP for non- hospital, out-of-network physician charges and the allowed amount plus balance-billing charges after the deductible. After reaching the out-of-pocket limit, you only pay balance-billing charges. *See Extended Medical Benefits Section of plan document.
	Physician/surgeon fees	Not covered	Not covered	
If you need immediate medical attention	Emergency room care	Not covered	Not covered	There is no coverage for this type of medical event. You must pay 100% of these expenses, even in-network. If you are enrolled in GHI- CBP, the Extended Medical Benefits pay 60% and you pay 40% of the difference between the amount reimbursed by GHI-CBP for non- hospital, out-of-network physician charges and the allowed amount plus balance-billing charges after the deductible. After reaching the out-of-pocket limit, you only pay balance-billing charges. *See Extended Medical Benefits Section of plan document.
	Emergency medical transportation	Not covered	Not covered	
	Urgent care	Not covered	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	
	Physician/surgeon fees	Not covered	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	Not covered	Not covered	
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	

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 need help recovering or have other special health needs	Home health care	Not covered	Not covered	There is no coverage for this type of medical event. You must pay 100% of these expenses, even in-network. If you are enrolled in GHI- CBP, the Extended Medical Benefits pay 60% and you pay 40% of the difference between the amount reimbursed by GHI-CBP non-hospital, out-of-network physician charges and the allowed amount plus balance-billing charges after the deductible. After reaching the out-of-pocket limit, you only pay balance-billing charges. *See Extended Medical Benefits Section of plan document.
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	Davis Vision: No charge	Amount over $200 plan allowance (combined with glasses)	Vision benefits are separately administered by Davis Vision. Limited to one eye exam and one pair of glasses or supply of contact lenses once per calendar year.
	Children's glasses	Davis Vision Frame Collection: No charge; Another frame from a network provider: Amount over $100 plan allowance, subject to a 20% discount	Amount over $200 plan allowance (combined with eye exam)	
	Children's dental check-up	Delta Dental: No charge Guardian: Amount over plan allowance	Delta Dental: Not covered; Guardian: Amount over plan allowance	Dental benefits are separately administered. Delta Dental: Limited to 1 check-up every 6 months Guardian: Check-ups limited to once every 4 months

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- All items in the "Common Medical Events" chart starting on page 2 except for prescription drugs and dental and eye care for children

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

- Dental care (Adult) (Delta Dental limited to 1 check-up every 6 months/Guardian limited to 2 check-ups per calendar year)
- Hearing aids (Limited to $750/ear every 36 months)
- Routine eye care (Adult) (Eye exam and glasses limited to once every 12 months)
- Weight loss programs (Limited to Weight Watchers registration fees and 50% of 8 weekly Weight Watchers meetings fees)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: PSC-CUNY Welfare Fund at 212-354-5230 or communications@psccunywf.org.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **No**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 212-354-5230.

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

* For more information about limitations and exceptions, see the plan document at www.psccunywf.org

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**N/A**
Specialist cost sharing	**N/A**
Hospital (facility) cost sharing	**N/A**
Other cost sharing	**N/A**

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$12,680
The total Peg would pay is	**$12,690**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**N/A**
Specialist cost sharing	**N/A**
Hospital (facility) cost sharing	**N/A**
Other cost sharing	**N/A**

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$150
What isn't covered	
Limits or exclusions	$5,280
The total Joe would pay is	**$5,430**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**N/A**
Specialist cost sharing	**N/A**
Hospital (facility) cost sharing	**N/A**
Other cost sharing	**N/A**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$2,790
The total Mia would pay is	**$2,800**

This Plan only provides supplemental benefits so these coverage examples are not applicable. See your employer's SBC for coverage of basic health benefits.
If you are covered under the GHI-CBP, this Plan may pay benefits for some unreimbursed expenses payable under the GHI benefit under the Extended Medical benefits.