PSC-CUNY Welfare Fund Medicare-Eligible Retirees

Coverage Period: 07/01/2023 – 06/30/2024

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual/Family** | **Plan Type: Supplemental**

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.psccunywf.org or by calling 212-354-5230.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 0	See the chart starting on page 2 for the costs and services this plan covers.
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?	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?	The plan has no out-of-pocket limit	Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any coverage limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of pharmacy In-Network providers, visit caremark.com. For a list of dental In-Network providers, visit www.psccunywf.org or call the Fund Office at 212-354-5230.	If you use an in-network **pharmacy** or participating **dentist**, the plan will pay some or all of the covered services. Be aware that participating providers may use a non-participating **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart beginning on page 2 for how this plan pays different kinds of **providers**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about excluded services

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 20% w 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 **provi 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**, **co-payments** and **co-insurance** amounts.

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

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 covers supplemental benefits. See your employer's Statement of Benefits and Coverage (SBC) for coverage of basic health benefits.
	Specialist visit	Not Covered	Not Covered	
	Other practitioner office 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	See your employer's SBC for coverage of basic health benefits.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition More information about **drug coverage:** Caremark.com	Generic drugs	Greater of $5 or 20% Retail Greater of $10 or 20% Mail	By schedule	
	Preferred brand drugs	Greater of $15 or 20% Retail Greater of $30 or 20% Mail	By schedule	Incentive to Use Mail Order : Co-pay for 90-day supply through mail order is equal to 60-day supply at retail pharmacy.
	Non-preferred brand drugs	Greater of $30 or 20% Retail Greater of $60 or 20% Mail	By schedule	
	Specialty drugs	Greater of $5 or 20% Retail Greater of $10 or 20% Mail	By schedule	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	See your employer's SBC for coverage of basic health benefits.
	Physician/surgeon fees			
If you need urgent medical attention	Emergency room services & urgent care			
	Emergency medical transportation			
	Urgent Care			
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	See your employer's SBC for coverage of basic health benefits.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	See your employer's SBC for coverage of basic health benefits.
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	See your employer's SBC for coverage of basic health benefits.
	Delivery and all inpatient services			

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	See your employer's SBC for coverage of basic health benefits.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam	$0	Charges less $100	Children 19 & under have yearly benefit. Can choose GVS, Davis, or up to $100 annual reimbursement at time of service.
	Glasses	No cost for basic plan frames		
	Dental check-up	$0	Charges less $24	Periodic oral evaluation: 2 per calendar year. Member elects either Delta or Guardian Plan

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.)

- 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
- Weight loss programs
- All items in the "Common Medical Events" on the prior pages except Prescription Drugs for members and Dental and Eye care for children

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.)

- Dental care (Adult & Child, excluding purely cosmetic dental treatment, more than one prophylactic dental visit every 6 months, temporomandibular joint TMJ dysfunction)
- Hearing aids
- Routine eye care (Adult & Child)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then depending on 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 you rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Fund Office at PSC-CUNY Welfare Fund Office, 61 Broadway, 15th Floor, New York, NY 10006 or via phone at 212-354-5230. 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** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: PSC-CUNY Welfare Fund, 212-354-5230 or communications@psccunywf.org. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 212-924-7220.

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. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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 to providers:** $7,540
- **Plan pays:** N/A
- **Patient pays:** N/A

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	N/A
Co-pays	N/A
Co-insurance	N/A
Limits or exclusions	N/A
Total	**N/A**

See your employer's SBC for coverage of basic health benefits.

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

- **Amount owed to providers:** $4,100
- **Plan pays:** N/A
- **Patient pays:** N/A

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Deductibles	N/A
Co-pays	N/A
Co-insurance	N/A
Limits or exclusions	N/A
Total	**N/A**

See your employer's SBC for coverage of basic health benefits.

Retirees' diabetic meds are covered the same as other Rx drugs.

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.