



Full-time Active Employees

Summary Plan Description

2010

**PSC-CUNY Welfare Fund
61 Broadway, 15th floor
New York, NY 10006**

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Eligibility

Full-time members of the instructional staff of CUNY paid by tax-levy funds and whose titles are covered within the Professional Staff Congress of CUNY are eligible for supplemental health benefits provided by the PSC-CUNY Welfare Fund. Qualified Continuing Education Teachers who have basic NYC Health Benefits coverage are eligible for regular and voluntary Welfare Fund benefits. In addition to these persons, certain management personnel and exempt titles are also covered. A complete list of covered titles is presented in Appendix A.

Eligibility is nearly coincident with employment. Benefits are available on the first day of the month following date of hire. Benefits are discontinued at the end of the month of termination of employment.

An eligible individual who waives coverage for self and or dependents because of other health insurance or group health plan coverage, may be able to enroll at a later time if that other coverage is subsequently terminated or significantly altered. The individual must complete an updated Enrollment Form indicating the events requiring amended status. Coverage will not be effective until the Welfare Fund Office receives the necessary Enrollment Form/Data Sheet and any applicable proof of dependent status. If the Welfare Fund Office receives the request for enrollment in these circumstances within 30 days of the event, coverage will be retroactive to the date of the event. If it is received after 30 days, coverage is effective the first of the month following receipt of the completed enrollment material.

The same provisions apply if an individual or dependent loses coverage through Medicaid or a State Children's Health Insurance Program (CHIP). If the Welfare Fund Office receives the request for enrollment due to loss of coverage in Medicaid or a CHIP or because of eligibility for a premium assistance program within 60 days of the event, coverage will be retroactive to the date of the event. If it is received after 60 days, coverage is effective the first of the month following receipt of the completed enrollment material.

Please note that the above does not apply to the Voluntary Benefits. There are special eligibility and enrollment rules for the Voluntary Benefits made available to Plan participants.

Dependent Eligibility

If you are covered, your **spouse** or qualified domestic partner is covered. Domestic partners are qualified if duly registered with the New York City Clerk's Office and able to demonstrate financial interdependence. Certain tax implications apply to benefits for domestic partners. These may be reviewed with qualified tax professionals.

If you are covered, your eligible **dependent children** are covered. The Fund defines eligible dependent children as natural or adopted children who are a) under age

19 or b) age 19 to 23 and unmarried, dependent, full-time students or c) totally and permanently disabled and who became so prior to their 19th birthday.

Dependents (spouse and children) must be *enrolled* with the Welfare Fund. Proof of school enrollment must be provided twice per year, in the spring and fall, for full-time students between 19 and 23.

Notwithstanding the above, for medical leaves of absence (or other changes in enrollment) that begin on or after January 1, 2010, the Plan will continue coverage for up to one year while a student is on a medically necessary leave of absence provided that:

- The Plan receives written certification from the child's physician that (a) the child is suffering from a serious illness or injury, and (b) the leave of absence (or other change in enrollment) from the post-secondary school is medically necessary; and
- The loss of student status would cause a loss of coverage under the Plan.

This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

Continuum of Coverage

Basic – CUNY / CITY Program

- ❖ All covered persons receive **basic health insurance** through the NYC Employee Health Program. This consists of hospital and medical insurance provided by one or more carriers chosen by the plan participant. Campus Human Resources offices or the New York City Health Benefits Program (NYC HBP) should be able to answer questions regarding this level of coverage.
- ❖ This basic health insurance also provides coverage for certain drugs. At the time of this writing, these are still called the **PICA drugs** but are limited to injectable and chemotherapy medications. Campus Human Resources officers or the NYC HBP should be consulted for further detail and updates. You will be issued a drug card specifically for the PICA drugs. It is not a Welfare Fund benefit. **The phone number for the NYC HBP is (212) 306-7200.**

Supplemental –PSC-CUNY Welfare Fund

- ❖ The PSC-CUNY Welfare Fund provides benefits referred to as **supplemental health insurance**. These are the benefits described in this book. Some of these Welfare Fund benefits vary according to which basic

health insurance a plan participant has. Enrollment in basic health insurance is generally a pre-requisite to Welfare Fund eligibility. Persons who waive their basic coverage should contact the Fund office for details.

- ❖ One of the benefits provided by the PSC-CUNY Welfare Fund, Long Term Disability, has an **optional (contributory) rider**. For an extra payment, typically through payroll deduction, a higher level of benefit can be obtained under the disability benefit.
- ❖ Also explained in this book are **three benefits not funded** by the Welfare Fund, but provided through favorable arrangements or negotiated agreements in order that plan participants may purchase quality programs at the best rates. These include **life insurance** coverage through NY State United Teachers (NYSUT), **catastrophic medical insurance** through US Life (brokered by Marsh Affinity) and **long-term care insurance** through John Hancock.

Initiation of Coverage

The starting point of enrollment in the Basic Program and the Welfare Fund is with the appropriate CUNY Human Resources office on campus. Forms and explanatory booklets are available to enroll in a choice of N.Y. City programs. Each new hire is also provided with an Enrollment Form (Data Sheet) to enroll in the PSC-CUNY Welfare Fund. These should be completed and returned as soon as possible. **No benefits are available until enrollment is completed and processed.**

Termination of Coverage

At the point that coverage terminates, plan participants will be notified of their rights to purchase benefits in accordance with the federal COBRA regulations. This notice is issued by your college personnel office and includes both the basic health insurance program and supplemental benefits under the PSC-CUNY Welfare Fund.

Dental Benefits

This Benefit was changed Effective 01/01/2007

Coverage is provided to plan participants and eligible dependents through either the **Guardian Life Insurance Company** or **Delta Dental**. Plan participants are required to select one of the options for themselves and their families. Those who do not make an election are automatically enrolled in the Guardian Program. Both the Guardian program and the Delta program are available to eligible members without premium payment. Neither has a “rider” option.

Guardian Dental Guard Preferred

This is a “preferred provider” (PPO) program with two components:

- 1) access to a panel of dental providers who charge **reduced fees**
- 2) partial reimbursement for services rendered (according to a **Reimbursement Schedule**)

Benefits include *most* standard dental procedures. There are no annual or lifetime maximum payment limitations. Plan participants may use any licensed dentist to provide services, although non-participating dentists are not required to charge the reduced fees, thereby eliminating the value of component 1). above.

The provider panel maintained by Guardian Life is **Dental Guard Preferred**. Information on participating dentists is available from Guardian:

Phone: (800) 848-4567
Website: [Guardian Providers](#)
Schedule: PSC-CUNY Guardian Schedule of Reimbursements

Frequency Limits: Standard prophylactic care (cleaning and necessary x-rays is covered once every six months.

Benefit Limits: Coverage is not provided for certain types of care. Please refer to [Guardian Benefit Limits](#) and [Guardian Contract Limitations](#). Limitations often involve technical matters. Pre-Treatment Review is recommended.

Pre-Treatment Review: Each plan participant is entitled to be informed by Guardian of the total cost, plan reimbursement and out-of-pocket costs associated with a course of dental treatment. Forms are available at participating dentist offices or from Guardian.

Filing a Claim: Claim forms are available [here](#) or from participating providers, by mail from Guardian and through the Guardian Website. Guardian Forms have the mailing address on them. Claim forms should be submitted to:

Guardian Group Dental Claims
P.O. Box 2459
Spokane, WA 99210-2459

DeltaCare USA

This is a dental Health Maintenance Organization; Members who enroll will select a primary care dentist for each eligible family member. That dentist will be responsible for all dental care including referral to specialists as necessary. Members will pay for dental services in accordance with the agreements that Delta has with the dentists. The patient fee is set for each service.

Unlike traditional insurance, there are no claims to complete or reimbursement to await. There is no annual or lifetime limit on services.

Enrollment in the Delta program is available each year and coincides with the City-wide open enrollment period.

The HMO program is sponsored by Delta Dental and called **DeltaCare USA**. It is administered by PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579

Information on dentists participating with the HMO is available from Delta at their
Phone: (800) 422-4234 NJ Residents Only : (800) 722-3524
Website: [Delta Main Page and DeltaCare Providers](#)
Schedule: [DeltaCare Provider Allowed Charges](#)

Benefit Limits: Coverage is not provided for certain types of care. Please refer to [Delta Exclusions and Limitations](#).

“Optional” Fee Payments: Certain procedures are deemed “optional” in the Delta Fee list which typically indicates that it is a procedure that may exceed an accepted norm of service. For example, color-matched fillings are above the norm on molars, whereas they are standard practice on front teeth. Members who decide to have color-matched fillings on molars would pay a higher fee and that fee is in accordance with the profile of each dentist maintained by Delta dental. PMI Dental Health can provide this information.

Emergency Care: Whereas members are generally required to use the primary dentist or an HMO specialist referred by that dentist, there is a provision for emergency treatment up to \$100 per year. Claim forms and regulations are available from PMI Dental Health at the address listed above.

Prescription Drug Benefits

Plan participants must be enrolled in a basic health plan to be eligible for the Medco Prescription Drug Program. Participating members will receive a Medco prescription **drug card** unless they elect to purchase an optional drug rider through certain basic health programs. Those who elect a rider over the card should refer to the *Stipend* section below.

Medco Drug Card

Scope of Benefit: The plan covers most drugs that legally require a prescription and have FDA approval for treatment of the specified condition. Drugs available without a prescription, classified as "over the counter," (OTC) are not covered

regardless of the existence of a physician's prescription. The Welfare Fund program through Medco encourages utilization of (a) generic equivalent medications, (b) selected drugs among clinical equivalents and (c) use of mail order (home delivery) systems to help contain costs.

(a) If a **generic equivalent** medication is available and you or your physician chose it, you pay the standard co-payment for a generic drug. If you choose a brand name drug (either preferred or non-preferred) when a generic is available, you will pay the brand name drug's co-payment *plus* the difference in cost between the generic drug and the brand name drug.

(b) Medco has determined a list of drugs that treat medical conditions in the most cost-efficient manner. This list, or **formulary**, is regularly reviewed and updated by physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-formulary drugs.

c) **Home delivery** (mail-order) is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. Using the mail-order program for a larger prescription (i.e. 3-month or 100-day supply) reduces the overall co-payment. After an initial fill and a two re-fills of any prescription at a local pharmacy, higher levels of co-payment are assessed for continued use of the retail pharmacy.

Maximum Annual and Lifetime Payment

The program carries a \$10,000 annual maximum and \$100,000 lifetime maximum for each individual covered.

Co-payment

A co-payment is the part of the drug cost that is paid by the plan participant. Co-payments calculations are based on the *category* (generic, formulary, and non-formulary) and *place of purchase* (retail pharmacy or mail-order pharmacy).

Retail Pharmacy Co-payments

(Maximum days' supply = 30 days)

First three prescriptions filled

Greater of \$ 5.00 or 20% for generic drugs

Greater of \$15.00 or 20% for formulary drugs

Greater of \$30.00 or 20% for non-formulary drugs

All subsequent fills of same medication

Greater of \$ 5.00 or **35%** for generic drugs

Greater of \$15.00 or **35%** for formulary drugs

Greater of \$30.00 or **35%** for non-formulary drugs

Non-Covered or Restricted Drugs

The program does **not** cover the following

- Fertility drugs
- Growth hormones
- Needles and syringes
- Experimental and investigational drugs
- **PICA** drugs (see **PICA** on page 11)
- Over the counter drugs (i.e., not requiring a prescription)
- Diabetic medications (refer to your NYC Health Benefits Plan carrier, i.e., GHI, HIP, etc.)
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers' Compensation

Mail-Order Pharmacy Co-payments

Maximum supply is 100 days

Greater of \$10.00 or 20% for generic drugs
Greater of \$30.00 or 20% for formulary drugs
Greater of \$60.00 or 20% for non-formulary drugs

- Medication taken or administered while a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution.
- Shingles vaccine
- Weight Management drugs

The following drugs are covered with limitations:

- Drugs for erectile dysfunction up to an annual maximum reimbursement of \$500, with a maximum of 18 tablets every 90 days.
- Smoking cessation drugs up to an 84-day supply

Reimbursement Practices

Prescriptions filled at participating pharmacies will require presentation of a valid drug card. The co-payment must be met in order to acquire medication.

Prescriptions filled at non-participating pharmacies or without presenting a drug card may require payment in full. In such cases, Medco will honor a Direct Reimbursement Claim for payment, but only to the extent of the amount that would have been paid to a participating pharmacy, adjusted for co-payment and deductible.

Using Mail Order

Participants may obtain a "Home Delivery Pharmacy Service Order" form by contacting Medco. Physicians may call 1-888-327-9791 for instructions on how to FAX a prescription.

Standard Shipping and handling is free; express delivery is available for an added charge. Temperature-sensitive items are packaged appropriately, but special measures may be necessary if there are delivery and receipt issues at an additional cost to the member.

Special Accommodations

Travel or Vacation

If a larger-than-normal supply of medication is required, a participant may contact the Welfare Fund - at least three weeks in advance - so that appropriate arrangements can be made with the prescription drug plan.

Eligible dependent children away at school

If an eligible dependent child is away at school, a separate card may be made available for that child by contacting the Fund. The initial card is issued at no cost but a payment of \$10.00 is required each time a card is re-issued. Prescriptions filled in other manners will require the student to pay the full cost of the prescription and submit a claim for direct (partial) reimbursement.

Contact Medco

Customer Service (866) 386-3797

Web Site www.medco.com

For information on

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms
- Interactive Pharmacy Locator
- Claim Form Download (or click [here](#))
- Mail-order tracking
- Formulary Drug Listing

Non-Medco Drug Coverage

PICA for Medco members

There are some drugs for which participants do *not* use the Medco card, but instead use another card, *not* issued by the Welfare Fund. For eligible full-time active participants, *Injectable* and *Chemotherapy* medications are available *only* through the **PICA** program, which is sponsored by the N.Y. City Employee Health Benefits Program, and – at the time of this writing – administered by Express Scripts. *The N.Y. City Employee Health Benefits Program, tel. 212-306-7200, should be consulted for further detail and updates.* Eligible individuals will be issued a drug card for PICA coverage.

Stipend for Rx coverage in lieu of Medco

Eligible full-time active participants who wish to opt out of Medco may purchase a drug rider through their basic health carrier if their carrier is Aetna US Health Care, CIGNA,

HIP Prime POS, or GHI HMO. This may be elected at the time of employment or during any open enrollment period through the city of New York. The plan participant will receive a stipend to offset cost. The current stipend is:

Individual	\$300 per year
Family	\$700 per year

Payment is made within 45 days of the end of a calendar year. If rider coverage was only in effect part of the year reimbursement will be pro-rated. The Fund office will provide claim forms on request.

Members who participate in a drug rider plan through a basic health carrier will automatically be dropped from the Medco plan.

Optical Benefits

Plan participants and their eligible dependents are entitled to a pair of glasses (**lenses and frames and an optometric examination**) *once every two years*. The benefit can be rendered through *one of two vendors* contracted by the Fund, General Vision Services or Davis Vision *or through other licensed providers*.

Service through the Fund's vendors has no out-of-pocket costs for a limited selection of frames and lenses. Service rendered through other providers is subject to a maximum reimbursement of \$100, claims should be submitted within 90 days of service. Eye examinations other than for purchase of glasses or contact lenses are not covered.

General Vision Services

Examination is provided by a licensed optometrist for determination of refractive index as well as detection of cataracts, glaucoma and retinal / corneal disorders.

Frames are available in the New York Metropolitan area stores in any style, up to a retail value of \$150. Outside of the area, stores have contracted to offer up to a \$100 retail value.

Lenses are all first quality and cover single vision, conventional bifocal, blended bifocal, progressive, trifocal, cataract, safety and oversize lenses. Cosmetic tint, Sunglass tint, UV coating and Scratch-resistant coating are available at no charge (New York metropolitan area outlets only).

Contact Lenses are available instead of glasses, for either standard soft daily wear or extended wear spherical, *or* a 3-month supply of basic disposable lenses; (2 boxes for a total of 12 lenses).

Special Dependent Coverage allows eligible children under 19 (23 if a full-time student) a pair of glasses (frame and lenses) every 12 months (known as the “off year” benefit).

Participating Providers : For a listing of General Vision Providers participants may go on-line to www.generalvision.com or call GVS at 1-800-847-4661.

To Use Your Benefit at General Vision, simply go to a location and say you are a PSC-CUNY Welfare Fund participant! You do not need to call the Welfare Fund to arrange anything. General Vision will verify your eligibility.

Davis Vision

Examination is provided by a licensed optometrist for determination of refractive index as well as detection of cataracts, glaucoma and retinal / corneal disorders. There is no co-payment when using an in- network provider.

Frames are available, with no co-payment, from the Davis Vision Designer Collection, up to a retail value of \$175. This collection is available at most in-network providers. A \$25 wholesale credit is applied toward frames outside of the Collection.

Lenses are all first quality and cover plastic or glass single vision, conventional bifocal or trifocal in any prescription range, blended bifocal or trifocal lenses, post-cataract lenses, oversize lenses, fashion, sun or gradient-tinted lenses, UV coating and scratch-resistant coating , photosensitive glass lenses and polycarbonate lenses (for children, monocular patients and those with a prescription of +/- 3.0 diopters or greater) are available at with no co-payment at any in-network provider.

Contact Lenses may be selected in lieu of glasses. An \$85 fee will be applied toward contact lenses from the provider’s own supply. The fee may be applied toward fitting fees and follow-up care. Medically necessary contact lenses will be covered in full with prior approval only.

Participating Providers : For a listing of Davis Vision providers by area, Davis Vision may be contacted directly at (800) 999-5431. **Participants may access the Davis Vision website at www.davisvision.com; click on “Find a Doctor” and use the access code 2022.**

To Use Your Benefit at Davis Vision: Before you go to a Davis outlet, you must call the Welfare Fund, 212-354-5230, to register and activate your eligibility. If you do not call the Fund first, you will not receive service.

Other Providers

Any Licensed Provider of vision services may be used as an alternative to General Vision Services or Davis Vision. The reimbursement will cover costs not to exceed

\$100 every two years. Claim Forms are available [here](#) and should be submitted within 90 days of service.

Eye examinations are covered through a participating provider when made in conjunction with the purchase of glasses or contact lenses. If the purchase of corrective lenses and frames is made at a later time, there is a three-month limit in order to qualify for the balance of the benefit.

Split Services may occur if a participant obtains an examination through a vendor, then elects to have the prescription filled elsewhere or not at all (doesn't file with the Fund) Reimbursement will be limited to the initial vendor. All services must be performed within 90 days. *Special Note: Split services are not available for contact lenses.* Prescriptions for contact lenses must be filled by the provider who performs the examination.

Disability Benefit

Basic Plan

This benefit is a partial income replacement plan available to plan participants with *at least one year of service* who become totally disabled. Total disability is defined as **the inability to work in any job for which you are fitted by education, training or experience, due to an illness or injury.** The carrier for this benefit is The Standard Life Insurance of New York.

Total disability must be **verified by an evaluating physician** approved by the carrier.

There is a six-month waiting period. Payments begin six months after determination of disability, providing that the disability has continued. However, if accumulated sick and vacation time payments are still being made at the end of the six-month period, the waiting period is extended until these payments are exhausted.

Income replacement provides 50% of your pre-disability basic salary, with a *minimum of \$1,250 per month* and a *maximum of \$2,500 per month.* Actual payment is net of required deductions. These deductions may include receipt of payments from Worker's Compensation, Social Security or CUNY retirement / salary continuation plans.

The duration of payments is up to five years (60 months) or attainment of age 70—if that event comes first—providing the total disability continues. If payment would otherwise cease due to the age 70 restriction, there is an override to provide a minimum of one year (12 months) of payments.

Long Term Plan

Participants may elect after one year of service to purchase **long term disability protection**. If the election is made ***within 60 days*** of your initial eligibility, issue is “guaranteed”—no medical evaluation is required to qualify for the higher level of protection. ***Later elections require a medical evaluation by the carrier.*** For a premium - met through payroll deduction - the benefits are improved three ways:

- 1) Income replacement is at **60% of your pre-disability basic salary** with a *minimum of \$1,500 per month and a maximum of \$6,000 per month.*
- 2) **The duration of payments is not constrained to five years**, but extends from inception to age 65. If you are over 60, the five-year / age-70 provision of the basic plan applies.
- 3) **Pension payments continue to be made** on your behalf to a TIAA-CREF pension in the amount of 10% of your pre-disability basic salary.

A detailed certificate explaining the features of the long term disability plan through the Standard Life Insurance Company is available [here](#). The premium is determined by an age and salary matrix available from the carrier.

Extended Medical Benefit

***This benefit changed, effective 01/01/2007
The carrier changed 07/01/2008***

Plan participants who have basic coverage through GHI-CBP have an additional level of medical cost protection through the PSC-CUNY Welfare Fund Extended Medical benefit. The benefit is designed to provide a buffer against large medical expenses associated with serious or long-term illness that are not met by the basic employer-provided insurance, and better coverage (additional payment) for out-of-network provider use of medical services. The program is administered by Administrative Services Only, Inc. (ASO). It was formerly administered by GHI. This extended medical benefit does not cover procedures that are not covered under the basic health plan, nor does it lift any frequency limitations.

Deductible

Expenses are considered after an annual deductible has been met. The amount of the deductible is determined by whether or not the participant has elected the GHI-CBP optional rider. If the participant has elected the rider, the deductible is \$1,000 per person for the year, with a maximum of \$2,000 for a family. If the participant has not elected the rider, the deductible is \$4,000 per person for the year, with a maximum of \$8,000 for a family. The amount that is applied to calculate the deductible is the total difference between the GHI-CBP allowance on covered services and the participant's payment to the provider for those services.

Coinsurance

After the deductible is met, the Welfare Fund Extended Medical plan will pay 60% of the difference between the amount reimbursed and the “reasonable and customary” charges. “Reasonable and Customary” charges are determined by a schedule maintained by the carrier and the Fund. This schedule may change from time to time at the discretion of the Trustees of the Fund. As of 1/1/2007, the Fund is using the 80th percentile level of the HIAA/Ingenix Schedule that is generally considered the industry standard. Once coinsurance payments have reached \$3,000 for a covered individual in a year (or \$6,000 for the family) the plan will pay without a co-insurance, i.e., 100% of the difference between the amount reimbursed and the reasonable and customary charges according to the schedule.

Limits

Benefits are limited to those covered by the GHI benefit plan. Annual and lifetime caps are in accordance with the GHI contract with the NYC Employee Benefits Program.

Death Benefit

The PSC-CUNY Welfare Fund provides a \$2,500 death benefit to the beneficiary of a full-time covered member who dies while in active service. Persons who joined the Welfare Fund after July 1, 2003 must fill out a Death Benefit Beneficiary Card, available at your personnel office. For employees prior to that time, the Fund will use the beneficiary card on file at the appropriate personnel office. If the primary member wishes to change beneficiary(ies), a new card needs to be completed.

First-Year Term Life Insurance

Many new full-time CUNY employees covered by PSC-CUNY Welfare Fund will receive Term Life Insurance with a face value of \$25,000 for one year, and with the option to purchase the \$25,000 coverage at the end of the year. The premium is determined by the age of the participant at the point the option is exercised.

The program is sponsored through the New York State United Teachers (NYSUT) Trust and is therefore limited to new NYSUT members. **Persons who were members of NYSUT prior to employment by CUNY are not eligible for this “first year” benefit.** The benefit is available to all persons eligible for the Welfare Fund, including management and excluded titles which can technically not become members of NYSUT.

Eligible employees are automatically enrolled by CUNY and receive a certificate of coverage. Upon completion of one year, an option is provided to continue coverage *by paying a premium*. For further information, please refer to the section on Voluntary Term Life Insurance.

Hearing Aid Benefit

Eligible plan participants and their dependents are eligible for hearing aid benefit every 36 months. Using a participating doctor will reduce your out-of-pocket costs. If you use a non-participating doctor you must submit a claim for reimbursement. Maximum reimbursement is \$500.

The following are **not** covered under this benefit.

- Expenses not recommended or approved by a physician or audiologist;
- Medical or surgical treatment of the ear or ears;
- Non-durable equipment, such as batteries, and
- Rental, trial period or repair of hearing aid.

Wellness Benefit

Eligible participants may receive partial reimbursement for fees associated with recognized programs of diet and weight control. Fees are restricted to registration and meeting costs and do not cover food products, vitamins or nutritional supplements.

Survivor Benefits

The Welfare Fund provides a package of benefits for the surviving covered spouse / covered domestic partner / and dependent child(ren) of an active covered employee who dies.

The extent of the coverage depends upon length of service and it may fully or partially replace federally-mandated COBRA coverage.

- The benefits are the following, as described elsewhere in this booklet:
- Prescription Drugs

- Dental
- Optical
- Hearing Aid
- Major Medical (if applicable)

If the deceased covered employee had **ten (10) or more years** of full-time service with CUNY, coverage is extended for up to *three years* (36 months). After that coverage is exhausted, the spouse and/or dependents may purchase a Survivor Benefit which carries a premium charge. The package of benefits is the same as listed above, with the *exclusion* of Major Medical.

If the deceased covered employee had **less than ten (10) years** of full-time service with CUNY, coverage is extended for up to *one year* (12 months). After that coverage is exhausted, the spouse and/or dependents may purchase up to 24 months of COBRA coverage (see page 19) for a premium. After COBRA entitlement expires, the spouse and/or dependents may purchase a Survivor Benefit which carries a premium charge. The package of benefits is the same as listed above, with the *exclusion* of Major Medical.

Premium information is available from college personnel offices, which will also provide continuation / COBRA information on basic (Medical / Surgical /Hospital) coverage.

It is the responsibility of the surviving spouse (or covered domestic partner / covered dependent child(ren)) to notify the college personnel office and the welfare fund office of the death of the covered employee.

Spouse and dependents must continue to meet the requirements of eligibility under the Welfare Fund. This coverage is available only to those without other, comparable coverage. Failure to pay the premium will discontinue coverage permanently. Application forms are provided upon notification. The surviving spouse/domestic partner/covered dependent has 30 days from the date of notification to decide to purchase benefits.

COBRA Continuation of Benefits

If Welfare Fund benefit coverage is lost, participants and dependents may be eligible to continue to receive some or all of those benefits by paying a premium. The right to continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 otherwise known as **COBRA**.

COBRA provides for a continuation of benefits when coverage would otherwise terminate due to a “**qualifying event**.” Specific qualifying events are listed below. After a qualifying event, COBRA coverage is made available to each person who is a “qualified beneficiary.” Participants (employees), spouses and dependent children may

become qualified beneficiaries. Those who elect COBRA continuation coverage must pay a premium which is established by the Fund actuaries in accordance with Federal COBRA regulations.

Welfare Fund COBRA coverage is separate and apart from basic Health Insurance COBRA coverage. Information on basic Health insurance COBRA is available from CUNY Benefits offices. Enrolling in basic Health insurance COBRA does not assure enrollment in Welfare Fund COBRA and vice versa.

Employee qualifying events include:

- Hours of employment are reduced to the extent plan eligibility is lost, or
- Employment is terminated for any reason other than your gross misconduct.

Spouse qualifying events include:

- The participant (employee) dies,
- The participant (employee)'s hours of employment are reduced to the extent plan eligibility is lost,
- The participant (employee)'s employment is terminated for any reason other than your gross misconduct,
- The participant (employee) and spouse divorce or legally separate resulting in a loss of coverage,
- The participant (employee)'s plan coverage changes from family to individual, or
- The participant (employee) becomes entitled to Medicare.

Dependent Child qualifying events include:

- The participant (employee) dies,
- The participant (employee)'s hours of employment are reduced to the extent plan eligibility is lost,
- The participant (employee)'s employment is terminated for any reason other than your gross misconduct,
- The parents divorce or legally separate resulting in a loss of coverage,
- Coverage under the plan changes from family to individual, or
- The child loses eligibility as a "dependent child".

Qualified beneficiaries and Duration of Benefit

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. A spouse or child may elect COBRA coverage independent of a terminated employee's decision.

- ✓ When the qualifying event is the *end of employment or reduction of the employee's hours* of employment, COBRA continuation coverage lasts for up to **18 months**.
- ✓ When the qualifying event is the *death of the employee, divorce, termination of a domestic partnership, change in plan coverage from family to individual or a dependent child's losing eligibility*, COBRA continuation coverage lasts for up to **36 months** for spouses and children who are qualified beneficiaries.

There are circumstances that may *extend the eligibility period*:

- 1) If a terminated participant covered through COBRA is determined by the Social Security Administration to have become disabled prior to the 60th day of COBRA coverage, the applicable family unit may be entitled to receive up to an additional 11 months or up until the termination of the disabling condition.
- 2) If a family experiences another qualifying event (participant death or a divorce or separation) while receiving 18 months of COBRA coverage, the spouse and dependent children in the applicable family may get up to 18 additional months of COBRA coverage, to a maximum of 36 months. If the second qualifying event is a child's loss of coverage, the right extends only to the child.

Notification Responsibilities

The Fund will offer COBRA continuation coverage to qualified beneficiaries only if properly notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, reporting is the responsibility of the employer.

For some qualifying events the responsibility for reporting rests with the participant. With a *divorce* or termination of domestic partnership or with a child losing dependency status due to age or school discontinuance, the participant affected parties must notify the Fund Office within 60 days of the later of date that the qualified beneficiary would lose coverage after the qualifying event or the qualifying event itself. The Fund Office and CUNY require supporting documentation.

As a practical matter CUNY campus HR offices distribute Welfare Fund COBRA information to new hires and COBRA qualified beneficiaries simultaneous with basic insurance COBRA information. Each person who has a qualifying COBRA event should receive basic insurance COBRA notice and enrollment material as well as Welfare Fund notice and enrollment form. Notice will include requirements for timely decisions and remittance of premium.

Choice of Coverage

Coverage and premium costs depend upon three factors:

- 1) qualified beneficiary's selection of "**Core coverage**" or "**Full coverage**"
 - *Core coverage* includes
 - drug, hearing aid, death and extended medical (as applicable)
 - *Full coverage* includes
 - core coverage (above) *plus* optical and dental,
- 2) the CUNY **Basic Health Insurance** of the participant,
 - GHI-CBP / Blue Cross
 - All other carriers or
 - None,
- 3) **Contract size**
 - Individual or
 - Family.

The combination of the three factors determines the monthly premium. Rates are available from campus benefit offices or from the PSC-CUNY Welfare Fund.

Termination of Coverage

COBRA continuation coverage is terminated at the earlier of the following:

- 1) exhaustion of the basic and (if applicable) extended periods as defined herein,
- 2) failure to pay the COBRA premium on a timely basis. The premium is due the first day of the month of coverage (after the initial period). Benefits will be suspended with all vendors and carriers at the end of eight (8) business days. If premium is not received by the end of the month, coverage is terminated permanently. The Fund does not bill.
- 3) Removal or reversal of the conditions of the qualifying event. This includes but is not limited to employment or re-employment or re-marriage that results in the opportunity for comparable group coverage
- 4) Medicare eligibility

More Information

COBRA regulations are voluminous and complex. Every effort has been made in this section to present highlights necessary to make appropriate decisions, but not to present all details of the program. Questions concerning COBRA continuation coverage rights may be addressed to the Fund Office or for more information, participants may wish to contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at <http://www.dol.gov/ebsa/>

HIPAA

The PSC-CUNY Welfare Fund is bound by federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund is in full compliance with all relevant parts of the Act. The full text of HIPAA can be found through the HIPAA Privacy Web site of the Office for Civil Rights (OCR): <http://www.hhs.gov/ocr/hipaa>. There are four components of HIPAA that impact participants of this Fund: Portability, Non-Discrimination, Privacy and Security.

Portability

The portability provisions of HIPAA provide rights and protections for participants and beneficiaries who move from one group health plan to another. HIPAA includes protections for coverage under group health plans that limit exclusions for preexisting conditions, and allows a special opportunity to enroll in a new plan to individuals in certain circumstances.

When your eligibility for health benefits from the Fund ends, or if you terminate coverage with the Fund, you, your spouse, and/or your dependents are entitled to a statement of covered benefits called a "Certificate of Creditable Coverage," which you may present in the course of enrolling in a new group health plan.

Certificates of Creditable Coverage indicate the period of time you, your spouse, and/or your dependents were entitled to Welfare Fund benefits, as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you, your spouse, and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within sixty-three (63) days after your eligibility for Welfare Fund benefits ends. The Certificate of Creditable Coverage is necessary because it may reduce or eliminate exclusion for pre-existing coverage periods that may apply to you, your spouse, and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you if you should request it within twenty-four (24) months after your eligibility for Welfare Fund benefits ends.

You should retain the Certificate(s) of Creditable Coverage as proof of prior coverage for your new health plan. For further information, contact the Fund Office.

Non-Discrimination

HIPAA prohibit discrimination against employees and dependents based on their health status.

Privacy

The privacy provisions of HIPAA were issued to protect the health information that identifies individuals who are living or deceased. The rule balances an individual's interest in keeping his or her health information confidential with other business, practical and social benefits.

PHI is defined as individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity, which is transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. For purposes of the Privacy Rule, genetic information is considered to be health information.

Obligations of the Fund to use or disclose PHI

- When requested by a plan participant.
- When required by city, state or federal law or requested in the course of an inquiry into the Fund's compliance with federal privacy law.

Rights of the Fund to disclose the minimal necessary PHI without Authorization

- To facilitate treatment or to coordinate or manage health care with covered providers, vendors or insurers, or to facilitate payment by provision of information regarding eligibility to covered providers, vendors or insurers.
- To promote quality assurance in support or programs designed to enhance quality of care with covered providers, vendors or insurers or to contact the

- participant for the provision of information designed to better avail plan features.
- In response to public health risks, to report reactions to medications, or to report victims of abuse, neglect or domestic violence, or in response to a court or administrative order, subpoena, discovery request or other lawful process, but only after reasonable efforts have been made to inform the participant .
 - To comply with workers' compensation laws and other similar legally established programs which provide benefits for work-related injuries or illnesses.

Rights of the Fund to disclose PHI with Authorization

- To a family member or other person identified by the participant as involved in a participant's health care or who assists in the payment of health care unless the Fund is duly notified to restrict the disclosure. If a family member contacts the Fund on behalf of a participant requesting PHI relating to treatment or payment for treatment, the Fund will, upon verification by requesting certain information (such as your Social Security number and date of birth) release such PHI to a family member unless a participant indicates to the Fund in writing to not disclose PHI in those circumstances.

Rights of the Participants regarding PHI disclosure

- To inspect and copy the PHI that the Fund maintains, to request that the Fund amend PHI, to receive an accounting of the Plan's disclosures of your PHI or to request a restriction on the uses and/or disclosures of PHI for treatments or payments, or to someone who is involved in the care rendered. The Fund is not required to agree to a restriction or amendment that is not in writing or does not include a reason that supports the request.

Participants who believe privacy rights have been violated, may file a complaint with the Fund or with the U.S. Department of Health and Human Services.

Security

The Security provisions of HIPAA establish a series of administrative, technical, and physical security procedures for this Fund to assure the confidentiality of electronic protected health information (EPHI). The standards are delineated into either required or addressable implementation specifications.

Much of the focus is on electronic transmission and storage of data. The PSC-CUNY Welfare Fund has taken all necessary measures to assure full compliance with the security regulations set forth. Information related to Security compliance may be reviewed upon request at the Fund office.

Review and Appeals Procedures

If a plan participant disagrees with a benefit or eligibility determination made by the PSC-CUNY Welfare Fund or parties contracting with the Fund to administer components of the program, there is a process to request pursue review.

Type of Review

If the adverse determination involves **eligibility** for benefits, the review should be requested of the Fund Office. The request must be in writing and filed within 60 days of the initial determination. The request should include any new information or documented extenuating conditions that will impact the course of the review.

A decision will be made about a claim of eligibility and notice rendered in writing of that decision within 90 days. Under special circumstances, another 90 days may be needed to review a claim, and the participant will be duly notified of the extension.

If a claim of eligibility is denied, in whole or in part, the following will be noted :

- the specific reasons for the denial;
- the plan provision(s) on which the decision was based
- what additional information may relevant, and
- which procedures should be followed to get further review or file an appeal.

If the adverse determination involves provision of or payment for **benefits**, the review should be directed to the appropriate contract vendor or insurance carrier, according to the type of benefit. The request must be in writing and filed within 30 days of the determination or receipt of notice of the determination. The request should include any new information, medical data or documented extenuating conditions that may impact the course of the review.

Type of Appeal

In the event that a review is negative, the decision may be appealed.

1) An appeal of a **negative eligibility decision** (except declination of coverage by a carrier related to medical suitability) must be directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.

2) An appeal of a **negative benefits decision** related a *non-insured product* [Medco Prescription Drugs, Guardian Dental, GHI Extended Medical, all Vision Care, hearing aids, death and wellness] must by directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.

3) An appeal of a **negative benefits decision** related an *insured product* [Standard Life Disability, Delta Dental HMO, certain HIP or Aetna Drug Riders, Hancock Long-Term Care, AIG Catastrophic Medical] must be directed to the carrier. The carrier is obligated to inform the participant of the appeals process, which will typically extend as far as the State Insurance Department. *These matters are not subject to review by the PSC-CUNY Welfare Fund Board of Trustees.* The Fund office may cooperate with provision of any available materials or with clarification of terms, but is not a party to the process.

An Appeal to the Board of Trustees must be in writing and should include any new information or arguments that you feel will affect the proceedings. In the event of a review regarding a non-insured benefit, this must include the negative determination letter from the vendor/carrier.

Appeals are reviewed by a committee of the Board which convenes as necessary. A decision will be made about an appeal within 90 days of its receipt by the Fund Office *and* determination that necessary information is provided. Under special circumstances, another 90 days may be required, and the participant will be duly notified.

If an Appeal is denied, in whole or in part, it will be noted:

- the specific reasons for the denial;
- the plan provision(s) on which the decision was based.

Voluntary Benefits

Voluntary benefits are those which are made available to Fund participants (and often other dependents) but are not part of the PSC-CUNY Welfare Fund's basic package paid by the employer's contribution. The Welfare Fund has been able to apply expertise and purchasing power to design insurance packages that provide quality benefits for reasonable premiums.

The premiums are borne by the participants (or dependents) themselves.

There are requirements for eligibility and enrollment.

Programs are underwritten and administered by insurance companies and brokers.

The descriptions provided here are intended to cover the salient points, but members are advised to contact the carriers for more complete information.

Voluntary Term Life Insurance

In addition to the \$25,000 first year coverage provided at no cost, Fund participants may elect further term life insurance by paying a premium. This is available to:

- 1) new full-time CUNY employees who are precluded from free first year coverage due to prior NYSUT membership,
- 2) participants who wish to purchase additional coverage during the first year and
- 3) participants who wish to purchase any level of coverage after the first year.

Qualifications and Restrictions

Election to purchase either the \$25,000 first year coverage due to condition 1) above and/or supplemental coverage under condition 2) above needs to be made by application to NYSUT within 30 days of date of hire.

Unmarried, dependent children ages 15 days to 23 years are eligible for \$10,000 coverage. One premium covers all children. Coverage limits are governed by age, not employment status.

Employee and spouse - or certified domestic partner – (under age 65) may purchase up to \$1,000,000 of life insurance through the NYSUT Term Life Insurance Plan. Spouse or domestic partner may be required to demonstrate medical eligibility.

At age 65 the amount of insurance coverage is reduced by 50% and will end at age 70. NYSUT offers a special **Senior Term Life Insurance Plan** at that point. The plan is designed for individuals between ages 65 and 84. Coverage amounts are lower and decrease with age. Coverage ends at age 85.

Persons participating in the Term Life Insurance Plan will be given the option to convert into the Senior Term Life Insurance Plan at age 70.

Coverage may be extended into retirement. NYSUT should be contacted directly for information on particulars. Once term life coverage has been initiated, it is not dependent upon continuing employment status.

Premium Payment

Payments may be made by direct billing or by payroll (or pension) deduction. Members who pay through payroll (or pension) deduction will receive a 15% discount, as well as free Travel, Accidental Death and Dismemberment Insurance (AD&D) up to a maximum of \$100,000, with an additional \$25,000 of AD&D benefits to cover any physical assault while involved in an employment activity.

Accelerated Benefits provision

Up to 60% of the value of the life insurance benefit may be available prior to death if an individual is under age 70 and diagnosed as terminally ill with less than 12 months to live. This can be used to help pay medical costs or maintain financial security.

Beneficiary

Every life insurance policy must have a designated beneficiary. This is named at the point of original application and may be changed as necessary by the covered person. The records of this benefit reside only with the covered person and the carrier. The family or the appropriate party should always be notified of beneficiary selection.

Voluntary Long-Term Care Insurance

Several options for Long-Term care insurance are available to participants of the PSC-CUNY Welfare Fund, including programs sponsored by NYSUT and by CUNY (through the Met Life program of the NY City Employee Health Benefit Program).

The Benefit described here is the John Hancock program specifically designed to meet the needs of participants of the PSC-CUNY Welfare Fund

Benefits

This policy is intended to provide payment toward care that becomes necessary for persons unable to care for themselves due to chronic illness, severe physical impairment, the normal aging process, or cognitive impairment, such as Alzheimer's disease or senile dementia, which requires constant supervision.

This long-term care insurance provides payment for services ranging from nursing home care to skilled nursing care to custodial care at home, including help with daily activities such as eating and dressing, to professional attention. It also includes services offered through adult day health care programs and other community agencies. The plans are designed to help safeguard financial assets and plan for the future by providing financial protection against the devastating cost of long-term care.

Eligibility

Full-time active or retired member of the PSC-CUNY Welfare Fund may enroll. Persons who do so must make the election within 60 days after hire or a medical qualification may be required. A spouse or domestic partner, parents and/or parents-in-law may also be covered, even if the primary Fund participant chooses not to enroll.

Upon separation from service, long-term care insurance may be continued by making direct payments.

Enrollment

In order to qualify for coverage, each person must complete and return an application directly to the LTC carrier: John Hancock Mutual Life Insurance Company. Payments may be made through payroll deductions by attaching a payroll deduction authorization card (available from the Company, through the Fund office or on the website).

Premium

Premiums are determined by the benefit chosen and age at initial enrollment.

Voluntary Catastrophe Major Medical Insurance

The Catastrophe Major Medical Insurance Plan has been designed to supplement the basic health insurance policy as well as supplemental policies provided by the PSC-CUNY Welfare Fund. Additionally, it pays in excess of Medicare Parts A & B. The plan includes a large deductible and may limit certain benefits. In addition to addressing uncovered expenses of the basic health insurance, benefits covered under this plan include: Convalescent Home Benefits, Home Health Benefits, and Private Duty Nursing Services.

Eligibility

Full-time or retired members, spouses and domestic partners are eligible to apply for coverage, regardless of age as long as all are covered under the NYC Health Benefits Program or Medicare (Parts A and B). An insured member's unmarried, dependent children from birth to 21 years (27 if attending school full-time) are also eligible.

Deductible

There is a \$10,000 deductible (or the amount paid by the health insurance if higher). When insured, reasonable and customary eligible expenses count toward meeting deductible in full. Even those eligible expenses paid for by the basic health insurance policy, as well as those paid out of own pocket, count toward the deductible.

Enrollment

Active employees should complete the Catastrophe Major Medical Insurance Plan Application and return to Marsh Affinity Group Services along with a Payroll Deduction Authorization Card.

TRS or TIAA-CREF retirees should complete the Catastrophe Major Medical Insurance Plan Application for Retired Members and return to Marsh Affinity Group Services along with the Pension Deduction Authorization Card.

Effective Date

Coverage will be effective following *receipt and acceptance* of the written application and applicable premium payment. *Applicants must meet medical conditions of insurability.*

Premium

The premium for this plan is based on age when insurance becomes effective and on attained age bracket on renewal dates.

Premiums may be paid through a) payroll/pension deduction (with the Authorization Card noted above), b) automatic check withdrawal or c) direct billing.

Benefit Period

An insured's benefit period begins on the date the first eligible expense is incurred and will cease at the earlier of: completion of 10 years from the day eligibility expenses were first incurred; \$2,000,000 has been paid; the insured recovers; after 24 months from the date the first eligible expense is incurred if 90 consecutive days pass without at least \$150 of eligible expenses being incurred; or the end of 12 consecutive months during which no charge is incurred.

Survivor's Coverage

Coverage continues for covered dependent spouse or domestic partner and children as long as the dependents meet eligibility requirements, premiums are paid at the adjusted rate (depending on the survivor's age) and the policy remains in force.

Legal Note

Diligence

This document is known as a Summary Plan Description. By its very nature, this is a condensation of many pages of concise contracts that the Fund holds with a number of insurance carriers and vendors. The officers of the Fund have used best efforts to assure that these terms are conveyed completely, accurately and in useable form. To the extent that ambiguities are perceived or interpretation differs, the contracts govern and supersede language employed herein.

Actions of Others

Because of the supplemental nature of the Fund, the Fund office relies upon the employer and the staff of related (CUNY) personnel offices to provide accurate and timely information. The Fund Office strives to assure that mutually beneficial communication is maintained. It cannot be responsible for unauthorized or inappropriate actions on the part of these or other third parties.

Beyond simple clarifications.....

The Fund office is prohibited from using its resources to counsel or represent Fund participants in actions against the employer, the NY City Employee Health Insurance Program or any related carriers. Nor can the Fund participate in legal activity that may relate to health expenses or medical conditions. We will diligently enforce the terms of contracts where the Fund is a party, but cannot extend involvement beyond that purview.

APPENDIX A

Full-Time Covered Titles for PSC-CUNY Welfare Fund

Faculty Titles

Professor
Associate Professor
Assistant Professor
Distinguished Professor
Chairperson of College Department
University Professor
Distinguished Lecturer
Lecturer
Instructor
Instructor (Nursing Science)
Continuing Education Teacher*

Registrar Titles

Senior Registrar
Registrar
Associate Registrar
Assistant Registrar

College Lab Tech Titles

Chief College Laboratory Technician
Senior College Laboratory Technician
College Laboratory Technician

Medical Title

College Physician

Research Titles

Research Associate
Research Assistant

Higher Education Officer Titles

Higher Education Officer
Higher Education Associate
Higher Education Assistant
Assistant to Higher Education Officer

Substitutes and Visiting Titles

Substitute (any covered full-time title)
Visiting (any covered full-time title)

Hunter Campus School Titles

Chairperson of Department
Teacher
Assistant Teacher
Substitute Teacher
Temporary Teacher
Guidance Counselor
Teacher of Library
College Laboratory Technician
Placement Director
Educational and Vocational Staff
Early Childhood Teacher
Teacher (Hourly)

Medical School Titles

Medical Professor (Basic Sciences)
Associate Medical Professor (Basic Sciences)
Assistant Medical Professor (Basic Sciences)
Medical Professor (Clinical)
Associate Medical Professor (Clinical)
Assistant Medical Professor (Clinical)
Medical Lecturer

Law School Titles

Law School Professor
Law School Associate Professor
Law School Assistant Professor
Law School Instructor
Law School Library Associate Professor
Law School Library Assistant Professor
Law School Lecturer
Law School Library Professor

Employment Opportunity Center Titles

EOC Lecturer
EOC HEO Series
EOC Assistant Registrar
EOC College Laboratory Technician
EOC Adjunct Lecturer
EOC Adjunct College Laboratory Technician
EOC Substitute (full-time title)

** Continuing Education Teachers must be appointed to a position that will continue for more than six months and that requires a minimum of 20 hours per week.*

Management Titles

Chancellor
Executive Vice Chancellor
Senior Vice Chancellor
Vice Chancellor
President
Deputy to the President
Senior Vice President
Vice President
Assistant Vice President
Dean
Associate Dean
Assistant Dean
Principal - Hunter College School
Director of Campus School
Executive Assistant to a CUNY Officer
Chief Librarian Director
Provost
Affirmative Action Officer
Personnel Director
Associate Personnel Director
Assistant Personnel Director
Dean of CUNY Law School
Law School Chief Librarian
Dean of CUNY Medical School
Business Manager
Occupational Safety and Health Officer

EOC Management Titles

EOC Director
EOC Associate Director
EOC Associate Director
EOC Coordinator

Building Maintenance, Security and Professional Titles

Administrative Superintendent of Building and Grounds
Assistant College Security Director
Chief Admin. Superintendent of Building and Grounds
Chief Admin. Supt. of Campus Buildings and Grounds
College Security Director
Computer Operations Manager
Computer Systems Manager
Deputy University Security Director
University Associate Chief Engineer
University Chief Architect
University Chief Engineer
University Security Director