



Adjunct Employees

Summary Plan Description

2011

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

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Eligibility

Initial Eligibility

Coverage is available to an adjunct employed by CUNY* who meets the following criteria:

- 1) Is not covered by or eligible to be covered by other basic health insurance by virtue of employment of self or spouse or through government entitlement.
- 2) Has fulfilled the *continuity requirement*, as either a:
 - a) *Teaching Adjunct*: Two consecutive semesters of adjunct instruction at CUNY immediately prior to the current semester **, or
 - b) *Non-Teaching Adjunct*: Two consecutive semesters of at least 10 hours per week at CUNY immediately prior to the current semester**.
- 3) Fulfills the *current hours requirement*, of either;
 - c) *Teaching Adjunct*: Carries a current teaching load of six or more hours per week at one or more than one CUNY institution (combined), or
 - d) *Non-Teaching Adjunct*: Is currently working at least 10 hours per week at CUNY.

* Excludes the Research Foundation or work through grant-support.

** Summer or winter “semesters” do not meet the requirement.

Spring (1) or spring (2) semesters may qualify if enough hours are taught, but the two combined shall not be construed to meet the two-consecutive-semester criterion.

Continued Coverage

After attaining initial eligibility—by meeting the continuity requirement and the current hour requirement—coverage continues until a semester where either a) insufficient hours are worked or b) other coverage becomes available. Coverage may be continued through summer months for persons who received adjunct health insurance during the spring semester and who represent—with college verification—that sufficient hours are anticipated in the fall semester.

Break in Continuous Eligibility

Even though coverage may be lost for a semester because current hours are too low, the continuity requirement will be met until there is a semester in each of two out of three consecutive academic years wherein a previously eligible individual is not employed as an adjunct by CUNY. Then a break occurs and the initial eligibility (the continuity requirement) must be re-established in order to be covered for benefits.

Persons who lose coverage or eligibility [for this and certain other reasons] may qualify for COBRA coverage and should contact the Fund office or the COBRA section of this book for further information.

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.

Dependents Eligibility Note

Dependent coverage is available through premium payment only. As of July 1, 2011, the Fund defines eligible dependent children as natural or adopted children who are a) under age 26 or b) totally and permanently disabled and who became so prior to their 19th birthday. Coverage for dependent children (not disabled) ends on the last day of the month that children turn 26.

Coverage Options

Coverage is Individual only. Dependent coverage is available through premium payment.

Residents of New York City may enroll free of charge in **HIP Prime**. **Blue Cross HMO** coverage is also available free of charge to residents of New York City and these contiguous counties of New Jersey: Bergen, Union, Passaic, Essex, Middlesex, Monmouth and Hudson. Connecticut residents and New Jersey residents outside of the Blue Cross HMO service area—*and only those residents outside of the service area*—have the opportunity to enroll in a **Blue Cross Preferred Provider Organization (PPO)**. Residents outside the Blue Cross HMO and PPO service areas may enroll free of charge in a **Blue Cross Exclusive Provider Organization (EPO)**. Enrollment forms are available on the Welfare Fund website, Printed Forms page.

Covered adjuncts may purchase coverage for their family. The cost is equal to the Blue Cross or HIP premium difference between an Individual contract and a Family contract.

A schedule of premium co-payments is available from the Fund office or through campus Human Resource Departments.

Enrollment Process

First-time enrollees must contact their college Human Resource Department for an Application. The college will need to verify that requirements have been met. If continuity and current hours necessarily involve more than one college, verification will be required from each. Applicants will be notified by the PSC-CUNY Welfare Fund, and/or the carrier, of acceptance. If the Family premium option is selected, a check covering the first 3 months is required.

Benefits

SUMMARY

HMO

Benefit	In-Network ¹
Lifetime Maximum	Unlimited
Dependent Children (covered to the end of the month)	Dependents to Age 26
Covered Preventive Services⁷	
Covered Adult Preventive Care	\$0
Annual Physical Exam	\$0
Well-Child Care (to age 19; including covered immunizations)	\$0
Preventive Well-Woman Care (no PCP referral required)	\$0
Home/Office/Outpatient Care	
Home/Office Visits (PCP or Specialist)	\$25 copay
webVisit ²	\$5 copay per online consultation
Emergency Room/Facility (Initial visit per occurrence)	\$75 copay (Waived if admitted within 24 hours)
Ambulatory/Outpatient Surgery ³	\$75
Presurgery Testing	\$0
Anesthesia	\$0
Office Surgery	\$25 copay
Chemotherapy, Radiation Therapy	\$0
Routine Maternity Care	\$0
Laboratory Tests	\$0
X-rays/ MRI ³ /MRA ³ , CAT ³ , PET ³ , Nuclear Cardiology ³	\$25 copay
Allergy Testing & Treatment	\$25 copay (Waived for treatment)
Chiropractic Care ⁵	\$25 copay
Home Healthcare (Up to 200 visits per calendar year)	\$0
Home Infusion Therapy	\$0
Hospice Care (Up to 210 days per lifetime)	\$0
Physical Therapy ³	\$25 copay in home or office
(Up to 30 visits per calendar year combined in home, office or outpatient facility)	
Speech/Language ³ , Occupational ³ , Vision Therapies ³	\$25 copay in home or office
(Up to 30 visits per calendar year combined in home, office or outpatient facility)	
Cardiac Rehabilitation	\$0
Second Surgical Opinion	\$0
Kidney Dialysis	\$0

Benefits

SUMMARY

HMO

Benefit	In-Network ¹
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board) Surgery, Surgical Assistant, Anesthesia Physical Therapy, Physical Medicine or Rehabilitation (Up to 30 inpatient days per calendar year) Skilled Nursing Facility (Up to 60 days per calendar year)	\$500/\$1,250 per admission/maximum per calendar year per contract \$0 \$500/\$1,250 per admission/maximum per calendar year per contract \$0
Outpatient Visits in Office Outpatient Visits in Facility Inpatient Care (As many days as medically necessary; semiprivate room and board)	\$25 copay \$0 \$500/\$1,250 per admission/maximum per calendar year per contract
Outpatient Visits in Office Outpatient Visits in Facility Inpatient Detoxification (As many days as medically necessary; semiprivate room and board) Inpatient Rehabilitation	\$25 copay \$0 \$500/\$1,250 per admission/maximum per calendar year per contract \$500/\$1,250 per admission/maximum per calendar year per contract
Medical Supplies ⁶ Durable Medical Equipment ^{3,6} Prosthetics & Orthotics ³ Ambulance (air ambulance) Prescription Drugs ⁸ Retail Program – One copay required for up to a 30-day supply Mail-Order Program ⁹ – Only two copays required for a 90-day supply	\$25 copay <u>20% coinsurance</u> <u>20% coinsurance</u> \$0 <u>\$100 Deductible per person per calendar year</u> Tier 1/Tier 2/Tier 3 \$10/\$25/\$50 copay Includes Contraceptives (Retail & Mail-Order) \$0 Mail-Order Program has the same copayments as the Retail Program listed above

Please see notes for Empire Blue Cross HMO on next page

Benefits

SUMMARY

HMO

- (1) A network provider must deliver all care with a PCP referral.
- (2) A webVisit enables you to receive a covered medical consultation for a non-urgent matter from a participating provider who has agreed to provide webVisits to Empire members online. Confirm your provider's participation by contacting your provider or his/her office staff. Visit our website or call for more details.
- (3) Empire's network provider must precertify in-network services or services may be denied; Empire's network providers cannot bill members beyond in-network copayment (if applicable) for covered services. For ambulatory surgery, preapproval is required for cosmetic/reconstructive procedures, outpatient transplants and ophthalmological or eye-related procedures.
- (4) Our Behavioral Health Care Management Program must preapprove all mental health and alcohol/substance abuse services.
- (5) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services, or services may be denied; Empire network providers cannot bill members beyond the in-network copayment for covered services.
- (6) Diabetic durable medical equipment, medical supplies, education, insulin and oral agents are subject to an office visit copayment for first 52 items (combined), then covered at 100% when covered under medical benefit.
- (7) The following benefits, if provided in-network for preventive care, are not subject to copayment: mammography screenings, cervical cancer screening, colorectal cancer screenings, prostate cancer screenings, hypercholesterol screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and up to two annual obstetric and gynecological examinations. Certain preventive benefits are subject to age and/or frequency limits. Consult policy for complete details.
- (8) All prescription drug plans, except Generic Only, listed on this Benefits Summary meet the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.
- (9) To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions. This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Empire believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Empire at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Benefits

SUMMARY

PPO

Benefit	In-Network ¹	Out-of-Network ^{2,3}
Deductible	N/A	\$3,000 per person; \$7500 maximum per family
Coinsurance	N/A	40%
Coinsurance Stop Loss	N/A	\$12,000 per person / \$30,00 maximum per family
Lifetime Maximum	Unlimited	\$1,000,000
Dependent Children (covered by premium payment)	To age 19; full-time students to age 23	To age 19; full-time students to age 23
Home/Office/Outpatient Care	Member Pays	Member Pays
Home/Office Visits	\$30 co-pay	Deductible and Coinsurance
Annual Physical Exam	\$30 co-pay	Covered in-network only
Well-Child Care (premium payment required) (Up to age 19; including covered immunizations)	\$0	Deductible and Coinsurance
Well-Woman Care	\$30 co-pay	Deductible and Coinsurance
Emergency Room/Facility (initial visit per occurrence)	\$75 co-pay (Waived if admitted within 24 hours)	\$75 co-pay (Waived if admitted within 24 hours)
Surgery ⁴ , Presurgical Testing, Anesthesia	\$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	\$0	Deductible and Coinsurance
Maternity Care	\$0	Deductible and Coinsurance
Mammograms	\$0	Deductible and Coinsurance
Cervical Cancer Screenings	\$0	Deductible and Coinsurance
Laboratory Tests, X-rays	\$0	Deductible and Coinsurance
MRI ⁵ /MRA ⁵ , CAT Scan ⁶ , PET ⁶ & Nuclear Cardiology ⁶	\$0	Deductible and Coinsurance
Allergy Testing & Treatment	\$30 co-pay (Waived for treatment)	Deductible and Coinsurance
Chiropractic Care ⁸	\$30 co-pay	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	\$0	Coinsurance (no deductible)
Home Infusion Therapy	\$0	Covered in-network only
Hospice Care (Up to 210 days per lifetime)	\$0	Covered in-network only
Physical Therapy ⁴ (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$30 co-pay	Covered in-network only
Other Short-Term Rehabilitative Therapies – Speech/Language ⁴ , Occupational ⁴ , Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$30 co-pay	Covered in-network only

(1) Network provider delivers care.

(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (7) for Mental Health and Alcohol/Substance Abuse Services.

(3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount.

(4) You are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.

(5) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the co-payment for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Empire's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

(6) Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the co-payment for covered services. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.

(7) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

(8) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network deductible and coinsurance for covered services. Authorization is not required for out-of-network services or for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.

Benefits

SUMMARY

PPO

	In-Network ¹	Out-of-Network ^{2,3}
Cardiac Rehabilitation	\$30 co-pay	Deductible and Coinsurance
Second Surgical Opinion ⁹	\$30 co-pay	Deductible and Coinsurance
Kidney Dialysis	\$0	Deductible and Coinsurance
	Member Pays	Member Pays
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	\$500/\$1250 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Surgery, Surgical Assistant, Anesthesia	\$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 30 inpatient days per calendar year)	\$500/\$1250 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	\$0	Covered in-network only
Outpatient Visits in Office or Facility (Up to 20 outpatient visits per calendar year)	\$25 co-pay per visit ⁷	Covered in-network only
Inpatient Care ⁷ (Up to 30 inpatient days per calendar year)	\$500/\$1250 per admission/maximum per calendar year per contract	Covered in-network only
Outpatient Visits (Up to 60 outpatient visits which include 20 family counseling visits per calendar year)	\$0	Deductible and Coinsurance
Inpatient Detoxification (Up to 7 days detox per calendar year)	\$500/\$1250 per admission/maximum per calendar year per contract	Covered in-network only
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor	Covered in-network only
Durable Medical Equipment ⁵	<u>\$0</u>	Covered in-network only
Prosthetics & Orthotics ⁵	<u>\$0</u>	Covered in-network only
Ambulance (air ambulance)	\$0	Covered in-network only
Prescription Drugs ¹⁰ Retail Program – One co-pay required for up to a 30-day supply	<u>\$100 Deductible</u> <u>\$10 co-pay for generic</u> \$25 co-pay for brand \$50 co-pay for non-formulary Includes Contraceptives (Retail & Mail-Order)	Covered in-network only
Mail-Order Program ¹¹ – Only two co-pays required for a 90-day supply	\$0 Deductible The Mail-Order Program has the same co-payments as the Retail Program listed above.	

In-network office visit co-pay applies to Second Surgical Opinion visit unless waived by Medical Management.

¹⁰) This prescription drug coverage meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.
 To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

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PPO Rev. Nov 06

Benefits

SUMMARY

EPO

Benefit	In-Network ¹
Lifetime Maximum	Unlimited
Dependent Children (covered by premium payment)	To age 19; full-time students to age 23
HOME/OFFICE/OUTPATIENT CARE	Member Pays
Home/Office Visits	\$30 co-pay
Annual Physical Exam	\$30 co-pay
Well-Child Care (Up to age 19; including covered immunizations)	\$0
Well-Woman Care	\$30 co-pay
Emergency Room/Facility (initial visit per occurrence)	\$75 co-pay (Waived if admitted within 24 hours)
Surgery ² , Pre-surgical Testing, Anesthesia	\$0
Chemotherapy, Radiation Therapy	\$0
Maternity Care	\$0
Mammograms	\$0
Cervical Cancer Screenings	\$0
Laboratory Tests, X-rays	\$0
MRI ⁴ /MRA ⁴ , CAT Scan ⁴ , PET ⁴ & Nuclear Cardiology ⁴	\$0
Allergy Testing & Treatment	\$30 co-pay (Waived for treatment)
Chiropractic Care ⁵	\$30 co-pay
Home Healthcare (Up to 200 visits per calendar year)	\$0
Home Infusion Therapy	\$0
Hospice Care (Up to 210 days per lifetime)	\$0
Physical Therapy ² (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$30 co-pay
Other Short-Term Rehabilitative Therapies ² – Speech/Language, Occupational, Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$30 co-pay
Cardiac Rehabilitation	\$30 co-pay
Second Surgical Opinion ⁶	\$30 co-pay
Kidney Dialysis	\$0

1. A network provider must deliver all care. There is no out-of-network option for this product, except for emergency care.
2. You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
3. Precertification is required by Empire's Behavioral Healthcare Management Program.
4. For services received from an Empire network provider, the provider must precertify in-network services; Empire's network providers cannot bill members for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers (with the exception of MRI, MRA, PET, CAT and Nuclear Cardiology services, which do not require precertification for services rendered from in-network BlueCard® PPO providers outside of Empire's network area). The BlueCard® PPO provider may call for you for services that do require precertification, but you will be responsible for penalties applied if precertification is not obtained.
5. Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network co-payment for covered services. Authorization is not required for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.
6. Office visit co-pay applies to Second Surgical Opinion visit unless waived by Medical Management.

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Benefits

SUMMARY

EPO

Benefit	In-Network ¹ Member Pays
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	\$500/\$1250 per admission/maximum per calendar year per contract
Surgery, Surgical Assistant, Anesthesia	\$0
Physical Therapy, Physical Medicine or Rehabilitation (Up to 30 inpatient days per calendar year)	\$500/\$1250 per admission/maximum per calendar year per contract
Skilled Nursing Facility (Up to 60 days per calendar year)	\$0
Mental Health³	
Outpatient Visits in Office or Facility (Up to 20 outpatient visits per calendar year)	\$25 co-pay per visit
Inpatient Care (Up to 30 inpatient days per calendar year)	\$500/\$1250 per admission/maximum per calendar year per contract
Alcohol/Substance Abuse³	
Outpatient Visits (Up to 60 outpatient visits, which include 20 family counseling visits per calendar year)	\$0
Inpatient Detoxification (Up to 7 days detox per calendar year)	\$500/\$1250 per admission/maximum per calendar year per contract
Other	
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor
Durable Medical Equipment ⁴	<u>\$0</u>
Prosthetics & Orthotics ⁴	<u>\$0</u>
Ambulance (air ambulance)	\$0

Prescription Drugs⁷
Retail Program – One co-pay required for up to a 30-day supply

\$100 Deductible

\$10 co-pay for generic

\$25 co-pay for brand

\$50 co-pay for non-formulary

Includes Contraceptives (Retail & Mail-Order)

Mail-Order Program⁸ – Only two co-pays required for a 90-day supply

\$0 Deductible

The Mail-Order Program has the same co-payments as the Retail Program listed above.

(7) This prescription drug coverage meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.

(8) To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

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EPO Rev Nov 06

PSC-CUNY Welfare Fund Adjunct Basic Health Insurance Program

HIP *Health Plan of New York*

HIP Prime

Major Co-Payment Provisions	
Primary Care Provider Office Visit Specialist Office Visit Hospital Admission Emergency Room Visit Prescription Drugs	\$ 15 Co-Payment \$ 15 Co-Payment \$ 250 Co-Payment \$ 35 Co-Payment \$5 Generic / \$15 Brand Formulary ¹ / \$35 Non-Formulary Up to 90-Day Supply with HIP Mail Order. Co-Payments at 50% Contraceptives Included
Inpatient Hospital Services	
Hospital and Physician Services Semi-Private Room and Board Operating Room / Recovery Room/ Intensive and Special Care General Nursing Care, Prescribed Drugs, Anesthesia, X-Ray, Lab Tests Short Term Physical/ Occupational/ Respiratory Therapy (as part of Acute Admission) Short Term Physical/ Occupational/ Respiratory Therapy (as part of Rehabilitation Admission) Radiation Therapy and Physical Therapy Pre-Admission Testing Human Organ Transplants	Subject to Hospital Admission Co-payment Included in Hospital Admission Co-payment Included in Hospital Admission Co-payment Included in Hospital Admission Co-payment Included in Hospital Admission Co-payment [short-term only] Subject to Hospital Admission Co-payment [90 Days per Calendar Year] Included in Hospital Admission Co-payment Included in Hospital Admission Co-payment Included in Hospital Admission Co-payment
Outpatient Medical Care	
Primary Care Provider Office Visit Specialist Office Visit	\$ 15 Co-Payment \$ 15 Co-Payment

Physical Exams, Eye/Ear Exams, PAP Smear, Mammography, Immunization	Included in Office Co-payment
Well-Child under 19	\$ 0 Co-Payment
Lab Tests EKG's and X-Ray / CAT / MRI	Included in Office Co-payment
Pre-Natal / Post-Natal Care in Physician Office	\$ 0 Co-Payment
Ambulatory Surgery	\$ 0 Co-Payment
Second Medical or Surgical Opinion	\$ 0 Co-Payment
Routine Foot Care	Not Covered
Chiropractic Service	\$ 15 Co-Payment
Mental Health and Substance Abuse	
Inpatient Mental Health	Subject to Hospital Co-Payment Limited to 30 Days per calendar year
Outpatient Mental Health	\$ 25 Co-Payment Limited to 20 Visits per calendar year
Inpatient Substance Abuse Detoxification	Subject to Hospital Co-Payment Limited to 7 Days per calendar year
Inpatient Substance Abuse Rehabilitation	Subject to Hospital Co-Payment Limited to 30 Days per calendar year
Outpatient Substance Abuse Rehabilitation	\$ 15 Co-Payment Limited to 60 Visits per calendar year
Special Kinds of Care	
Urgent Care Facility	\$ 15 Co-Payment
Ambulance Service to Hospital	\$ 0 Co-Payment
Home Health Care	\$ 0 Co-Payment Limited to 200 Visits per calendar year
Hospice Care	\$ 0 Co-Payment Limited to 210 Days
Skilled Nursing Facility	\$ 0 Co-Payment
Renal Dialysis	\$ 15 Co-Payment
Diabetes Equipment / Supplies / Education	\$ 15 Co-Payment per Month
Outpatient Physical/ Speech/ Occupational/ Respiratory therapy	\$15 Co-Payment Limited to 30 Visits per calendar year
Family Planning	Covered
Infertility Diagnosis and Treatment	\$ 15 Co-Payment
Dental Care - General	Offered at Reduced Fee Schedule
Dental Care - Preventive Only	Oral Exam [1per 6 months] \$5 Co-Payment Cleaning [1per 6 months] \$10 Co-Payment Child (≤ 16) Fluoride Treatment [1 per 6 months] \$5 Co-Payment
Durable Medical Equipment	No annual Deductible
Private Duty Nursing	Covered
Hearing Aids	Not Covered
Optical Care - Examination	\$ 0 Co-Payment
Optical Care - Eyeglasses	\$ 45 Co-Payment Limited to once every 24 months

1) Drugs are dispensed in accordance with the HIP Drug Formulary

* Except for Emergency Care, HIP Benefits and Services or covered only when provided by or referred by a HIP Primary Care Physician or Approved in advance by the HIP Care Management Program.

* HIP Participating Physicians Have contracted with HIP To provide care and are not employees, agents or representatives of HIP.

* This Summary is for information only and does not contain complete details of the HIP Prime program which are available only in the Contract

Voluntary Welfare Fund Benefits Available to Adjuncts

Adjuncts are eligible to enroll in two special programs designed by the PSC-CUNY Welfare Fund: the John Hancock Long Term Care Insurance and the Marsh Catastrophic Major Medical Plan. Both are completely self-pay -- as they are for full-time active personnel and covered retirees.

Enrollment in either or both plans will require a monthly payment either through direct remittance or through an arrangement with the carrier for direct (EFT) deductions from an available bank account. Both plans are portable as long as underlying requirements are met.

Limitations: Each plan has limitations, the most important of which is the ability of the insurance carrier to require medical assessment and ultimately the right to not issue a policy (refuse coverage).

John Hancock Long Term Care Insurance: The carrier will require evidence of insurability except during periods of guaranteed acceptance to those who meet the criteria. The criteria are *similar* to those of the Welfare Fund for basic coverage: The adjunct must be:

- 1) teaching at least six (6) credit hours in the current semester,
- 2) in at least the third consecutive semester as a teaching adjunct,
- 3) under 70 years of age.

Newly qualified adjuncts each semester will be afforded guaranteed acceptance if application is made within 60 days of the beginning of the term.

Long-term care is fully portable. It may be continued regardless of whether the terms of initial eligibility continue to be met, as long as premiums are paid.

Marsh Catastrophic Major Medical Plan: The carrier will require evidence of insurability. Furthermore, the carrier will require evidence of basic health insurance coverage equivalent to that which qualified adjuncts have through the adjunct basic health program of the PSC-CUNY Welfare Fund or which qualified full-time active employees have through the NY City Employee Health Program and the PSC-CUNY Welfare Fund.

This coverage is partially portable. That means it may be continued as long as sufficient basic health coverage is maintained and an affiliation with PSC-CUNY is continued and premiums continue to be paid.

How to Enroll: Application should be made directly to the carrier. Forms are available through campus Benefits Offices or from the PSC-CUNY Welfare Fund. Long-term care enrollment forms are also available directly from the carrier.

Review and Appeals Procedures

If a member adjunct disagrees with an eligibility or benefit determination made by the PSC-CUNY Welfare Fund or parties contracting with the Fund to insure components of the program, the member has the right to request a 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 you feel will impact the course of the review.

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

If a claim of eligibility is denied, in whole or in part, notice will include :

- 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 for further review or to file an appeal.

If the adverse determination involves provision of or payment for **benefits**, the review should be directed to the appropriate insurance carrier (Empire or HIP). 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 participant may appeal.

- 1) An appeal of a **negative eligibility decision** 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** must be directed to the carrier. The carrier is obligated to inform the participant of the appeals process which may 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 will 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 may affect the proceedings.

Appeals are reviewed by a committee of the Board which convenes as necessary. A decision will be made on 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 notice will be given.

If an Appeal is denied, in whole or in part, the participant will be told:

- the specific reasons for the denial;

- the plan provision(s) on which the decision was based.

COBRA Continuation of Benefits

If adjunct basic benefit coverage is lost, participants and covered eligible dependents may continue to receive 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.

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 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, or
- The participant (employee) and spouse divorce or legally separate resulting in a loss of coverage,

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, 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 or a dependent child's losing eligibility*, COBRA continuation coverage lasts for up to **36 months** for spouses and children who are qualified beneficiaries.

Notification Responsibilities

The Fund can 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 or affected parties must notify the Fund Office within 60 days of the date that the qualified beneficiary would lose coverage after the qualifying event or of the qualifying event itself. The Fund Office requires supporting documentation.

Type of Coverage

- 1) If the COBRA event is the loss of coverage by the *adjunct participant*, the insurance coverage (carrier and contract size) in effect immediately prior to the event may be continued by paying the COBRA premium directly to the PSC-CUNY Welfare Fund.
- 2) If the COBRA event is the *spouse's* loss of coverage due to divorce or the death of the adjunct participant, the insurance coverage (carrier) in effect immediately prior to the event may be continued by paying the COBRA premium directly to the PSC-CUNY Welfare Fund. The spouse will have an individual COBRA contract.
- 3) If the COBRA event is the *dependent child's* loss of coverage due to the death of the adjunct participant, the child can join the surviving spouse on a family COBRA contract or elect individual coverage. If the COBRA event is the *dependent child's* loss of coverage due to exceeding the age limit or no longer being a full-time student, the child may elect an individual COBRA contract

The premium is set by law at 102% of the premium paid by the Fund to the carrier.

Termination of COBRA Coverage

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

- 1) exhaustion of the benefit duration limit 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 five (5) 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 marriage that results in the opportunity for comparable group coverage.

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 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 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.

Insurance carriers used by the Fund are also bound by the regulations of HIPAA and are required to duly notify participants in the program.

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.

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.

Rights of the Trustees

The Board of Trustees has a fiduciary responsibility to assure the financial health of the Fund. The Trustees intend to continue the programs described in any of the Fund's Plans of Benefits indefinitely. Nevertheless the Trustees continue to reserve the right, which they are given in the Fund's Trust Indenture, subject to the provisions of any applicable collective bargaining agreement, to terminate or amend

any of the plans or programs of benefits. Summary Plan Descriptions are made available to you by the Fund office for your convenience and describe the benefits administered by the Fund and those that you can purchase from other providers. However, each benefit plan or program is always subject to: a) the full terms of each contract between the Fund and the benefit's or program's provider or administrator as it is described in the contract between the Fund and the provider or administrator or b) the applicable insurance policy at the time the claim occurs.

Programs and benefits for all participants are not guaranteed. The Trustees reserve the right to change or discontinue at any time the types and amounts of benefits and the eligibility rules under the plans and programs.