



# **Retiree Summary Plan Description**

## *2007*

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

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# Eligibility

## Member Eligibility

Retirees are covered under the PSC-CUNY Welfare Fund at different levels of benefits depending upon the year and conditions under which the member retired from a covered title in the CUNY system. These differences result from variances in the employer contributions.

### Retiree Plan 82

- Includes members who retired September 1, 1982 or later and who meet all of the requirements listed below.

### Retiree Plan 80

- Includes members who retired prior to August 31, 1982 and who meet the *Rule of 80*<sup>1</sup> and who meet all of the requirements listed below.

### Retiree Plan 70

- Includes members who retired between June 30, 1970 and August 31, 1982 but who do not meet the *Rule of 80*<sup>1</sup> and who meet all requirements listed below.

## Requirements

- Must be collecting a pension through a CUNY-related program
- Must be eligible for Welfare Fund benefits at the point of retirement
- Must be eligible for basic coverage through the NYC Retiree Health Program

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<sup>1</sup> The *Rule of 80* applies to retirees who – at the time of retirement – were at least 55 years old and whose age plus years of service in a covered CUNY title equaled or exceeded 80.

## Dependent Eligibility

If you are covered, your **spouse/ qualified domestic partner**<sup>2</sup> and/or eligible **dependent child(ren)** 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. There are additional, periodic proof-of-schooling requirements for full-time students between the ages of 19 and 23.

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<sup>2</sup> **Domestic partners** are qualified if duly registered with the New York City Clerk's Office. Certain tax implications apply to benefits for domestic partners. These may be reviewed with qualified tax professionals.

## **Scope of Welfare Fund Coverage**

**A.** All eligible retirees receive **basic health insurance** through the NYC Retiree Health Program. This consists of hospital and medical insurance and - for non-Medicare retirees - also provides coverage for certain drugs (see Drug Benefit - PICA). Questions on **basic health insurance** and **PICA** should be directed to the NYC Retiree Health Program. Phone numbers are listed at the back of this booklet.

**B.** **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 the basic health insurance plan the participant has elected. Eligibility for basic health insurance is a pre-requisite to Welfare Fund eligibility.

Persons who waive basic coverage should contact the Fund office.

## **Enrollment**

Benefit officers employed at each CUNY campus in the Human Resources (Personnel) Department provide eligible persons with information packets and enrollment applications for **both the basic health insurance plans and Welfare Fund supplemental benefits.** Completed applications must be returned to the Human Resource office for processing. Welfare Fund applications are forwarded to the PSC-CUNY Welfare Fund by the college.

## **Termination of Coverage**

Retirees have lifetime coverage. **Coverage for dependents ceases upon the death of the participant.** Benefits may be continued by purchase options (See COBRA and Survivors).

## Dental Benefits

Retiree Plan 82

***This Benefit has 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” program with two components:

- 1) access to a panel of dental providers who charge **reduced fees**, and
- 2) partial reimbursement for services rendered (by a **Fee 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 Fee Schedule](#)

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 Limitations](#) for Exclusions and 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 from participating providers, by mail from Guardian or 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 Providers](#)  
Schedule: [DeltaCare Provider Allowed Charges](#)

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

### **Dental Benefits -**

**Retiree Plan 80**

The Fund will reimburse up to \$150 per year per plan participant (in combination with dependents) for covered dental expenses. Claim forms are available from the Fund Office.

### **Dental Benefits -**

**Retiree Plan 70**

The Fund will reimburse up to \$300 per year per plan participant (in combination with dependents) for covered dental expenses. Claim forms are available from the Fund Office.

## **Prescription Drug Benefit**

**Retiree Plan 82**

**Retiree Plan 80**

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 or are classified as "over the counter" (OTC) are not covered, regardless of the existence of a physician's prescription. The Welfare Fund program, administered by 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 a list of preferred drugs called a **formulary**. This list 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 long-term prescription (i.e. 3 month or 100 day supply) reduces the overall co-payment. After an initial fill and a two re-fills of a long-term drug prescription at a retail pharmacy, higher levels of co-payment are assessed for continued use of the pharmacy.

### **Deductible**

Each retiree is subject to an annual \$50 deductible. This is charged on the first fill or re-fill of each calendar year. If the deductible amount exceeds the amount otherwise covered, a balance is carried forward.

### **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

### **Mail-Order** Pharmacy Co-payments

(Maximum days' supply) = 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

## 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 for any retiree who is non-Medicare eligible (see **PICA** below)
- Over the counter drugs
- Insulin for non-Medicare eligible retirees (see **PICA** below)
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers' Compensation
- Medication taken or administered while a patient in a hospital rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution.

The program covers drugs for erectile dysfunction up to an annual maximum reimbursement of \$500.

## Reimbursement Practices

Prescriptions filled at -participating pharmacies will require presentation of a valid drug card. The co-payment (and applicable deductible) 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 or that child by contacting the Fund. The initial card is issued at no cost and 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 with Medco

Customer Service (866) 386-3797

Web Site [www.medco.com](http://www.medco.com)

## For information on

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms
  
- Interactive Pharmacy Locator
- Claim Form Download
- Mail-order tracking
- Formulary Drug Listing

## **Non- Medco Drug Coverage**

### **PICA for Non-Medicare 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 **non-Medicare eligible retirees**, **I**njectable and **C**hemotherapy medications are available under the **PICA** program. The NY City Retiree Health Program should be consulted for further detail and updates. Eligible individuals will be issued a drug card for PICA coverage. For retirees with Medicare, the IC drugs are treated as any other medications which are covered by the Fund.

### **Stipend for Non-Medicare [in lieu of Medco]**

**Non-Medicare eligible retirees** 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 retirement 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.

### **HIP VIP, Aetna Medicare Advantage [in lieu of Medco]**

Retired members over the age of 65 and enrolled for basic health insurance in the HIP VIP or Aetna Medicare Advantage Programs have drugs coverage through these programs. This drug option is paid for by the PSC CUNY Welfare Fund.

## **Drug Benefits**

[Retiree Plan 70 & Plan 80](#)

The Fund will reimburse up to \$400 per year per plan participant (in combination with dependents). Claim forms are available from the Fund Office.

## **Medicare Part D [in lieu of Medco]**

### **Basics**

The Federal government recently enacted a limited, catastrophic drug program for qualified retirees, over age 65 who are covered under Medicare Part A (hospital) and [at least eligible for] Part B (medical). It is commonly referred to as Medicare Part D.

The Part D program is privately administered by insurance companies who offer a variety of policies featuring: 1) a formulary of covered drugs, 2) a “front-end” deductible, 3) a range of annual costs where the enrollee pays a moderate percentage co-pay, 4) a range of annual costs where the enrollee pays all costs – 100% co-pay – also known as the “doughnut hole” and 5) a range of annual costs where the enrollee pays minimal percentage co-payment toward drug costs. For this coverage, the Medicare Part D enrollee pays a premium.

The prototype on which the program is based applies a \$250 deductible, a 25% co-payment on the next \$2,000 of annual drug spending, no coverage between \$2,250 and \$5,100 annually and a 5% co-payment on annual expenses exceeding \$5,100.

The monthly premium estimated on that model was to have been approximately \$37 in the first year (2006). Many areas around the country had 40 to 50 competing plans in the first year of operation, with wide variances on premium, deductibles, co-payments and formularies.

### **The PSC-CUNY Welfare Fund Drug Benefit**

Eligible plan participants may chose a Medicare Part D plan instead of the Welfare Fund retiree drug plan. Those who do so would relinquish Welfare Fund drug coverage. It is often not advisable to do so.

Analysis of average drug utilization among covered retirees has determined that most retirees would be financially better off with the PSC-CUNY Welfare Fund Medco program. The exception would be those individuals who incur high annual costs. If annual costs exceed \$13,800, the Part D program might be beneficial.

The Fund actuaries have calculated that on the average the Welfare Fund drug coverage is equal to or better than the Medicare Part D program. This “Actuarial Equivalence” enables the Welfare Fund to issue a Notice of Creditable Coverage to its eligible retired members. This Notice assures that a future decision by a participant to enroll directly in Part D (e.g., by a spouse if a retiree dies) is not met with a substantial premium surcharge.

Fund office staff is unable to personally advise on choice of coverage. More information is available on-line at [www.medicare.gov](http://www.medicare.gov).

## Optical Benefits

Retiree Plan 82

Retiree Plan 80

Retiree Plan 70

Plan participants and their eligible dependents are entitled to a pair of glasses (lens 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 services with other licensed providers.

Service through the Fund's vendors has no out-of-pocket costs for a limited but substantial 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.

### 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. There is no co-payment when using an in-network provider. The GVS network also includes select Cohen's Fashion Optical and select Sterling Optical outlets.

**Frames** are available in the New York Metropolitan area stores in any style, up to a retail value of \$150. A credit of \$150 is given toward frames outside of the plan. 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, gradient tint, UV coating and scratch-resistant coating are available at no charge (New York metropolitan area outlets only). Polycarbonate lenses are available for children up to 14 years of age.

**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). Fitting fees and follow-up care is included.

**Special Dependent Coverage** allows eligible children under 19 (23 if a full - time student) a pair of glasses (frame and lenses) every 12 months ("off year").

Participating Providers : For a listing of General Vision Services Providers or to schedule your appointment on-line, participants may go to [www.generalvision.com](http://www.generalvision.com) or call GVS at 1-800-VISION1 or contact the PSC-CUNY Welfare Fund.

## 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 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](http://www.davisvision.com) ; click on "Find a Doctor" and use the access code 2022. Participants may also contact the PSC-CUNY Welfare Fund office

## Other Providers

Additionally, 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 from the Fund Office, claims should be submitted within 90 days of service..

**Split Services** may occur if a participant obtains an examination through an out-of-network vendor, then elects to have the prescription filled elsewhere or not at all (doesn't file with the Fund) Reimbursement will be pro-rated. All services must be performed within 90 days.

## **Extended Medical Benefits**

**Retiree Plan 82**

**Retiree Plan 80**

### ***This Benefit has changed Effective 01/01/2007***

Retirees under age 65 (non-Medicare) who have **basic coverage through GHI-CBP** and Blue Cross 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.

The program is administered by GHI. [It was formerly administered by CIGNA.] Not only does GHI provide initial coverage, but under contract to the PSC-CUNY Welfare Fund, GHI also provides an extended level of coverage. This extended medical benefit does not cover procedures that are not covered under the basic, nor does it lift any frequency limitations. It is intended to provide better coverage for out-of-network provider use of medical services.

### **Deductible**

Expenses are considered after an annual deductible has been met. The amount of the deductible is determined by whether the participant has elected the GHI-CBP optional rider or not. 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, GHI Extended Medical 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 80<sup>th</sup> 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) GHI 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**

There is no annual limit on amount reimbursed. There is a cap of \$5 million lifetime.

## **Hearing Aid Benefits**

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.

## **COBRA Continuation of Benefits**

If a retiree's Welfare Fund benefit coverage is lost, the spouse and/or dependent child(ren) may be eligible to 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." A retiree's spouse and eligible 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 (CUNY) basic Health insurance COBRA is available from the offices of the New York City Retiree Health Insurance Program. Enrolling in the (CUNY) New York City basic Health insurance COBRA does **not** assure enrollment in Welfare Fund COBRA and vice versa.

### **Spouse qualifying events include:**

- The participant (retiree) dies, or
- The participant (retiree) obtains a divorce or termination of domestic partnership.

### **Dependent Child qualifying events include:**

- The participant (retiree) dies, 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. A spouse or eligible child may elect COBRA coverage separately.

Because the qualifying event is either the death of the retiree, a divorce, termination of a domestic partnership, or a dependent child's loss of eligibility, COBRA continuation coverage lasts for up to **36 months** for qualified beneficiaries.

## **Notification Responsibilities**

The Fund can offer COBRA continuation coverage to qualified beneficiaries only if properly notified that a qualifying event has occurred. The responsibility for notification rests with the surviving spouse or child(ren). In the case of a divorce, either party may notify the Fund. The Fund Office must be notified with 60 days of the qualifying event.

The CUNY (New York City) Retiree Health Insurance Program requires separate notification.

## **Benefits**

Benefits are the same as those covered before the COBRA event, but with the Medicare status of the qualified beneficiary as the factor determining basic health coverage. The Welfare Fund offers:

Drug\*, optical, hearing aid, extended medical\*\*, and dental,

- \* Diabetic Medication and "PICA" drugs will continue to be available only through NYC basic insurance and will require COBRA continuation of those policies.
- \*\* Only for Non-Medicare enrollees in the GHI-CBP program.

## **Cost of Coverage**

Coverage and premium costs depend upon:

- 1) **Medicare status** of the spouse which determines whether coverage is
  - regular (under 65) or
  - senior care
- 2) 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 COBRA 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 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) Re-marriage that results in the opportunity for comparable group coverage

## **Post-Termination Options**

Upon expiration of the 36-month COBRA period, a spouse may be eligible to continue coverage through the Survivor Benefit (see page 23).

This is for the Welfare Fund only.

Coverage through the CUNY basic program typically expires with finality when COBRA reaches the time limitation.

### **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](http://www.dol.gov/ebsa).

## **Survivor Benefits**

The spouse and/or dependents of an eligible retiree who dies are eligible to purchase Survivor benefits. This may be done in lieu of COBRA or after COBRA benefits expire.

For a premium charge the Welfare Fund provides the following benefits

- Prescription Drugs
- Dental
- Optical
- Hearing Aid
- Major Medical (for persons who qualify as non-Medicare eligible)

It is the responsibility of the surviving spouse/domestic partner/covered dependent to notify the welfare fund office of the death of the covered retiree. Spouse/domestic partner/covered dependent must continue to meet the requirements of eligibility under the Welfare Fund. The 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.

## HIPAA Rights and Protections

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 Two principal components of HIPAA that impact retired participants of this Fund: Privacy and Security.

### **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 be 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.

## **Legal Notice**

### **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 variety 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. The Fund cannot be responsible for unauthorized or inappropriate actions on the part of 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.

### **Special Transition Note**

The particular document you are reading is newly posted on our web site and does yet represent the complete Summary Plan Description which is maintained in the Fund Office. When the process is completed, it will be so indicated