Retiree Summary Plan Description

2011

PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
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*** [1] 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*** [1] 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

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.

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[1] **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.

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

Dependent Eligibility

If you are covered, your **spouse/ same sex spouse/ qualified domestic partner**[2] and/or eligible **dependent child(ren)** are covered. 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.

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2 **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. Retirees who reach age 65 must apply for Medicare Parts A & B to receive full supplemental benefits. Those 65 and over who waive basic coverage from Medicare are not eligible for the Medco prescription drug program.

Persons who waive basic coverage should contact the Fund office.

Enrollment

Benefit officers employed at each CUNY campus in the Human Resources 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 changed, effective 01/01/2007.

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

Guardian Dental Guard Preferred

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

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

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

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

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

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

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

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

Filing a Claim: Claim forms are available by clicking here , 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 here:
Phone: (800) 422-4234
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 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. Retirees age 65 or older must be enrolled in Medicare Parts A and B. 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. *Please note that the Medco Prescription Drug Program restricts coordination of benefits with other drug coverage.*

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 two re-fills of a long-term (maintenance) 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.
- Shingles vaccine
- Weight Management drugs

The following drugs are covered with limitations:

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

Reimbursement Practices

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

Using Mail Order

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

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

Special Accommodations

Travel or Vacation

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

Eligible dependent children away at school

If an eligible dependent child is away at school, a separate card may be made available for that child by contacting the Fund. The initial card is issued at no cost 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

		For information on
Customer Service	(866) 386-3797	- Location of Pharmacies - Direct Reimbursement - Eligibility issues - Mail Order Forms
Web Site	www.medco.com	- 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**, injectable and chemotherapy (IC) medications are available under the **PICA** program. The N.Y. City Retiree Benefits Health Program should be consulted for further detail and updates, tel. 212-306-7200. 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 members, 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 Ætna 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.

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

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 drug coverage through these programs. This drug option is paid for by the PSC-CUNY Welfare Fund. Members who change coverage from one program to another must notify the Fund in order to maintain accurate payment records.

Drug Benefits

Retiree Plan 70

The Fund will reimburse up to $400 per year per family. Claim forms are available from the Fund Office.

Medicare Part D, in lieu of Medco

In 2006 the Federal government enacted a limited, catastrophic drug program for qualified retirees, over age 65 who are covered under Medicare Part A (hospital) and who are 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 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.

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. Eye examinations other than for purchase of glasses or contact lenses are not covered.

General Vision Services

Examination is provided by a licensed optometrist for determination of refractive index as well as detection of cataracts, glaucoma and retinal / corneal disorders. 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 26 a pair of glasses (frame and lenses) every 12 months (known as the “off year” benefit).

Participating Providers: For a listing of General Vision Services Providers or to schedule your appointment on-line, participants may go to www.generalvision.com or call GVS at 1-800-847-4661. For the General Vision Services brochure, click here.

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

Davis Vision

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

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

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

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

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

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

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

Other Providers

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

$100 every two years. Claim Forms are available by clicking here and 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 limited to the initial vendor. All services must be performed within 90 days. Special Note: Split Services are not available for contact lenses. Contact lens prescriptions must be filled by the provider who writes the prescription.

Extended Medical Benefits

Retiree Plan 82 | **Retiree Plan 80**

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

Retirees under age 65 (non-Medicare) who have **basic coverage through GHI-CBP** have an additional level of medical cost protection through the PSC-CUNY Welfare Fund Extended Medical benefit. The benefit is designed to provide a buffer against large medical expenses associated with serious or long-term illness that are not met by the basic employer-provided insurance. The program is administered by Administrative Services Only, Inc. (ASO). It was formerly administered by GHI. This extended medical benefit does not cover procedures that are not covered under the basic, nor does it lift any frequency limitations.

Deductible

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

i.e., 100% of the difference between the amount reimbursed and the reasonable and customary charges according to the schedule.

Limits

Benefits are limited to those covered by the GHI benefit plan. Annual and lifetime caps are in accordance with the GHI contract with the NYC Employee Benefits Program. *Reimbursement claims should be filed no later than 3 months after the end of the calendar year during which medical services and procedures were performed.*

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 eight (8) business days. If premium is not received by the end of the month, coverage is terminated permanently. The Fund does not bill.
3) 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 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. The surviving spouse/ domestic partner/ covered dependent has 30 days from the date of notification to decide to purchase benefits. Spouse/domestic partner/covered dependents 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 converge 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 by directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.

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

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

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

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

- the specific reasons for the denial;

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

Voluntary Benefits

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

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

There are requirements for eligibility and enrollment.

Programs are underwritten and administered by insurance companies and brokers.

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

Voluntary Term Life Insurance

This is a NYSUT Member Benefits Trust-endorsed policy. Limited amounts of coverage are available for those ages 65-84. Those between ages of 65 and 84 may apply for up to $30,000 in coverage, depending on age at issue. Coverage terminates at the billing anniversary date coinciding with or next following the date an insured person attains age 85. Please visit www.memberbenefits.nysut.org for application form and more information. All coverage is subject to medical underwriting.

Voluntary Long-Term Care Insurance

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

The Benefit described here is the John Hancock program specifically designed to meet

the needs of participants of the PSC-CUNY Welfare Fund.

Benefits

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

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

Eligibility

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

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

Enrollment

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

Premium

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

Voluntary Catastrophe Major Medical Insurance

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

Eligibility

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

Deductible

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

Enrollment

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

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

Effective Date

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

Premium

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

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

Benefit Period

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

Survivor's Coverage

Coverage continues for covered dependent spouse or domestic partner and children

as long as the dependents meet eligibility requirements, premiums are paid at the adjusted rate (depending on the survivor's age) and the policy remains in force.

Legal Note

Diligence

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

Actions of Others

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

Beyond Simple Clarifications...

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

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.