



Summary Plan Description

Full-Time Actives



Summary Plan Description for Full-Time Actives

Eligibility

Am I eligible for Welfare Fund benefits?

You are eligible for [supplemental health insurance benefits](#) defined in this Summary Plan Description and provided by the PSC-CUNY Welfare Fund if you are a full-time member of the CUNY professional staff. Qualified Continuing Education Teachers who have basic NYC Health Benefits and certain management personnel and exempt titles are also eligible. A complete list of covered titles is included below. Eligible members must meet all of the following requirements:

- You are paid by tax-levy funds
- You work at least 20 hours a week with an appointment expected to last for more than six months
- Your title is covered within the Professional Staff Congress of CUNY

If the Welfare Fund Enrollment Form and dependent documentation are received by the Fund within 31 days of the date of hire, Welfare Fund coverage will begin on the first day of the month following the date of hire. If you miss the 31-day enrollment period you will not be able to enroll in or make changes to your benefit elections until the next annual Open Enrollment period (held annually in the fall; changes are effective January 1 of the following year), unless you experience an IRS-defined change in status.

Are my dependents eligible for Welfare Fund Benefits?

If you are an employee enrolled in the Welfare Fund Plan, you may enroll your eligible dependents. Your eligible dependents include your legal spouse, your qualified domestic partner and your dependent children, including the children of your spouse or domestic partner, provided they meet the plan requirements listed below.

Domestic partners are qualified if duly registered with the New York City Clerk's Office and able to demonstrate financial interdependence. Certain tax implications apply to benefits for domestic partners you may want to consult with your tax professional.

The Fund defines eligible dependent children as natural or adopted children who are under age 26.

The eligibility for continued coverage of disabled dependent children only applies to current employees whose disabled dependent children reach the age limitation (26) while covered by a NYC HBP health plan. New employees with disabled dependent children already over the age limitation may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage if the child is already over age 26.

Coverage for dependent children (not disabled) ends on the last day of the month that children turn 26.

When does my Welfare Fund benefits coverage start?

Your CUNY campus Benefits Office provides plan descriptions and forms for enrollment in the NYC Health Benefits Program and the Welfare Fund Supplemental Health Insurance Benefits Plan. No benefits are available until enrollment is completed and processed.

When does my Welfare Fund benefits coverage end?

Welfare Fund coverage stops at the end of the month employment terminates. Coverage for dependent children (not disabled) ends on the last day of the month that children turn 26. At the point that coverage terminates, plan participants will be notified of their rights to purchase benefits in accordance with the federal COBRA regulations. This notice is issued by your campus Benefits Office and includes both the NYC Health Benefits Program and Welfare Fund Supplemental Insurance Benefits from the PSC-CUNY Welfare Fund.

What health benefits are covered by CUNY?

Upon enrollment all eligible full-time active employees receive basic health insurance for themselves and eligible dependents through the New York City Health Benefits Program (NYC HBP). Basic health insurance includes hospital and medical coverage provided by one or more carriers chosen by the plan participant. The [NYC HBP Summary Program Description](#) provided by your campus Benefits Office describes your coverage, and additional information is available on the [Office of Labor Relations website](#). If you have questions regarding your basic health insurance, contact your campus Benefits Office.

What happens if I waive my CUNY & Welfare Fund benefits because I have other insurance, but that insurance gets terminated?

An eligible individual who waives personal and/or dependent coverage because of other health insurance may enroll at a later time if that other coverage is terminated or significantly altered. Certain IRS-defined changes in status permit you to make benefits changes during the year that normally can only be made during the annual Open Enrollment period. If you experience an IRS-defined change in status, you have 30 days from the date of the IRS-defined change in status to make any eligible changes. Change(s) must be consistent with the IRS-defined change in status. For example, you may be allowed to make changes to your benefits if you do any of the following:

- Get married or register a domestic partnership
- Get divorced
- Have or adopt a child

- Experience a death
- Have a dependent who loses or gains eligibility elsewhere
- Experience a change in employment status—that is, you or your eligible dependent begins or ends employment, or takes an unpaid leave of absence or family medical leave
- Experience a significant change in medical coverage or cost for you or your eligible dependent
- Move out of your plan's service area

Fund Benefits

What is covered by the PSC-CUNY Welfare Fund Supplemental Benefits Plan?

Upon enrollment, eligible full-time active employees and their eligible dependents have the following benefits at **no payroll deduction** :

- [Dental](#)
- [Prescription Drug](#) (if enrolled in the NYC Health Benefits Program)
- [Vision](#)
- [Basic disability](#)
- [Extended medical](#) (if enrolled in GHI-CBP basic health coverage)
- [Hearing aid](#)

These optional benefits are also available; however, you pay a premium:

- [Optional extended disability](#)
- [Optional term life insurance](#) (first year free if new NYSUT member)

These benefits are in addition to the basic health insurance provided by CUNY through the NYC Health Benefits Program. **Employees who waive coverage from the NYC HBP are eligible for [dental](#), [vision](#) and [hearing aid](#) benefits but are ineligible for the [prescription drug program](#) and the [extended medical benefit](#).**

Dental

How does the Welfare Fund dental benefit work?

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 at no payroll deduction. Neither has a "rider" option.

Guardian Dental Guard Preferred

See the Guardian Fee Schedule

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

1. Access to a panel of [dental providers](#) who charge reduced fees
2. A higher Welfare Fund rate paid to participating dentists (according to the Guardian 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 reducing the value of the benefit. Also, non-participating dentists are not eligible for the higher Welfare Fund rate paid to participating dentists.

The provider panel maintained by Guardian Life is Dental Guard Preferred. Your Group Plan Number is 381084.

Information on participating dentists is available from Guardian on their [website](#) or by phone (1-800-848-4567).

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

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. Pre-treatment review is recommended.

How do I file an out-of-network dental claim?

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

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

What is not covered by my Guardian Dental Plan?

Coverage is not provided for certain types of care. [Treatment exclusions](#) often involve technical matters. There are also [procedural limitations](#) by frequency or age.

DeltaCare USA

This is a dental Health Maintenance Organization. DeltaCare USA will assign a primary care dentist for members upon enrollment. (Once enrolled, you have the opportunity to switch to another participating Delta dentist by calling 800-422-4234.) That dentist will be responsible for all dental care including referral to specialists as necessary. Members will pay for dental services in accordance with a [copay schedule](#) that Delta has negotiated 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 on their [website](#) (Select network for DeltaCare USA) or by phone (1-800-422-4234).

Please be aware that most participating Delta dentists are located in New York and New Jersey. For availability of Delta dentists outside those areas, call Delta or check the Delta [website](#).

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.

Exclusions and Limitations

Coverage is not provided for certain types of care. Be sure to review the [limitations and exclusions](#) for both standard benefits and orthodontic benefits.

Drug

How does the Welfare Fund drug coverage work?

Plan participants must be enrolled in an NYC Health Benefits Program basic health insurance plan to be eligible for the CVS/Caremark Prescription Drug Program.

Participating members will receive a CVS/Caremark prescription drug card unless they elect to purchase an optional drug rider through certain basic health programs. Those who elect a rider over the CVS Plan should refer to the stipend section below. Please note that the CVS/Caremark Prescription Drug Program restricts coordination of benefits with another drug coverage.

What does the CVS Prescription Drug Program cover?

- The plan covers most drugs that legally require a prescription and have FDA approval for treatment of the specified condition(s). Drugs available without a prescription, classified as "over the counter" (OTC), are not covered regardless of the existence of a physician's prescription. The Welfare Fund program through CVS/Caremark encourages utilization of (a) generic equivalent medications, (b) selected drugs among clinical equivalents.
- 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.
- CVS/Caremark has determined a list of drugs that treat medical conditions in the most cost-efficient manner. This [list, or formulary](#), is regularly reviewed and updated by physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-preferred drugs.
- Home delivery (mail-order) or use of a CVS pharmacy is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. After an initial fill and two re-fills of any prescription at a local pharmacy, higher levels of co-payment are assessed for continued use of the retail pharmacy.

Copayment

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

How Much You Pay for a Covered Prescription Drug*			
	Retail Pharmacy (up to a 30-day supply)	CVS/Caremark Mail or CVS Pharmacy (90-day supply)	
	First Three Fills	Each Subsequent Refill	
Generic	20% (\$5 minimum)	35% (\$5 minimum)	20% (\$10 minimum)
Preferred	20% (\$15 minimum)	35% (\$15 minimum)	20% (\$30 minimum)
Non-Preferred	20% (\$30 minimum)	35% (\$30 minimum)	20% (\$60 minimum)

*On July 1, 2014, the maximum benefit limit was lifted in compliance with the Affordable Care Act. Under the current benefit, the member will continue to pay a 20% co-pay until the cost to the Fund reaches \$10,000. When the cost to the Fund is between \$10,000 and \$15,000, the member's co-pay will be 50%.

For Annual Plan Expenditures Between \$10K and \$15K			
	Retail Pharmacy (up to a 30-day supply)	CVS/Caremark Mail or CVS Pharmacy (90-day supply)	
	First Three Fills	Each Subsequent Refill	
Generic	50% (\$5 minimum)	50% (\$5 minimum)	50% (\$10 minimum)
Preferred Formulary	50% (\$15 minimum)	50% (\$15 minimum)	50% (\$30 minimum)
Non-Preferred Formulary	50% (\$30 minimum)	50% (\$30 minimum)	50% (\$60 minimum)

When the cost to the Fund exceeds \$15,000, the member's co-pay will become 80%.

For Annual Plan Expenditures Over \$15K			
	Retail Pharmacy (up to a 30-day supply)	CVS/Caremark Mail or CVS Pharmacy (90-day supply)	
	First Three Fills	Each Subsequent Refill	
Generic	80% (\$5 minimum)	80% (\$5 minimum)	80% (\$10 minimum)
Preferred Formulary	80% (\$15 minimum)	80% (\$15 minimum)	80% (\$30 minimum)
Non-Preferred Formulary	80% (\$30 minimum)	80% (\$30 minimum)	80% (\$60 minimum)

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](#)
- Over the counter drugs (i.e., not requiring a prescription)
- Diabetic medications (refer to your NYC Health Benefits Plan carrier, GHI, HIP, etc.)
- 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 Welfare Fund expenditure 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 (CVS, Duane Reade, Rite Aid, Walgreen, etc.) 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 (very rare) or without presenting a drug card may require payment in full. In such cases, CVS/Caremark 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.

Using Mail Order

To use mail order, participants may register on the [CVS/Caremark website](#) or use the [Mail Service Order Form](#). Physicians may call 1-866-209-6177 for instructions on how to FAX a prescription.

Standard shipping and handling are 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 CVS 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. 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.

How to Contact CVS/Caremark

Call Customer Service at 1-866-209-6177 for

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms

Visit the [CVS/Caremark website](#) for:

- Interactive Pharmacy Locator
- Claim Form Download
- Mail-order tracking
- Formulary Drug Listing

Other (Non-CVS/Caremark) Drug Coverage:

NYC PICA Program through Express Scripts

There are some drugs for which participants do not use the CVS/Caremark card, but instead use another card, not issued by the Welfare Fund. For eligible full-time active participants, Injectable and Chemotherapy medications are available only through the **PICA Drug Program**, which is sponsored by the N.Y. City Employee Health Benefits Program and the Municipal Labor Committee. At the time of this writing it is administered by Express Scripts. Call the [NYC Health Benefits PICA Drug Program](#) (212-306-7464) for further detail and updates. Eligible individuals will be issued a drug card for PICA coverage.

Stipend for Rx coverage in lieu of CVS/Caremark

Eligible full-time active participants who wish to opt out of the Welfare Fund drug plan may purchase a drug rider through their basic health carrier if their carrier is CIGNA, HIP Prime POS, or GHI HMO. This may be elected at the time of employment or during any open enrollment period through the city of New York. The plan participant will receive a stipend to offset out-of-pocket costs. 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 Welfare Fund drug plan.

0\$ Generic Copay Program and 10% Generic Copay Program

Beginning January 1, 2020, Active, Adjunct members and Retirees under 65 enrolled in the PSC-CUNY Welfare Fund Prescription Plan will have no copay when filling a prescription for a generic drug included in the Welfare Fund's CVS [\\$0 Generic Copay Formulary](#) and when the

prescription is filled at a CVS pharmacy or through the CVS Mail program. Generic drugs purchased outside of a CVS pharmacy are not included in the program.

How does the \$0 Generic Copay Program work?

Here are examples of prescription fills to clarify the service eligible for the benefit:

Example: A member who fills a prescription for a generic drug listed on the \$0 generic copay formulary at CVS or CVS mail facility would not pay a copay.

Example: A member who fills a prescription for a generic drug listed on the \$0 generic copay formulary at a retail pharmacy other than CVS will not have a reduced copay, and the claim will be processed according to the Welfare Fund Prescription Plan's current tiered copay schedule. This means most members using non-CVS pharmacies will continue to pay a 20% copay.

Members should be aware that the \$0 generic copay formulary list may not include the medications they are taking, but they will be able to take advantage of the 10% Generic Copay Program.

Generic drugs on the [Welfare Fund Drug List](#) that are not included in the \$0 Generic Copay Formulary are reduced from 20% to 10% when the prescription is filled at CVS or CVS mail **until the Welfare Fund's costs reach the Tier 1 limit** (when the Fund has paid \$10,000 in annual drug expenses).

When the member reaches the **Tier 1** limit the copay will increase to the **Tier 2** copay of 50% until the **Tier 2** limit is reached (when the Fund has paid \$15,000 in annual drug expenses).

At that point the member's copay will move up to the **Tier 3** copay of 80%.

Importantly, when the member reaches the **Tier 1** limit they should then be eligible to apply for copay reimbursement under the new [High-Cost Rx Program](#).

Therefore, members who anticipate their drug costs may exceed the annual Tier 1 limit (\$10,000 in the Welfare Fund's drug expenses) should SAVE ALL CVS PRESCRIPTION DRUG RECEIPTS! Receipts for all CVS prescription purchases will be required for High-Cost Rx Program reimbursement claims.

High-Cost Rx Program

This new program goes into effect Jan. 1, 2020. The High-Cost Rx Program is designed to include an additional \$25,000 of coverage for out-of-pocket prescription drug costs when certain conditions are met. The plan is designed to assist Active, Adjunct members and Retirees under 65 who are enrolled in the PSC-CUNY Welfare Fund Prescription Plan, and who are experiencing significant out-of-pocket drug expenses.

How does the High-Cost Rx Program work?

Fund members will be able to apply for reimbursement when their Welfare Fund prescription drug expense exceeds \$10,000 and their eligible out-of-pocket costs exceed \$2,500 on an annual basis. The Fund will reimburse up to \$25,000 per person per plan year. The first \$2,500 of out-of-pocket is treated as a deductible and not eligible for reimbursement.

PSC-CUNY Welfare Catastrophe Major Medical (CMM) policy holders are required to file claims to Mercer Consumer/AIG before submitting to the Welfare Fund and must include a claim rejection from Mercer/AIG as part of claim to the Fund reimbursement plan.

How do I make a claim?

Members must submit the following to ASO:

- [High-Cost Rx Program Claim Form](#)
- Cashier's receipt AND
- Rx package receipt that shows:
 - Patient's full name
 - Name of Drug
 - Date of Service
 - Amount paid
 - Any Coupons

Examples of eligible receipts are [here](#). CVS/Caremark member portal claims printouts are NOT accepted as receipts.

What claims are eligible for reimbursement?

- All in-network pharmacy claims may be eligible for reimbursement if they are for drugs on the PSC-CUNY Welfare Fund's CVS formulary or drugs with a valid Prior Authorization
- Specialty Drug claims are eligible ONLY through the CVS Specialty program

What costs are NOT eligible and DO NOT COUNT towards Deductible and/or Accumulators?

The following are not eligible:

- Dispensing penalties
- Copay costs:
 - Already paid by Manufacturer's Copay Assistance of Pharma Co.

- Related to Ineligible Drug Claims
- Related to other non-CVS specialty program drug expenses

What drug costs are not eligible for reimbursement?

The following drugs are not eligible for reimbursement:

- PICA drugs (covered by NYC Health Benefits Program)
- Diabetes drugs (covered by basic health insurance)
- Drugs not included in the Welfare Fund CVS formulary or plan
- Erectile Dysfunction (ED) drug coverage maximum (up to \$500)
- ACA preventive list drugs (list available on pscunywf.org)
- Drugs covered by any provider other than PSC-CUNY Welfare Fund Prescription Plan
- Specialty Drug claims not purchased through the CVS Specialty program

When can a claim be submitted?

Claims must be submitted on a quarterly basis according to the following dates:

Q1 (Jan. 1 – Mar. 31) on or after April 15

Q2 (Jan. 1 – June 30) on or after July 15

Q3 (Jan. 1 – Sept. 30) on or after Oct. 15

Q4 (Jan. 1 – Dec. 31) on or after Jan. 15

Claims will not be accepted until the 15 day following the end of the quarter. Claims will be accepted up to March 31st of the following year for claims with date of service in the prior plan year. Only one (1) claims submission per quarter will be accepted.

IMPORTANT: When your eligible out-of-pocket copay costs exceed \$2,500 you should make a claim for reimbursement at the earliest quarterly date, even if it is only for a small amount. That will insure timely processing for full copay reimbursement in the next quarter.

Please be aware fraudulent claims are grounds for permanent disenrollment from the Fund Plan.

Vision

Plan participants and their eligible dependents are entitled to a pair of glasses (lenses and frames and an optometric examination) once every 12 months (24 months for out-of-network providers). This benefit can be rendered through the vendor contracted by the Fund, Davis Vision, or through other licensed providers.

How does the Davis Vision plan work?

Service through Davis Vision has no out-of-pocket costs for a limited selection of frames and lenses. Service rendered through other providers is subject to a maximum reimbursement of up to \$200. If you use a provider that is not part of Davis Vision, [a Direct Reimbursement claim form](#) should be submitted within 90 days of service. In order for the Fund to maintain accurate records, reimbursement claims should be submitted and will only be accepted once every two years (24 months), no matter the amount.

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

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

You may choose any Fashion, Designer or Premier-level frame from Davis Vision's Frame Collection, free of charge.

If you visit a Davis Vision participating provider and you select a non-plan frame, a \$100 credit, plus a 20% discount will be applied. This credit would also apply at retail locations that do not carry the Frame Collection.

If you visit a Davis Vision Visionworks location, and choose a non-plan frame, a \$175 credit plus 20% discount is available.

Members are responsible for the amount over \$100 (or \$175 at a Visionworks location), less the applicable discount.

Lenses

A range of special lenses and coatings is available with no co-payment at any in-network provider. For a complete list, see the [Davis Vision brochure](#).

Contact Lenses

In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision's Contact Lens Collection are available at no charge. Evaluation, fitting and follow-up care will also be covered. The Davis Vision Premium Contact Lens Collection includes disposable (8 boxes) and standard replacement lenses (4 boxes).

Members may use their \$150 credit, plus a 15% discount toward non-Davis Vision Collection contact lenses, evaluation, fitting and follow-up care.

Visually required contact lenses will be covered up to \$105 with prior approval and may be prescribed only for certain medical conditions, such as Keratoconus.

Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. The Davis Vision collection is available at most participating independent provider locations.

Special Dependent Coverage: Dependent children up to age 19 are allowed a pair of glasses (frame and lenses) every 12 months (known as the "off year" benefit). There is no reimbursement from the Fund for Special Dependent Coverage from non-participating providers.

Eye examinations are covered through a participating Davis Vision 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.

How do I find a participating Davis Vision eyeglass store?

Access Davis Vision's website at www.davisvision.com and use the "Find a Doctor" feature (On the Davis homepage, click on the "Members" tab, which will bring you to a menu. Type in the client code 2022 and submit) or call 1.800.999.5431 for the names and addresses of the network providers nearest you. Call the network provider of your choice and schedule an appointment. Identify yourself as a PSC-CUNY Welfare Fund member or dependent and Davis Vision member. Provide the office with your name, SS# and the name and date of birth of any covered member/dependent needing services. The provider's office will verify your eligibility for services. You may also create a personal account by logging onto the Davis Vision website. See the Davis Vision benefit brochure [here](#).

What if I don't go to Davis Vision?

Any licensed provider of vision services may be used as an alternative to Davis Vision providers. The reimbursement will cover frames, lenses or contact lenses costs not to exceed \$200 (for service provided after Jan. 1, 2017) every two years. A [claim form](#) should be submitted within 90 days of service.

Disability

How does the Fund's disability insurance work?

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

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

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

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

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

The basic plan applies to all eligible participants without additional premium contributions.

Welfare Fund Continuation of Benefits During Disability Payment Period

Other Welfare Fund benefits continue for the duration of the benefit payment period, including the waiting period. (The Prescription Drug benefit is limited to members who maintain enrollment in a basic health insurance plan.) The benefit payment period may end for a variety of reasons, most typically the end of the disabling condition or return to work, or attainment of the maximum age or duration limit of the benefit, whether it is the basic coverage or the extended coverage. **When the benefit payments stop, eligibility for other benefits also stops** .*

A brochure providing more detailed information on the PSC-CUNY Welfare Fund Long Term Disability Program is part of the material distributed to each new employee who will be a plan participant.

An [insurance certificate](#) explains the features of the long term disability plan through the Standard Life Insurance Company. Copies of the insurance certificate are also available off-line and may be requested through a campus Benefits Officer or by contacting the PSC-CUNY Welfare Fund. [An Important Notice relating to claims made on the Plan on or after April 1, 2018, and the right to request a review, is herein posted.](#)

*This description was expanded and clarified, April 2011.

Extended Medical

What medical costs will the Fund partially reimburse?

Plan participants who have basic coverage through GHI-CBP have an additional level of medical cost protection through the PSC-CUNY Welfare Fund extended medical benefit. The benefit is designed to provide a buffer against large medical expenses associated with out-of-network physicians and services that are not reimbursed in full by your basic GHI-CBP plan. The program is administered by Administrative Services Only, Inc. (ASO). This extended medical benefit does not cover procedures that are not covered under the basic health plan, nor does it lift any frequency limitations.

How does the deductible work?

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

How much will the Fund reimburse?

After the deductible is met, the Welfare Fund extended medical benefit will pay 60% of the difference between the amount paid by GHI and the allowed charges. Allowed charges are determined by a schedule maintained by the contracted administrator and set, as well as changed from time to time, at the discretion of the Trustees of the Fund. 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 allowed charges according to the schedule.

Limits

Benefit limits are in accordance with the GHI contract with the NYC Employee Benefits Program. **Reimbursement claims must be filed no later than March 31 of the year following the calendar year during which medical services and procedures were performed. Members who are participating in the group [Catastrophic Major Medical benefit](#) must first [submit reimbursement claims to The United States Life Insurance Company in the City of New York](#) .**

Life Insurance

What life insurance coverage is available to me?

Many newly-hired full-time CUNY employees covered by the PSC-CUNY Welfare Fund will receive Term Life Insurance with a face value of up to \$25,000 for one year, with the option to purchase coverage at the end of the year with no medical underwriting. The premium is determined by the age of the participant at the point of purchase.

The benefit is sponsored by the New York State United Teachers (NYSUT) Member Benefits Trust and is available to all CUNY employees who are eligible for PSC-CUNY Welfare Fund benefits. **Persons who were members of NYSUT prior to employment by CUNY are not eligible for this "first year" benefit .**

Eligible employees (dues-paying members of the PSC) under age 40 are automatically enrolled and receive a certificate of coverage in the mail. Those age 40 and over will receive the no-cost coverage if they can successfully answer several medical questions as part of a simplified issue offer. Upon completion of one year, an option is provided to continue coverage by paying a premium. For further information, please refer to [Optional Life Insurance](#).

Employees not in the PSC collective bargaining unit (management and other excluded titles) must contact the Welfare Fund to begin the enrollment process.

Death Benefit

The PSC-CUNY Welfare Fund provides a \$2,500 death benefit to the beneficiary of a full-time covered member who dies while in active service. Members must fill out form, available from their campus HR and benefits office, and have it on file at the benefits office. If members wish to change beneficiary(ies), a new form needs to be completed.

Designated beneficiaries have one year from the member's date of death to file a claim with the Welfare Fund office.

Hearing Aid

How does the HearUSA plan work?

Hearing aid benefits are available to you and your covered dependents every 36 months. The Fund has chosen HearUSA to be the exclusive hearing aid network to provide members and their eligible dependents with a program for hearing tests and hearing aids.

You can purchase a hearing aid for a discounted price from HearUSA or use a nonparticipating provider and receive direct reimbursement of up to \$500 every 36 months. **For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum \$500 direct reimbursement.**

To obtain service from HearUSA, members begin by calling the toll-free number (800) 442-8231 to schedule an appointment with a provider. You will be given the names of three participating HearUSA practitioners in your area and the nearest HearUSA store. You may continue to request additional names of participating practitioners until you are satisfied with your choices. If you have a specific hearing aid manufacturer in mind, you may also request the names of nearby HearUSA participating practitioners who carry hearing aids from that particular manufacturer. HearUSA offers hearing aids from 11 manufacturers.

Members and Dependents are eligible for:

- Free annual hearing screening
- In-plan Hearing Aid Benefit \$1,500 per ear (\$3,000 total) every 36 months.
- Guaranteed price discounts on all hearing aids
- Unlimited visits during the first year of purchase (adjustments, cleaning programming)
- Loaner hearing aids available when your hearing aids are being serviced
- 3-Year Warranty: repair and one-time replacement due to loss or damage (deductible applies)
- 3-Year supply of batteries
- 12-Month interest free financing available
- 10% off hearingshop.com for accessories and batteries using code EARUSA
- Out-of-network maximum direct reimbursement of \$500 every 36 months in lieu of in network purchase. **For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum \$500 direct reimbursement.**

To learn more or to make an appointment with a HearUSA provider, you must contact HearUSA directly at (800) 442-8231 and let them know that you are a member of the PSC-CUNY Welfare Fund, so they can determine your eligibility.

Wellness

How does the NYC Weight Watchers program work?

The NYC Weight Watchers program is a partnership between Weight Watchers and the City of New York. With the City's program, **employees have access to a subsidy reducing the cost** of membership by more than 50% off the regular price. Benefit-eligible **dependents (spouses, children 18-26) and retirees can enjoy discounted pricing**. Spouses and dependents of retirees are not eligible for the discount. The dollar value of this contribution/benefit will be included as taxable income to the employee.

Meetings (includes OnlinePlus)	
Employees	\$15/Month
Spouses/Domestic Partners/Dependents (over age 18)/Retirees	\$30/Month

OnlinePlus	
Employees	\$7/Month
Spouses/Domestic Partners/Dependents (over age 18)/Retirees*	\$14/Month

*Spouses and dependents of retirees are not eligible for the discount.

Before you begin:	View Registration Instructions for Employees
	View Registration Instructions for Retirees

[View the FAQs](#)

[View the At Work Meeting Schedule](#)

[Join Weight Watchers](#)

Optional Benefits

Optional benefits 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. They include:

- [Optional extended disability](#)
- [Optional term life insurance](#)

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 paid by the participants themselves.
- There are requirements for eligibility and enrollment.
- Programs are underwritten and administered by insurance companies and brokers.

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

Extended Disability

How can I extend my disability coverage beyond the basic plan?

After one year of service participants may elect to purchase the **Optional Extended Long-Term Disability plan**. If the election is made **within 60 days** of the anniversary of the date of hire, no medical evaluation is required to qualify, and acceptance is guaranteed. **Later elections require a medical evaluation by the carrier**. The medical forms are available here for residents of [New York](#), [New Jersey](#), [Connecticut](#) or [Pennsylvania](#). Address is on the form.

Total disability is defined as **the inability to work in any job for which you are fitted by education, training or experience, due to an illness or injury**. The carrier for this benefit is **The Standard Life Insurance of New York**.

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

For a premium that is generally met through payroll deduction the benefits are improved three ways:

- **Income replacement is at 60% of pre-disability basic salary** with a minimum of \$1,500 per month and a maximum of \$6,000 per month. Actual payment is net of required deductions, as described above.

- **The duration of payments is not constrained to five years** but extends from inception to age 65. If the participant is over 60 on the disability effective date, the five-year/age-70 provision of the basic plan applies.
- **Pension payments are made** on behalf of the participant to a TIAA-CREF (defined contribution) pension in the amount of 10% of pre-disability basic salary.

The premium is determined by an age and salary matrix available from the carrier or from the PSC-CUNY Welfare Fund. It will change from time to time with changes to salary and increases to age. The plan year begins April 1st. Premium changes according to age and salary will be reflected in the employee's paycheck deduction or billing at the start of the applicable plan year.

Welfare Fund Continuation of Benefits During Disability Payment Period

Other Welfare Fund benefits continue for the duration of the benefit payment period. The benefit payment period may end for a variety of reasons, most typically the end of the disabling condition or return to work, or attainment of the maximum age or duration limit of the benefit, whether it is the basic coverage or the extended coverage. **When the benefit payments stop, eligibility for other benefits also stops.***

A brochure providing more detailed information on the PSC-CUNY Welfare Fund Long Term Disability Program is part of the material distributed to each new employee who will be a plan participant.

An insurance certificate explaining the features of the long term disability plan through the Standard Life Insurance Company is available [here](#). Copies of the insurance certificate are also available off-line and may be requested through a campus Benefits Officer or by contacting the PSC-CUNY Welfare Fund. [An Important Notice relating to claims made on the Plan on or after April 1, 2018, and the right to request a review, is herein posted.](#)

[Certificate Amendment: Corporate Address Change.](#)

This description was expanded and clarified, April 2011.

Life Insurance

What group life insurance is available to members?

If under age 65, you and your spouse can apply for up to \$1 million in Term Life insurance and \$1 million in Level Term Life Insurance at premiums negotiated specifically for NYSUT members. If you are between the ages of 65 and 84, you may be eligible for a lesser amount of insurance. The life insurance is underwritten by Metropolitan Life Insurance Company, and the program is administered by Mercer Consumer.

For more information on how to apply, please review these [Frequently Asked Questions](#). For links to online applications, follow this link to [NYSUT Member Benefits Term Life Insurance](#) .

Long-Term Care

Closed to New Enrollments

Enrollment in the benefit described here is closed. This description is meant to serve as a brief overview of the John Hancock program for current plan participants. A complete policy certificate is available to plan participants by calling 888-513-2071 or 800-543-7108.

Welfare Fund members who wish to enroll in a long-term care program may choose a benefit endorsed by New York State United Teachers (NYSUT). Information on the program offered by New York Long Term Care Brokers is available [here](#).

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.

Some plan benefits vary according to personal choices made at the time of enrollment and during periodic premium rate increases. However, all participants have contracted for a specific Daily Maximum Benefit (DMB), usually an amount between \$100 and \$350, which is the most the insurance may pay for all covered services received on any day, for a term of four or five years, depending on the contract.

Participants become eligible for benefits when a John Hancock Coordinator verifies that eligibility requirements have been met. Generally, this is when the participant needs substantial assistance by another person to perform two or more of the five Activities of Daily Living: bathing and/or dressing, eating, transferring, toileting, and maintaining continence, due to loss of functional capacity which is expected to continue for at least 90 days. Benefits begin when a 90-day Qualification Period has been completed.

Personal Policy Information

Coverage under the plan varies according to choices made by policy holders at the time of enrollment and during periodic premium rate increases. For specific details, plan participants must refer to the individual *certificate* issued by the John Hancock company. **If a certificate has been lost or misplaced, participants must call John Hancock at 888-513-2071 or 800-543-7108 for a replacement.**

Catastrophic Major Medical

Enrollment in the benefit described here is closed. This description is meant to serve as a broad overview of the Welfare Fund Catastrophe Major Medical program for current policy holders.

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.

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.

[Catastrophe Major Medical Insurance Description](#) from Mercer Consumer

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 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.

Thinking of Retiring?

How do I get ready to retire?

Before making an appointment with the Retirement Benefits Counselor, please answer [this questionnaire](#) and email the information to Welfare Fund Retiree Benefits counselor Sandra Zaconeta, szaconeta@psccunywf.org.

Many of your questions must be directed to CUNY HR, the Teachers Retirement System or TIAA. Here's [a list of those questions and who to contact](#).

For information on the retirement process, Travia leave, retiree benefits, forms, etc., begin with the Benefits Office at your campus or workplace. CUNY holds pre-retirement information seminars throughout the year. Your [benefits officer](#) will have the dates.

If you have a Teachers' Retirement System pension, call [\(888\) 869-2877](tel:(888)869-2877) and schedule an appointment at the TRS office on 55 Water Street. Visit the very useful [TRS website](#).

If you have a TIAA retirement account, meet with the TIAA representative on your campus.

Take a look at the Thinking of Retiring Checklist:

- One to two years before your expected retirement date, meet with Human Resources at your college and with the Welfare Fund pension counselor.
- A year before your retirement, consider requesting a [Travia Leave](#) form from HR. If your intention is to take a spring Travia, go to HR during Thanksgiving week. If your intention is to take a fall Travia, go to HR during spring break.
- After you've submitted a Travia Leave form, meet with HR about the various other forms that need to be filed, e.g. health, pension, Medicare reimbursement, etc.
- When you meet with HR, ask if they have some form of "clearance check-list" that requires the library, building facility, or other departments to sign-off that you have returned any library books, building keys, etc.
- If you are 65 or older, apply for Medicare Part B three months before your Travia leave ends. Doing so will help ensure Medicare becomes your primary insurance at the time of your retirement.

- While on Travia, contact your retirement plan and fill out all the necessary forms. Keep a copy of all documents given to both HR and the retirement system and get signed receipts.
- If you are paying for optional benefits by payroll deduction, contact insurers to be billed directly at your home. Payment by pension deduction comes later.
- In the weeks before you retire, obtain a college retiree I.D. card to use in the library and other facilities (per Article 27.6 of the PSC/CUNY contract).
- To continue your NYSUT member benefits and to stay active with the PSC, update your status with the [PSC membership department](#) and join the [Retirees Chapter](#).

If You Take a Leave of Absence

What are my benefits while on leave from CUNY?

Plan participants who go on employer-approved leave with or without pay are covered for up to 24 months for the following supplemental benefits:

- Prescription Drugs
- Dental
- Vision
- Hearing Aid
- Disability
- Death
- Extended Medical (if basic health coverage is GHI-CBP)

The Extended Medical benefit is available only if the basic GHI coverage is in place.

The CVS Prescription Drug Plan benefit from the Welfare Fund is available only if basic health coverage is maintained.

If CUNY does not provide basic health coverage for any portion of the 24-month period, it must be obtained via [COBRA](#) or other direct payment in order to qualify for full Welfare Fund benefits coverage. Participants taking a leave of absence must provide the Welfare Fund with a letter stating how their basic health coverage is being maintained while on leave.

If basic health coverage is in place, benefits are available to participants during a leave of absence to the same extent as they were prior to a leave. Benefits continue to apply to eligible dependents.

If You Die in Service

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

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

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

- Prescription Drugs
- Dental
- Vision
- Hearing Aid
- Extended Medical (if applicable)

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

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

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

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

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

COBRA

What if I lose my benefits coverage?

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

COBRA provides for a continuation of benefits when coverage would otherwise terminate due to a "**qualifying event**." Specific qualifying events are listed below. After a qualifying event, COBRA coverage is made available to each person who is a "qualified beneficiary." Participants (employees), spouses and dependent children may become qualified beneficiaries. Those who elect COBRA continuation coverage must pay a premium which is established by the Fund actuaries in accordance with Federal COBRA regulations.

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

Employee qualifying events include:

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

Spouse qualifying events include:

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

Dependent Child qualifying events include:

- The participant (employee) dies,
- The participant (employee)'s hours of employment are reduced to the extent plan eligibility is lost,

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

Qualified Beneficiaries and Duration of Benefit

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

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

There are circumstances that may extend the eligibility period:

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

Other coverage options besides COBRA: Health Insurance Marketplace Instead of enrolling in COBRA continuation coverage, there may be other insurance options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plans (such as a spouse's plan) under what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage and provide greater flexibility. By obtaining coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options at www.healthcare.gov.

Notification Responsibilities

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

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

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

Choice of Coverage

Coverage and premium costs depend upon three factors:

- Qualified beneficiary's selection of " **Core coverage** " or " **Full coverage** "
- Core coverage includes Drug, Hearing Aid and Extended Medical (as applicable)
- Full coverage includes core coverage (above) plus Vision and Dental
- the CUNY **Basic Health Insurance** of the participant:
 - GHI-CBP/Blue Cross
 - All other carriers, or
 - None
- **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.

When does COBRA coverage end?

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

- exhaustion of the basic and (if applicable) extended periods as defined herein
- 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.
- removal or reversal of the conditions of the qualifying event. This includes but is not limited to employment or re-employment or re-marriage that results in the opportunity for comparable group coverage
- Medicare eligibility

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 want 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](#) .

HIPAA

How is my personal health information (PHI) protected?

The PSC-CUNY Welfare Fund is bound by federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund is in full compliance with all relevant parts of the Act. The full text of HIPAA can be found through the [HIPAA website of the Office for Civil Rights \(OCR\)](#). There are four components of HIPAA that impact participants of this Fund: Portability, Non-Discrimination, Privacy and Security.

Portability

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

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

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

reduce or eliminate exclusion for pre-existing coverage periods that may apply to you, your spouse, and/or your dependents under the new group health plan or health insurance policy. The Certificate of Creditable Coverage will be provided to you if you should request it within twenty-four (24) months after your eligibility for Welfare Fund benefits ends.

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

Non-Discrimination

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

Privacy

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

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

Obligations of the Fund to use or disclose PHI

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

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

- To facilitate treatment or to coordinate or manage health care with covered providers, vendors or insurers, or to facilitate payment by provision of information regarding eligibility to covered providers, vendors or insurers.
- To promote quality assurance in support or programs designed to enhance quality of care with covered providers, vendors or insurers or to contact the participant for the provision of information designed to better avail plan features.
- In response to public health risks, to report reactions to medications, or to report victims of abuse, neglect or domestic violence, or in response to a court or administrative order,

subpoena, discovery request or other lawful process, but only after reasonable efforts have been made to inform the participant.

- To comply with workers' compensation laws and other similar legally established programs which provide benefits for work-related injuries or illnesses.

Rights of the Fund to disclose PHI without 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

How do I ask for a review of a benefits decision?

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 pursue a review.

Type of Review

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

- 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.
- An appeal of a negative benefits decision related to a non-insured product (CVS 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.

- An appeal of a negative benefits decision related to an insured product (Standard Life Disability, Hancock Long-Term Care, AIG Catastrophe Major 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, the denial will include:

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

Other Important Info

Diligence

This document is known as a Summary Plan Description. By its very nature, this is a condensation of many pages of 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 CUNY, the NYC Health Benefits 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.

Appendix

Covered Titles

Full-Time Covered Titles for PSC-CUNY Welfare Fund

Faculty Titles

Professor Associate Professor Assistant Professor Distinguished Professor Chairperson of College Department University Professor Distinguished Lecturer Lecturer Instructor Instructor

(Nursing Science) Continuing Education Teacher (must be appointed to a position that will continue for more than six months and that requires a minimum of 20 hours per week)

Registrar Titles

Senior Registrar Registrar Associate Registrar Assistant Registrar

College Lab Tech Titles

Chief College Laboratory Technician Senior College Laboratory Technician College Laboratory Technician

Medical Title

College Physician

Research Titles

Research Associate Research Assistant

Higher Education Officer Titles

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

Substitutes and Visiting Titles

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

Hunter Campus School Titles

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

Medical School Titles

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

Law School Titles

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

Employment Opportunity Center Titles

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

Management Titles

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

EOC Management Titles

EOC Director EOC Associate Director EOC Assistant Director EOC Coordinator

Building Maintenance, Security and Professional Titles

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

Guardian Dental Exclusions

- Purely cosmetic treatment
- More than one prophylactic visit every 4 months
- Temporomandibular joint (TMJ) dysfunction
- Replacement of stolen or lost appliances
- Services that do not meet commonly acceptable dental standards
- Services covered under Basic Health Insurance
- Any service or supply not included on Guardians List of Covered Services
- Procedures related to or performed in conjunction with non-covered work
- Educational, instructional or counseling services
- Precision attachments, magnetic retention or overdenture attachments
- Replacement of a part of above
- Services related to overdentures e.g., root canal therapy on supporting teeth

- General anesthesia or sedation, except inhalation sedation related to periodontal surgery, surgical extractions, apicoectomies, root amputations or certain other oral surgical procedures
- Local anesthetic, except as part of procedure
- Restoration, procedure, appliance or device used solely to alter vertical dimension, restore or maintain occlusion, treat a condition resulting from attrition or abrasion or splint or stabilize teeth for periodontal reasons
- Cephalometric radiographs or oral/facial imaging
- Fabrication of spare appliances
- Prescription medication
- De-sensitizing medicaments or resins
- Pulp viability or caries susceptibility testing
- Bite registration or analysis
- Gingival curettage
- Localized delivery of chemotherapeutic agents
- Maxillofacial prosthetics
- Temporary dental prosthesis or appliances except interim partials to replace anterior teeth extracted while covered
- Replacing an existing appliance, except when it is over 10 years old and deemed unusable or it is damaged by injury while covered and not reparable.
- A fixed bridge replacing the extracted portion of a hemisected tooth
- Replacement of one or more unit of crown and/or bridge per tooth
- Replacement of extracted / missing third molars
- Treatment of congenital or developmental malformations
- Endodontic, periodontal, crown or bridge abutment procedure or appliance related to tooth with guarded or worse prognosis
- Treatment for work-related injury
- Treatment for which no charge is made
- Detailed or extensive oral evaluations
- Evaluations and consultations for non-covered services

Guardian Contract Limitations

- Two Prophylaxes (1110 or 1120) or Periodontal Maintenance Treatments (4910) per calendar year.
- Two Fluoride Treatments (1201 or 1203 or 1205), limited to under age 14, per calendar year.

- One Unilateral Space Maintainer (1510 or 1520), limited to under age 16 and replacing lost/extracted deciduous teeth, per arch per lifetime.
- One Bilateral Space Maintainer (1515 or 1525), limited to under age 16 and replacing lost/extracted deciduous teeth, per arch per lifetime.
- One Emergency Palliative Treatment (9110) in any 6-month period.
- One Full-Mouth Series or Panoramic Film (0210 or 0330) in any 60 consecutive month period.
- One Sealant Treatment to Permanent Molar (1351), limited to under age 16 on unrestored tooth, per tooth in any 36 consecutive month period.
- One Diagnostic Consultation by Non-treating Dentist (9310) per dental specialty in any 12 consecutive month period.
- Appliance to Control Harmful Habits (8220) limited to under age 14.
- Replacement of Amalgam Restoration (2110 through 2161) only after 12 or more months since prior procedure, if under age 19.
- Replacement of Amalgam Restoration (2110 through 2161) only after 36 or more months since prior procedure, if age 19 or older.
- Replacement of Resin Restoration (2330 through 2388) only after 12 or more months since prior procedure, if under age 19.
- Replacement of Resin Restoration (2330 through 2388) only after 36 or more months since prior procedure, if age 19 or older.
- One Crown (2336 or 2337 or 2710 or 2930 - 2933) per tooth in any 24 consecutive month period.
- Recement Bridge (6930) only after 12 or more months since initial insertion.
- One Denture Rebase (5710 or 5711 or 5720 or 5721) per 24 consecutive month period and only 12 or more months after insertion.
- One Denture Reline (5730 through 5761) per 24 consecutive month period and only 12 or more months after insertion.
- One Denture Adjustment (5410 or 5411 or 5421 or 5422) in any 24 consecutive month period.
- One Tissue Conditioning (5850 or 5851) per arch per 12 consecutive month period and only 12 or more months after denture insertion.
- One Periodontal Root Planing (4341), with evidence of bone loss, per quadrant in any 24 consecutive month period.
- One Periodontal Scaling (4341), in the absence of related work in prior 36 months, per quadrant in any 36 consecutive month period.
- One Distal or Proximal Wedge (4274), with evidence of periodontal disease of each tooth, per quadrant per 36 consecutive month period.

- One Gingivectomy or Crown Lengthen (4211 or 4249), with evidence of periodontal disease of each tooth, per 12 consecutive month period.
- One Soft Tissue Graft or Subepithelial Connective Tissue Graft (4270 or 4271 or 4273), per quadrant in any 36 consecutive month period.
- One Bone Graft or Guided Tissue Regeneration (4263 or 4266 or 4267) per tooth or area, in a lifetime period.
- Two visits for Occlusal Adjustment (9951 or 9952), with appropriate evidence, in any 6 month period after scaling / root planing / osseous surgery.

Guardian Dental Program Limitations by Best Practice or Cosmetic Determinants

- Labial Veneers are covered only for decay or injury to permanent tooth that cannot be restored with amalgam or composite filling
- Resin Restoration (2330 through 2388) limited to anterior teeth. Resin Restoration to posterior teeth is reimbursed at amalgam rates.
- Specialized techniques and characterizations for Bridge Abutments, Crown (6791 or 6792) are not covered.
- Crowns (2720 through 2792), Buildups(2950), Inlays/Onlays (2510 through 2664) and Core Buildups for Retainer (6973) only with decay or injury when the tooth cannot be restored with amalgam or composite filling material. Permanent teeth only.
- Cast Post and Cores (2952 through 2972) only with decay or injury, when done in conjunction with a covered unit of crown or bridge and when needed substantial loss of tooth structure. Permanent teeth only.

Delta Exclusions and Limitations

- Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance);
- Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
- Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
- Crown(s) and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement;
- Denture relines are limited to one per denture during any 12 consecutive months;
- Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months;
- Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;

- Bitewing x-rays are limited to not more than one series of four films in any six month period;
- A full mouth x ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
- Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits also include the repair or replacement of a sealant on any tooth within three years of its application by the same Contract Dentist who placed the sealant;
- Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;
- Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist's usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment;
- Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment;
- Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspid;
- A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, nonfunctional bridge and it meets the five year limitation for replacement;
- Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;
- Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis;
- Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment;
- Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's filed fees for the covered procedure and Optional treatment, plus any Copayment for the covered procedure;

Delta Dental HMO – Standard Benefit Exclusions

- General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
- Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;
- Treatment required by reason of war, declared or undeclared;
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
- Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities which are medical in nature;
- Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
- Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;
- Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;
- Cysts and malignancies which are medical in nature;
- Prescription drugs;
- Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;
- Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;
- Prophylactic removal of impactions (asymptomatic, nonpathological);
- "Consultations" for noncovered procedures;
- Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
- Placement of a crown where there is sufficient tooth structure to retain a standard filling;

- Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information;
- Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;
- Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
- Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
- Soft tissue management (irrigation, infusion, special toothbrush);
- Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
- Restorative work caused by orthodontic treatment;
- Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations

The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in the Description of Benefits and Co-payments (Schedule A) subject to the following:

- Orthodontic treatment must be provided by a Contract Orthodontist;
- Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months;

- For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed \$75 per month;
- Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist;
- Three re-cementations or replacements of a bracket/band on the same tooth or a total of five re-bracketings /re-bandings on different teeth during the covered course of treatment are benefits. If any additional re-cementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the contract orthodontist's usual fee;
- The Co-payment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Co-payment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment;

Delta Dental HMO – Orthodontic Benefit Exclusions

- Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
- Re-treatment of orthodontic cases;
- Surgical procedures incidental to orthodontic treatment;
- Myofunctional therapy;
- Surgical procedures which are medical in nature related to cleft palate, micrognathia, or macrognathia;
- Treatment related to temporomandibular joint disturbances which are medical in nature;
- Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to, palatal expander, habit control appliance, pendulum, quad helix or herbst;
- Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed \$75 per month;
- Restorative work caused by orthodontic treatment;
- Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
- Extractions solely for the purpose of orthodontics;

- Treatment in progress at inception of eligibility;
- Patient initiated transfer after bands have been placed;
- Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

* Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.