Summary Plan Description
Retirees

Summary Plan Description for Retirees

Eligibility

Who is covered by the Welfare Fund Supplemental Benefits plan for retirees?

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

Retiree Plan 82 includes members who retired September 1, 1982, or later and who meet all of the requirements listed below.

Retiree Plan 80 includes members who retired prior to August 31, 1982, and who meet the **Rule of 80** and who meet all of the requirements listed below. The Rule of 80 applies to retirees who-at the time of retirement-were at least 55 years old and whose age plus years of service in a covered CUNY title equaled or exceeded 80.

Retiree Plan 70 includes members who retired between June 30, 1970, and August 31, 1982 but who do not meet the Rule of 80 (described above) and who meet all requirements listed below.

What are the eligibility requirements for Welfare Fund retiree benefits?

- You must be collecting a pension through a CUNY-related program
- You must be eligible for retiree health coverage through the NYC Health Benefits Program
- You must be eligible for Welfare Fund benefits at the point of retirement

How do I enroll in retiree benefits?

At the time you file your CUNY retirement papers the benefit officers employed at each CUNY campus in the Human Resources Department will provide eligible persons with information packets and enrollment applications for **both the basic health insurance plans and Welfare Fund supplemental benefits** . Completed applications must be returned to the Human Resource office for processing. Welfare Fund applications are forwarded to the PSC-CUNY Welfare Fund by the college.

When does coverage end?

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

Fund Benefits

What is covered by the Welfare Fund Supplemental Benefits plan?

The PSC-CUNY Welfare Fund provides the following supplemental retiree benefits: dental, prescription drugs, vision and hearing benefits. These benefits are described in this Summary Plan Description. Some of these Welfare Fund benefits vary according to whether the retiree is over or under age 65

What if I am a retiree who is under 65 years old?

You are eligible to apply for Welfare Fund retiree benefits if you are eligible for CUNY basic health insurance (NYC Health Benefits Program) as a retiree. If you waive CUNY basic health insurance, you will not be eligible for the Welfare Fund Prescription Drug Plan. Your Welfare Fund benefits will be limited to Dental, Vision and Hearing.

What if I am a retiree who is over 65 years old?

You are eligible to apply for Welfare Fund Supplemental Benefits coverage if you are enrolled in both Medicare Part A & Part B. If you are eligible for Medicare Parts A & B but not enrolled in either program you will not be eligible for any prescription drug coverage.

Persons who waive basic health insurance coverage through the NYC Health Benefits Plan should contact the Fund office.

Dental

Retiree Plan 82

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 here.

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 981572 El Paso, TX 79998-1572

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.

Retiree Plan 80

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

Retiree Plan 70

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

Drug

How does the Welfare Fund drug coverage work?

Retiree Plan 80 and Retiree Plan 82

Plan participants must be enrolled in Medicare A & B to be eligible for the Welfare Fund SilverScript Medicare Part D Prescription Drug Program.

Retirees who are not yet Medicare-eligible, please refer to the **CVS/Caremark Prescription Plan** described in the section following this one.

SilverScript Medicare Part D Prescription Plan *for Medicare-eligible Retirees*

Effective January 1, 2012, all Medicare-eligible retiree participants who qualify for the Welfare Fund retiree drug coverage are enrolled in a joint Welfare Fund-Medicare Part D prescription program. This includes all Medicare-eligible dependents of retiree members of the Welfare Fund. Eligible dependents under age 65 will continue to be covered by the regular (non-Medicare) CVS/Caremark plan. In order for a participant to be eligible for the drug benefit, the primary participant must be enrolled in the NYC HBP basic health insurance program. Retiree participants residing outside of the U.S. cannot participate in the Medicare program.

Upon eligibility, participants will be issued a new SilverScript card and are entitled to fill prescriptions at any pharmacy or through the CVS/Caremark mail order program, subject to the terms and conditions of the benefit.

What drugs are covered by the Welfare Fund program?

The plan covers drugs that legally require a prescription and have FDA approval for treatment of the specified condition. Restrictions and limitations are listed on the following pages. Drugs available without a prescription or classified as "over the counter" (OTC) are not covered, regardless of the existence of a physician's prescription. The Welfare Fund program, administered by SilverScript, encourages utilization of (a) generic equivalent medications and (b) selected drugs among clinical equivalents.

(a) If a generic equivalent medication is available and you or your physician choose it, you pay the standard co-payment for a generic drug.

(b) SilverScript has a list of preferred drugs called a formulary. This list of predominantly brand name drugs is regularly reviewed and updated by physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-formulary drugs.

Deductible, Annual and Lifetime Limits

As of January 1, 2012, the Welfare Fund Retiree Drug benefit for Medicare-eligible participants has no annual deductible and no annual or lifetime limitation on allowable drug expenditures.

Co-payment

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

How Much You Pay for a Covered Prescription Drug			
Retail Pharmacy (up to a 90-day supply)			
	Retail, 31 days	**Retail, 90 days**	
Generic	**If filled at CVS** : No Copay for Generics on SilverScript Formulary	**If filled at CVS** : No Copay for Generics on SilverScript Formulary	No Copay for Generics on SilverScript Formulary
Preferred Formulary	20% ($15 minimum)	20% ($45 minimum)	20% ($30 minimum)
Non-Preferred Formulary	20% ($30 minimum)	20% ($90 minimum)	20% ($60 minimum)

The co-payment levels above refer only to that phase in any calendar year when total drug expenditure is not yet in the "catastrophic phase" as defined by the Medicare Part D program. The "catastrophic phase" is determined by calculations on behalf of each individual and is currently no more than $10,000 per year. Those who attain the catastrophic level in any year will be pay a reduced co-pay of 5% for the balance of the year.

Non-Covered or Restricted Drugs

The program does not cover the following:

- Fertility drugs
- Growth hormones
- Experimental and investigational drugs
- Over the counter drugs
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers' Compensation
- Weight Management drugs

The following drugs are covered with limitations:

- Drugs for erectile dysfunction up to an annual maximum reimbursement of $500, with a maximum of 18 tablets every 90 days.
- Smoking cessation drugs up to an 84-day supply
- Medication taken or administered while a patient in a hospital rest home, extended care facility, convalescent hospital, nursing home or similar institution.

Reimbursement Practices

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

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

Using Mail Order

Participants may obtain a CVS/Caremark Mail Service Order Form here. Physicians may call 1-866-881-8573 for instructions on how to FAX a prescription. 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 participant.

Special Accommodations

Travel or Vacation

If a larger than normal supply of medication is required, a participant may contact SilverScript 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.

When to Contact SilverScript

Call SilverScript customer service, 866-881-8573, or visit the SilverScript website, for information on:

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms
- Interactive Pharmacy Locator
- Claims Form Download
- Mail-order tracking
- Formulary Drug Listing
- Replacing Lost Prescription Drug Cards

CVS/Caremark Prescription Drug Program for Retirees Not Enrolled in Medicare

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/Caremark Plan 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.

As of January 1, 2021, along with the medications that are removed as a result of Annual Formulary changes, brand-name medications that have generic equivalents are no longer covered.

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. The Welfare Fund Drug List is regularly reviewed and updated by

physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-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.

Co-payment

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 Will I 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	: No Copay for Generics on Welfare Fund Drug List	35% ($5 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	: No Copay for Generics on Welfare Fund Drug List 50% ($5 minimum)	50% ($5 minimum)	No Copay for Generics on Welfare Fund Drug List
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	If filled at CVS: No Copay for Generics on Welfare Fund Drug List 80% ($5 minimum) at all Non-CVS pharmacies	80% ($5 minimum)	No Copay for Generics on Welfare Fund Drug List
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

Beginning July 1, 2021, Retirees under 65 enrolled in the PSC-CUNY Welfare Fund Prescription Plan, as well as Retirees enrolled in the SilverScript Medicare Part D Prescription Plan will have no copay when filling a prescription for a generic drug included in the PSC-CUNY Welfare Fund Drug List (under 65) or the SilverScript Formulary (for Medicare-eligible retirees) 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 Welfare Fund Drug List or the SilverScript 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 Welfare Fund Drug List or the SilverScript Formulary at a retail pharmacy other than CVS will not have a reduced copay. This means most members using non-CVS pharmacies will continue to pay a 20% copay.

Retirees Under 65

Member copays for generic drugs on the Welfare Fund Drug List purchased at non-CVS pharmacies are 20% ***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 for generics purchased at non-CVS pharmacies 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 copay for generics purchased at non-CVS pharmacies 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

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 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 Jennifer Melfi at the Welfare Fund, jmelfi@psccunywf.org:

- High-Cost Rx Program Claim Form
- Receipts (CVS pharmacy cashier's receipt, CVS mail order invoice or CVS Specialty Pharmacy invoice) AND
- Rx package receipt that shows:
  - Patient's full name
  - Name of Drug
  - Date of Service
  - Amount paid
  - Any Coupons

Here are examples of eligible receipts:

- Pharmacy Cashier's Receipt
- Mail Order Invoice/Receipt
- Specialty Pharmacy Invoice

CVS/Caremark member portal claims printouts are NOT accepted as receipts. **Generic drugs that cost less than $10 do not require receipts but must still be listed on the Claim Form.**

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 ONLYthrough 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 psccunywf.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.

Have you moved to a temporary address?

If you have moved to a temporary address for the duration of the Covid-19 period, please attach a note to your Hi-Cost Rx Claim form that indicates your reimbursement check should be mailed to your temporary address. Otherwise, reimbursement checks will be mailed to the permanent address you have on file with the Welfare Fund.

Vision

What is covered by my Vision benefit?

Retiree Plan 82, Retiree Plan 80 and Retiree Plan 70

Plan participants and their eligible dependents are entitled to a pair of glasses (lenses and frames and an optometric examination) once per calendar year, to be purchased at any time during the calendar year. 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 per year, no matter the amount.

Eye examinations are covered through a participating Davis Vision provider when made in conjunction with the purchase of glasses or contact lenses. Eye examinations other than for purchase of glasses or contact lenses are not covered. **Glasses must be purchased on the date of the examination. Split services are not permitted within the provider network.**

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.

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.

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 once per year. A claim form should be submitted within 90 days of service.

Hearing Aid

If you need help with your hearing aid during the pandemic office closures, please call HearUSA at 800-442-8231, not your audiologist.

How does the HearUSA benefit work?

Retiree Plan 70, Retiree Plan 80 and Retiree Plan 82

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 (small 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.

Extended Medical

What is Extended Medical coverage?

Plan 82 and Plan 80 Under Age 65

Retirees under age 65 (non-Medicare) who have **basic health insurance 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 *non-hospital* 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.

Deductible

Expenses are considered after an annual deductible has been met. The amount of the deductible is determined by whether the participant has elected the GHI-CBP optional rider or not. If the participant has elected the rider, the deductible is $1,000 per person for the year, with a maximum of $2,000 for a family. If the participant has not elected the rider, the deductible is $4,000 per person for the year, with a maximum of $8,000 for a family. The

amount that is applied to calculate the deductible is the total difference between the GHI-CBP allowance on covered services and the participant's payment to the provider for those services.

Coinsurance

After the deductible is met, the Welfare Fund extended medical benefit will pay 60% of the difference between the amount reimbursed 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 caps 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.**

Wellness

How does the NYC Weight Watchers program work?

The NYC Weight Watchers programis apartnership 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

What optional benefits are available to retirees?

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 currently include only **Term Life Insurance** , provided by the NYSUT Member Benefits Trust.

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

There are requirements for eligibility and enrollment.

Programs are underwritten and administered by insurance companies and brokers.

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

Please be aware that enrollment in the group Catastrophe Major Medical and Long Term Care plans previously offered through the Welfare Fund are currently closed. If and when we have a date for open enrollment, we will announce it on the website homepage.

Life Insurance

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

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 require 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
Closed to New Enrollees

The PSC-CUNY Welfare Fund Catastrophe Major Medical Plan is closed to new enrollment. The information provided below is for the use of 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.

Eligibility

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

Deductible

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

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) pension deduction (with the Pension Deduction Authorization), 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.

When You Retire

What happens to my health insurance when I retire?

When you retire, both your basic health insurance and your supplemental health insurance may continue. The basic health plan for hospitalization and major medical insurance (such as GHI-CBP/Empire Blue Cross, for example) remains available to eligible retirees under 65 participating in the New York City Health Benefits Program. Retirees also continue to receive the supplemental health insurance benefits (dental, optical, prescription drugs, etc.) provided by the PSC-CUNY Welfare Fund. To be eligible for coverage in retirement, you must be:

- collecting a pension through a CUNY-related program
- be eligible for Welfare Fund benefits at the point of retirement, and
- be eligible for basic coverage through the NYC retiree health program.

Preparing for Self-Pay

Between the time you go off payroll deduction and the time you go on pension deduction, there is a period of self-pay for:

- Catastrophic Major Medical (Mercer Consumer)
- John Hancock Long Term Care
- NYSUT Member Benefits Trust Programs (i.e., life insurance)

During this time, you must have direct pay arrangements, such as automatic bank withdrawals (will be continued if already in place) or direct premium remittance (e.g., by personal check). The insurance carrier can bill you, but there is a risk that the bill will get lost or you overlook it or mistake it for a general solicitation. If you do not pay (regardless of the reason), your coverage may be cancelled permanently, or you may be required to provide medical qualification, which could lead to cancellation. It is very important that you make sure that each insurance carrier has your correct mailing address, phone number and e-mail address.

For benefit provider phone & email contacts, see the Contacts Page.

If you are not sure of what coverage you have as you're about to retire, make sure that you check your pay stub and understand each deduction. You can also consult the bi-annual communication from NYSUT for clarification.

What happens when I become eligible for Medicare?

New York City policy requires retirees who reach age 65 to apply for Medicare B, which becomes their primary health insurance. Their City benefits insurance plan (GHI, HIP, etc.) becomes their secondary coverage. Likewise, The PSC-CUNY Welfare Fund follows the NYC HBP policy. To enroll in the Welfare Fund SilverScript prescription drug program, retirees who reach age 65 are required to enroll in Medicare Part B. Likewise, when a dependent spouse/partner reaches age 65, enrollment is Medicare Part B is mandatory. The City benefit plan, such as GHI, continues but becomes secondary coverage.

You (or your covered dependent) should apply for Medicare Part B approximately three months before reaching age 65 by contacting your local Social Security Administration (1-800-772-1213). If your dependent is under the age of 65 but is receiving Social Security disability payments for 24 months or more, your dependent must also apply for Medicare B.

Do NOT enroll yourself or your dependent spouse/partner in ANY Medicare Part D drug program. Medicare-eligible retirees participating in the Welfare Fund Medco drug plan are enrolled by the Fund in the SilverScript Medicare Part D Prescription Plan when their Welfare Fund retiree enrollment forms are processed. Enrollment in other Medicare Part D plans makes you ineligible for Welfare Fund drug coverage.

Medicare Part B requires a monthly premium that is automatically deducted each month from your Social Security check and usually changes each January 1. You can contact the Social Security Administration for the current premium.

If you are a TRS/ERS retiree, the City will reimburse you and your eligible dependents on Medicare for a portion of the monthly premium for Medicare Part B. You must be receiving a City pension check and be enrolled as the contract holder for City health benefits in order to receive reimbursement. You must notify the NYC Health Benefits Program (40 Rector Street, 3rd floor, New York, NY, 10006) in writing immediately upon receipt of your and your dependent's Medicare card. Medicare Part B reimbursements will be made to retirees who elect Medicare as primary coverage.

If you are a TIAA-CREF retiree, you are also eligible for a partial reimbursement of the monthly Medicare Part B premium if you are:

- receiving a TIAA-CREF retirement annuity check, and
- enrolled in the New York City Health Benefits Program as the contract holder, and
- enrolled in and paying premiums for Medicare Part B.

In addition, your spouse/domestic partner and/or disabled dependent may be eligible to receive Medicare Part B reimbursement in the year in which you retire (or in the year he or she becomes eligible for Medicare Part B following your retirement date) if he or she is enrolled in Medicare Part B and covered under your retiree health benefits plan.

TIAA-CREF retirees must submit a Medicare Part B Application for Reimbursement form, available here at the bottom of the Forms page or from your College Human Resources Office. Complete and forward the application to Hollace Humphrey, The City University of New York, 395 Hudson St., New York, NY 10014. You must include a copy of the Health Insurance and Medicare Part A and Part B cards for yourself and eligible spouse/domestic partner and/or disabled dependent(s). Reimbursements are not permitted for retirees who live outside of the United States.

Medicare Part B reimbursement checks are processed in the year following your retirement. The City will generally process the payments once a year for those who retired during the previous calendar year. As a result, the application approval process may take six months or more depending on the application submission date.

For More Information

If you have questions about your benefits in retirement contact the New York City Health Benefits Program at ***212 513-0470*** . You can visit their website at www.nyc.gov/html/olr. You can also call the Welfare Fund at 212-354-5230, or e-mail us at communications@psccunywf.org.

Detailed information and advice about Medicare is available online from the Medicare Rights Center (MRC) [www.medicarerights.org] or by calling its Consumer Hotline (1-800-333-4114). MRC provides counseling to individuals who need answers to Medicare-related questions or help getting care. Hotline counselors are available Monday through Friday, 9AM - 6PM.

Survivor Benefits

What if I pre-decease my benefit dependents?

The spouse and/or dependents of an eligible retiree who dies are eligible to purchase Welfare Fund survivor benefits, at a rate of $1,735 per year (2019 rate). This may be done in lieu of COBRA or after COBRA benefits expire. These benefits do NOT include basic medical/hospital insurance.

For a premium charge the Welfare Fund provides the following benefits:

- Prescription Drugs
- Dental
- Vision
- Hearing Aid
- Extended Medical Coverage (for persons not yet Medicare-eligible)

It is the responsibility of the surviving spouse/domestic partner/covered dependent to notify the Welfare Fund office of the death of the covered retiree. The surviving spouse/domestic partner/covered dependent has 30 days from the date of notification to decide to purchase

benefits. Spouse/domestic partner/covered dependents must continue to meet the requirements of eligibility under the Welfare Fund. The coverage is available only to those without other comparable coverage. Failure to pay the premium will discontinue coverage permanently. Application forms are provided upon notification of the Fund, 212-354-5230.

COBRA

What is COBRA?

The right to continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 otherwise known as COBRA. COBRA refers to the Consolidated Omnibus Budget Reconciliation Act, a federal law that may let you keep your employer group health plan coverage for a limited time after your employment ends or after you would otherwise lose coverage. This is called “continuation coverage,” according to the Center for Medicare & Medicaid Services. Group coverage under COBRA usually lasts up to 18 months, although it may be extended to 36 months under certain circumstances.

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

Welfare Fund COBRA coverage is separate and apart from basic Health Insurance COBRA coverage. Information on (CUNY) basic Health Insurance COBRA is available from the offices of the New York City Retiree Health Insurance Program. Enrolling in the (CUNY) New York City basic Health insurance COBRA does **not** assure enrollment in Welfare Fund COBRA and vice versa.

Spouse qualifying events include:

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

Dependent Child qualifying events include:

- The participant (retiree) dies, or
- The child loses eligibility as a "dependent child"
- Qualified Beneficiaries and Duration of Benefit

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. A spouse or eligible child may elect COBRA coverage separately.

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

Notification Responsibilities

How is the Fund notified?

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

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

What benefits am I entitled to under COBRA?

Benefits are the same as those covered before the COBRA event, but with the Medicare status of the qualified beneficiary as the factor determining basic health coverage. The Welfare Fund offers Dental, Drug*, Extended Medical**, Hearing Aid and Vision benefits.

*Diabetic, "PICA," and ACA Preventative Medications will continue to be available only through NYC HBP basic health insurance and will require COBRA continuation of those policies.

** Only for Non-Medicare enrollees in the GHI-CBP program.

Cost of Coverage

What determines the cost of COBRA Coverage?

- **Medicare status** of the spouse/dependent(s), which determines whether coverage is
  - New York City Basic Health Insurance (if under 65) or
  - Medicare Supplemental (such as GHI SeniorCare)
  - NYC HBP insurance planof 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. The Welfare Fund supplemental benefits rates are available from campus benefit offices or from the PSC-CUNY Welfare Fund, or at the PSC-CUNY Welfare Fund's website, psccunywf.org

Termination of COBRA Coverage

When does COBRA continuation coverage end?

It 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.
- Re-marriage that results in the opportunity for comparable group coverage.

Post-Termination Options

Upon expiration of the 36-month COBRA period, a spouse may be eligible to continue coverage through the Survivor Benefit. This is for the Welfare Fund only. Coverage through the CUNY basic program typically expires with finality when COBRA reaches the time limitation.

More Information

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

HIPAA

Protection of Personal Health Information

The PSC-CUNY Welfare Fund is bound by federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund is in full compliance with all relevant parts of the Act. The full text of HIPAA can be found through the HIPAA Privacy Web site of the Office for Civil Rights (OCR). There are two principal components of HIPAA that impact retired participants of this Fund: Privacy and Security.

Privacy

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

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

Obligations of the Fund to use or disclose PHI:

- When requested by a plan participant.
- When required by city, state or federal law or requested in the course of an inquiry into the Fund's compliance with federal privacy law.
- Rights of the Fund to disclose the minimal necessary PHI without Authorization:
- To facilitate treatment or to coordinate or manage health care with covered providers, vendors or insurers, or to facilitate payment by provision of information regarding eligibility to covered providers, vendors or insurers.
- To promote quality assurance in support or programs designed to enhance quality of care with covered providers, vendors or insurers or to contact the participant for the provision of information designed to better avail plan features.
- In response to public health risks, to report reactions to medications, or to report victims of abuse, neglect or domestic violence, or in response to a court or administrative order, subpoena, discovery request or other lawful process, but only after reasonable efforts have been made to inform the participant.
- To comply with workers' compensation laws and other similar legally established programs which provide benefits for work-related injuries or illnesses.

Rights of the Fund to Disclose PHI with Authorization:

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

Rights of the Participants Regarding PHI Disclosure:

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

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

Security

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

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

Review and Appeals

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 request a review.

Type of Review

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

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

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

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

- what additional information may relevant, and
- which procedures should be followed to get further review or file an appeal.

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

Type of Appeal

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

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, a letter to the member will state:

- 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 concise contracts that the Fund holds with a number of insurance carriers and vendors. The officers of the Fund have used best efforts to assure that these terms are conveyed completely, accurately and in useable form. To the extent that ambiguities are perceived, or interpretation differs, the contracts govern and supersede language employed herein.

Notice of Grandfathered Status

The PSC-CUNY Welfare Fund believes this Plan of benefits is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health

coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 212-354-5230 or communications@psccunywf.org. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov

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

Beyond Simple Clarifications

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

Rights of the Trustees

The Board of Trustees has a fiduciary responsibility to assure the financial health of the Fund. The Trustees intend to continue the programs described in any of the Fund's Plans of Benefits indefinitely. Nevertheless, the Trustees continue to reserve the right, which they are given in the Fund's Trust Indenture, subject to the provisions of any applicable collective bargaining agreement, to terminate or amend any of the plans or programs of benefits. Summary Plan Descriptions are made available to you by the Fund office for your convenience and describe the benefits administered by the Fund and those that you can purchase from other providers. However, each benefit plan or program is always subject to: a) the full terms of each contract between the Fund and the benefit's or program's provider or administrator as it is described in the contract between the Fund and the provider or administrator or b) the applicable insurance policy at the time the claim occurs.

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

Appendix

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

- Three 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 dedicuous teeth, per arch per lifetime.
- One Bilateral Space Maintainer (1515 or 1525), limited to under age 16 and replacing lost/extracted dedicuous teeth, per arch per lifetime.
- One Emergency Paliative 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 bicuspids;
- 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.