Summary Plan Description
Retirees

Prescription Drug Benefit (Retirees)

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.

↑ Back to contents

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.

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 90-day supply)	Retail, 31 days	Retail, 90 days
Generic	**If filled at CVS:** No Copay for Generics on SilverScript Formulary 20% ($5 minimum) at all Non-CVS pharmacies	**If filled at CVS:** No Copay for Generics on SilverScript Formulary 20% ($15 minimum) at all Non-CVS pharmacies
Preferred	20% ($15 minimum)	20% ($45 minimum)
Non-Preferred	20% ($30 minimum)	20% ($90 minimum)

CVS/Caremark Mail or CVS Pharmacy (up to a 90-day supply)	Cost
Generic	No Copay for Generics on SilverScript Formulary
Preferred	20% ($30 minimum)
Non-Preferred	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

↑ Back to contents

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 You Pay for a Covered Prescription Drug*

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List **20% at all Non-CVS pharmacies**	35% ($5 minimum)
Preferred	20% ($15 minimum)	35% ($15 minimum)
Non-Preferred	20% ($30 minimum)	35% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (up to a 90-day supply)	Cost
Generic	No Copay for Generics on SilverScript Formulary
Preferred	20% ($30 minimum)
Non-Preferred	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)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List 50% ($5 minimum) at all Non-CVS pharmacies	50% ($5 minimum)
Preferred	50% ($15 minimum)	50% ($15 minimum)
Non-Preferred	50% ($30 minimum)	50% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	50% ($30 minimum)
Non-Preferred	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)	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)
Preferred	80% ($15 minimum)	80% ($15 minimum)
Non-Preferred	80% ($30 minimum)	80% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	80% ($30 minimum)
Non-Preferred	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.

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

↑ Back to contents

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.

↑ Back to contents

$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] 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 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.

↑ Back to contents

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, 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 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 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 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 15th
Q2 (Jan. 1 – June 30) on or after July 15th
Q3 (Jan. 1 – Sept. 30) on or after Oct. 15th
Q4 (Jan. 1 – Dec. 31) on or after Jan. 15th

Claims will not be accepted until the 15th 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.

↑ Back to contents

Save as a pdf

This page Entire

Contacts

CVS/Caremark
866-209-6177
caremark.com

SilverScipt

Retirees in Medicare
866-881-8573
Website

Related Content

Provider Contacts
FAQs
Forms
Emblem Health Covers PrEP Medications at No Copay
Low-Dose Statins, No Copay from Emblem Health
Preventive Meds Covered by GHI-CBP
NYC “PICA” Drug Program for Injectable and Chemo Drugs
Your 3 Drugs Cards & When to Use Them
In-depth Background on Your Drug Coverage